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A 000	Initial Comments Initial Comments: TYPE OF SURVEY: Standard Survey and Covid-19 Focused Infection Control Census: 112 Sample Size: 5 The facility is not in substantial compliance with all of the standards in the New Jersey Administrative Code 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs. The facility must submit a plan of correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations. The Standard Survey, conducted 02/02/2022 - 02/04/2022, resulted in three immediacy situations. A revisit was conducted on 02/19/2022. The facility remained out of compliance due to one of the immediacy situations still being present. An additional revisit was conducted on 03/19/2022 and the facility was back in compliance.	A 000		
A 310	8:36-3.4(a)(1) Administration (a) The administrator or designee shall be responsible for, but not limited to, the following: 1. Ensuring the development, implementation, and enforcement of all policies	A 310		

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A 310	Continued From page 1 and procedures, including resident rights; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the Administrator failed to develop and implement an effective infection control and prevention program (ICPP) and failed to ensure fire safety procedures were followed for an emergency fire exit door, Fire Exit Door #14 on the 400 Unit of the facility, which was not functioning and was barricaded. These deficient practices and the non-compliance with the requirements placed all residents' health and safety at risks, and likely to cause serious harm, injury, impairment, or death to residents which included the following: 1) failure to screen all staff entering the building for [redacted] symptoms; 2) failure to ensure that staff changed disposable gloves between patient; 3) failure to ensure that staff performed hand hygiene (washing or sanitizing hands) after removing disposable gloves; 4) failure to ensure that staff wore appropriate personal protective equipment (PPE - protective clothing) when in patient [redacted] rooms; 5) failure to ensure that staff donned (put on) and doffed (removed) [redacted] correctly; 6) failure to ensure that all staff wore	A 310		

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A 310	Continued From page 2 NJ Ex Or masks (masks that offer NJ Ex Order 26.4(b)(1) over their nose and mouth when interacting with residents or in resident hallways; 7) failure to ensure that staff maintained a closed door on a NJ Ex Order 26.4(b)(1) resident's room as part of the facility's NJ Ex Order 26.4(b) plan (a plan designed to limit transmission o NJ Ex Order 26.4(b)(1) 8) failure to ensure that a NJ Ex Order 2 resident was NJ Ex Order 26.4(b)(1) for 14 days after the resident's admission; and 9) failure to ensure the Emergency Fire Exit #14 was functioning and the door was barricaded shut. Findings included: Infection Control 1. On 2/3/22 at 8:36 AM, the surveyor observed Certified Medication Aide (CMA) #5 from the hallway of the NJ Ex O Unit of the facility. CMA #5 was not wearing a mask while escorting a resident out of resident Room # NJ Ex Ord CMA #5 confirmed that she was not wearing a mask and stated that the facility expectation was that staff were to wear masks when in resident areas. 2. On 02/03/2022 at 9:05 AM, in the entranceway of the facility, the surveyor observed the Executive Director (ED) entering the facility, NJ Ex Order 26.4(b)(1) with a NJ Ex Order 26.4(b)(1) located on the entranceway wall, and then walked into the facility. A surveyor's review of a facility document titled, " NJ Ex Order 26.4(b)(1) Screening Roster - Staff," dated NJ Ex Order 26.4(b)(1), indicated that employees were to respond to screening questions and document their NJ Ex Order 26.4(b)(1) when reporting to work. The surveyor also reviewed the facility policy titled, "Infection Prevention Readiness for COVID-19," undated, which revealed that all employees were	A 310		

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A 310	Continued From page 3 to be screened for signs and symptoms of NJ Ex Order 26.4(b)(1) when they report to work. The surveyor did not observe the ED complete the NJ Ex Order 26.4(b)(1) screening questions nor documented the temperature reading before reporting for work and entering the facility (on NJ Ex Order 26 On 02/04/2022 at 12:25 PM, the surveyor interviewed the ED. During the interview, the ED was unable to describe the screening process, including the facility's policy to complete the screening questions when entering the facility to report for work. The ED acknowledged that the facility policy was not followed. 3. On 02/03/2022 at 9:31 AM, the surveyor conducted an observation at the NJ Ex O Unit of the facility and observed a precaution sign posted at the door of Room # NJ Ex Ord The NJ Ex Order 26.4(b)(1) sign indicated that staff were to wear gloves, a NJ Ex Order 2 and a face mask when entering Room NJ Ex Ord CMA #3 was observed entering the room to provide the resident medication wearing only a NJ Ex Or mask. During an interview with the surveyor, Certified Medication Aide (CMA #3) stated that she thought the resident might be on NJ Ex Order 26.4(b)(1)) due to having NJ Ex Order 26.4(b)(1). On 02/03/22 at 12:25 PM, the surveyor interviewed the Assistant Director of Nursing (ADON) who stated that the resident in Room # NJ Ex O was on NJ Ex Ord due to suspected NJ Ex Order 26.4(b)(1) based on the resident's symptoms. On 2/03/2022 at 12:41 PM, the surveyor interviewed the Director of Nursing (DON). The DON stated that the facility expectation was that	A 310		

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staff would wear the PPE indicated on signs posted outside of residents' rooms. The DON acknowledged that the facility was not following its policy.

Surveyor's review of a facility policy titled, "Infection Prevention Readiness for COVID-19," undated, revealed that if a resident was suspected or known to have COVID-19, any staff entering those resident rooms should wear a gown, gloves, face shield, and N95 mask (a mask that provides a higher level of protection from infectious disease transmission).

A review of a facility policy titled, "Outbreak Plan," undated, revealed that staff were to follow transmission-based precautions (TBP - additional protective measure used to prevent the spread of infectious diseases) when indicated to provide safe resident care. Further review showed that staff were to implement TBP when entering a resident's room based on signage posted at the door of the resident's room.

4. On 02/03/2022 at 12:00 PM, observations on the [redacted] Unit revealed NJ Ex Order 26.4(b)(1) signs on Room #[redacted] The door to the room was open to the common area of the unit. During an interview conducted on 02/04/2022 with the DON, the DON stated that staff were to close the bottom portion of the room doors for any residents who were on NJ Ex Order 26.4(b)(1). The DON stated that if doors were left open on the NJ Ex Order 26.4(b)(1) rooms, the facility was not following its policy.

5. On 2/3/22 at 12:02 PM, during an observation conducted on the [redacted] Unit, CMA #3 was observed wearing a [redacted] mask under the tip of her nose. CMA #3 stated that it was a

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facility-provided mask and that CMA #3 had not been fit tested (a test done to ensure that a mask fits an individual's face in a way to ensure optimum protection from respiratory particles) for that mask. CMA #3 stated that the mask made her hot and nauseated, and that CMA #3 preferred to wear the mask below her nose. CMA #3 acknowledged that was not the correct way to wear a mask.

6. On 2/3/22 at 12:10 p.m., on [redacted] Unit of the facility, the surveyor observed Home Health Aide (HHA) #1 delivering a meal tray to resident at Room #[redacted] a [redacted] room, wearing gloves upon entering the room and exiting the room. The surveyor did not observe HHA #1 don nor doff any personal protective equipment (PPE) prior to entering the [redacted] room. HHA #1 was picking up another food tray for delivery when the surveyor interviewed her. HHA #1 stated that she should have changed her gloves and washed her hands before delivering another tray. She stated she should have put on full PPE prior to entering the room to deliver the lunch tray.

7. On 02/03/2022 at 12:12 PM, the surveyor observed HHA #2 carrying a lunch tray into Room #[redacted] a [redacted] room, without wearing PPE. Upon surveyor's interview, HHA #2 stated that she did not wear the correct PPE into Room #[redacted] and that she was supposed to put on a [redacted] gloves [redacted], and get a new mask. HHA #2 stated, "No, I did not do that right. We are just trying to get the food out." At 12:16 PM, HHA #2 was again observed entering another [redacted] room, Room #[redacted] without donning any PPE.

At 12:25 PM, the surveyor interviewed the Assistant Director of Nursing (ADON). The

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A 310	Continued From page 6 ADON stated that the staff had received numerous trainings regarding changing gloves, hand washing, and donning and doffing of PPE. The ADON stated that the expectation was that staff should have been donning and doffing full PPE when entering and exiting any room with a resident on [NJ Ex Order 26.4(] precautions. The facility did not provide a policy regarding PPE. However, a review of facility policy titled, "Infection Control" dated 03/08/2007, revealed that staff were to perform hand hygiene after removing gloves. 8. On 02/03/2022 at 12:27 PM, during an observation on the [NJ Ex O] Unit, the surveyor observed HHA #3 donning PPE to enter an [NJ Ex Order 26.4(] room. HHA #3 was observed dragging the [NJ Ex Order] on the floor while trying to tie the neck so she could slip it over her head. After donning [NJ Ex Order 26.4(b)(] she put on her [NJ Ex Order 26.4(b)(1)] and gloves. HHA #3 was already wearing an [NJ Ex O] mask with a surgical mask over it. HHA #3 exited the room wearing full PPE. HHA #3 removed the [NJ Ex Or] and dropped it onto the floor, potentially contaminating the floor, removed her [NJ Ex Order] failed to roll it inside out, and proceeded to shake [NJ Ex] out, before placing [NJ Ex Order 26.4(b)] in the soiled linen bin. She then removed her gloves and threw them away. HHA #3 was not observed to change her mask(s). HHA #3 then picked the [NJ Ex Order 26.4(b)(1)] up off the floor and proceeded to carry the contaminated [NJ Ex Order 26.4(b)(1)] approximately 15 feet to the nurse's station. HHA #3 was not observed performing hand hygiene. On 02/03/2022 at 12:41 PM, the surveyor conducted an interview with the ADON. During the interview, the ADON confirmed that HHA #3 did not follow the correct donning and doffing	A 310		

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PPE procedures and acknowledged that the facility policy was not followed.

9. On 2/3/2022 at 4:41 PM, while on the [redacted] Unit of the facility, the surveyor observed an [redacted] cart with PPE that was outside of Room #[redacted]. No signage was at the door of Room #[redacted] to indicate PPE was to be used when entering the room, and three family members were in the room. During an interview conducted at 4:44 PM with the three family members in Room #[redacted] they stated the resident in Room #[redacted] had been admitted on [redacted] and was currently visiting with other residents in the facility's day room. The family members further stated that the resident in Room #[redacted] had not been NJ Ex Order 26.4(b)(1) and had recently recovered from [redacted]. One family member stated that when they had met with the facility ED, it was shared that the newly admitted resident would have to be on [redacted] upon admission due to [redacted]. The family member then stated that when they arrived on [redacted], nothing was mentioned about [redacted] and the [redacted] resident was welcomed into the day room.

On 2/04/2022 at 12:47 PM, during an interview with the ED, the ED confirmed that the [redacted] resident in Room #[redacted] should have been placed in [redacted] upon admission and that the facility was not following its policy.

A review of a policy titled, "Infection Prevention Readiness for COVID-19," undated, revealed that all newly admitted residents should be placed in a private room under isolation precautions for 14 days.

On 02/04/2022 at 7:00 PM, the ED provided the

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surveyors with an acceptable Removal Plan with a completion date of 2/4/2022.

Surveyors reviewed the Removal Plan which read as follows:
"Reeducation on Proper handwashing while caring for a resident, touching infected areas and other hygiene opportunities and with regards to proper Ppe [PPE] wear for contact/droplet precautions in isolation and following signage accordingly. Will have return demonstration given on handwashing & Donning/Doffing Ppe [PPE] correctly. Reeducation with regards to selections of proper PPE precautions as ordered, to include review of precaution signage & Return quiz on proper isolation wear ...

Nursing RN [Registered Nurse] or DON will also do random pop ups on every shift for a demonstration of handwashing and PPE donning/doffing to prevent spread of infection.
A pop-up review form will be completed and any deficient practice shall be immediately reported to Admin [Administrator] and employee shall be counseled with RN, DON, and Administrator.
Reeducation of all staff for handwashing to prevent spread of any infection to all areas in paragraph 1, will be done by 2/21/22. Random pop-ups will be done daily for 30 days, then quarterly ...
An in-service with all staff shall be completed by 2-7-2022. The in-service will include but not be limited to, temperature checks, proper screening paperwork, correct mask wearing and contact tracing for residents leaving the facility. The facility will identify any other entrances and take the necessary precautions for entering the facility with the proper screening. On-going inspections from the facility administration will continue to observe the visiting for and screening format

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established."

On 2/19/22, an onsite revisit was conducted to determine compliance and implementation of the Removal Plan provided to the surveyor on 2/4/22.

During the revisit, it was determined that imminent danger still persisted. Surveyors observed the facility staff entering [NJ Ex Order 26.4(] rooms without wearing the proper personal protective equipment (PPE) required. In addition, surveyors observed staff failed to wear fit tested [NJ Ex Or] masks or wear them properly to ensure masks' good fit. Surveyors then requested for another Removal Plan for the facility's ongoing [NJ Ex Order 26.4(] control issues.

On 02/19/2022 at 9:25 PM, the Removal Plan with a completion date of 02/19/2022 was provided to the surveyors.

The Removal Plan read as follows:
"Employees failed to follow facility protocol by failing to wear the facility assigned N95/or not wearing their N95 mask correctly.
- Bayside Manor requires that when in an outbreak, all employees wear 3M Model 8210 N95 mask. Employees at Bayside Manor have been fit tested for 3M Model 8210 N95 mask, no other N95 masks shall be worn.
- The Director of Nursing or designee will see that all other masks supplied by Bayside Manor shall be removed and placed in emergency storage until out of outbreak status by February 22nd, 2022. The Director [Director of Nursing], Assistant Director [Assistant Director of Nursing]/designee will ensure that only 3M Model 8210 N95 masks are supplied to Bayside Manor.
- The Director, Assistant Director or designee will review all personal protective equipment (PPE)

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orders prior to ordering N95 masks.
- Documented education with our supply personnel will be conducted by February 21, 2022, to ensure that only 3M Model 8210 N95 masks are distributed to Bayside Manor personnel. Education will be completed by the Director of Nursing or designee.
- All employees will be in-serviced on the proper protocol for the type of N95 to wear and on the correct way to wear the N95 mask. Inservice shall be completed by February 23, 2022. Employee(s) who fail to attend training by February 23 2022, shall be suspended until such in service education has been completed. Education will be conducted to the Director of Nursing or designee.
- After all in-services have been completed, the Director of Nursing or designee will conduct random audits on all shifts for 3 times a week for 4 weeks, then once week for 4 weeks, then quarterly. Audit findings will be reported at the quarterly Q&A meetings.
- The Administrator/Owner will be responsible for the implementation of the Removal Plan.
Employee Failure to follow isolation precautions...
- All employees will be in-serviced on the different types of isolation. All employees will be educated on what personal protective equipment (PPE) is used for the different types of isolation, and when to use the PPE. Training will include the facility's requirement to wear PPE that is designated per isolation sign. Employees will follow the required PPE and must don PPE prior to entering any room with an isolation sign. This would include, but not limited to delivering a meal tray, housekeeping and/or to provide care. Training will include the policy and procedure for handwashing, infection control, mask use, wearing gloves, donning & doffing of gowns, and review of the different PPE signage usage. All

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in-services require employee signatures and time and date training occurred.
- Inservice(s) shall be completed by February 23rd, 2022. Education will be provided by the Director of Nursing or designee. Employee(s) who fail to attend training by February 23, 2022, shall be suspended until such in-service education has been completed.
- After all in-services have been completed, the Director of Nursing or designee will conduct random audits on all shifts for 3 times a week for 4 weeks, then once week for 4 weeks, then quarterly. Audit findings will be reported at the quarterly Q&A [Quality Assurance] meetings.
- The Administrator/Owner will be responsible for the implementation of the Removal Plan."

Emergency Fire Exit Barricaded
1. On 02/03/2022 at 12:32 PM, on the 400 Unit, the surveyor observed that the Emergency Fire Exit Door #14 was barricaded by a 2 x 4-inch piece of wood approximately 8 feet in length. The 2 x 4-inch piece of wood was horizontal to the floor, approximately 34 inches above the floor and stretched across the door. The wood was tied to the emergency exit push bar with a rope, leaving the emergency push bar inoperable. The piece of wood was placed on top of planters that were located on either side of the door's frame and above the door was a lighted exit sign.

On 02/04/2022 at 10:17 AM, on the 400 Unit, a secured dementia/memory care unit, the surveyor observed that the 2 x 4-inch piece of wood had been removed and that the magnetic locking mechanism for the door was not functional. The door was unlocked.

On 02/04/2022 at 10:18 AM, the surveyor interviewed Housekeeper #1. She stated that the

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A 310	Continued From page 12 door had been tied "like that" for a while but could not say how long. She stated, "Maybe a couple of weeks?" On 02/04/2022 at 10:19 AM, during a surveyor's interview with Licensed Practical Nurse (LPN) #9, she stated that she was the NJ Ex Order 26.4b1 [redacted] However, she stated that she did not know why the door was tied shut and that it had been that way for a couple of weeks. On 02/04/2022 at 10:25 AM, the Director of Maintenance (DM) was interviewed. The DM stated the door kept popping open, so the barricade was put up, so residents did not wander out. He stated that the magnet did not work. He stated that he did not know who put up the barricade, but that he recalled the barricade being up for about a week. He stated he had not had time to address the issue. On 02/04/2022 at 10:30 AM, the surveyor interviewed the Maintenance Assistant (MA). The MA stated that it had been barricaded for several weeks and was working with the alarm company to get the magnet fixed. He stated the parts were on order. On 02/04/2022 at 12:25 PM, the Executive Director (ED) was informed of the imminent threat of having a fire door barricaded. A removal plan was requested. During a follow-up interview with the ED on 02/04/2022 at 1:12 PM, the ED stated, "I thought the rule of thumb was there needed to be two means of egress and there is a second fire exit (close by to Door #14) on the other side of the room." He stated he would reach out to the Fire Marshall to see if that door really needed to be a	A 310		

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A 310	Continued From page 13	A 310		

designated fire exit. The ED acknowledged that the door had been barricaded, but that the ED assumed it was "OK" since there was another fire door in the same room. He stated, "[redacted]"

The facility did not provide a policy related to fire exit doors.

On 02/04/2022 at 6:42 PM, a Removal Plan for the imminent danger was submitted by the facility and was accepted. Review of the Removal Plan revealed a completion date of 02/04/2022, read as follows:
"Effective 02-4-2022 the exit door is fully accessible. The resident area of security is not affected as there is a key code doorway to enter the living area. The exit door leads to a secure courtyard. The facility will routinely on each shift check all other exit doors for obstruction. The shift supervisor will make necessary repairs and changes to any of the exit doors devices as necessary. All above will be documented."

On 02/04/2022 at 6:50 PM, the survey team observed and verified that the imminent danger of the blockade at Fire Exit Door #14 had been removed and that the key coded doorway into the living area was secured and functional.

On 2/19/2021, a revisit was conducted to the facility to determine compliance and implementation of the removal. During an interview with the Administrator at 12:30 PM, the Administrator stated that they had obtained a new consultant Administrator, DON, and Infection Control Nurse.

Refer to tag:

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A 310	Continued From page 14 8:36-18.3(a)(5)	A 310		
A 891	8:36-10.5(a) Dining Services (a) The facility and personnel shall comply with the provisions of N.J.A.C. 8:24, Retail Food Establishments and Food and Beverage Vending Machines Chapter XII of the New Jersey Sanitary Code. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to comply with the provisions of the New Jersey Administrative Code (NJAC) 8:24, Retail Food Establishments and Food and Beverage Vending Machines Chapter XII of the New Jersey Sanitary Code. Specifically, the facility failed to ensure: 1) facility staff were not allowed into the kitchen without wearing a hair restraint; 2) temperatures of all food served, both hot and cold were recorded; 3) the dishwasher machine water temperature met the minimum temperature requirement; 4) the rag sanitizer buckets had the required amount of sanitizer; 5)Freezer and refrigerator temperatures were being logged/monitored; 6) unpasteurized shelled eggs were not being served; and 7) food items were labeled and dated when opened.	A 891		

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A 891	Continued From page 15 Findings included: 1. Hair nets Reference: NJAC 8:24-2.1 Supervision, indicates, " ...2. That persons unnecessary to the retail food establishment operation are not allowed in the food preparation, food storage, or warewashing areas; 3. That employees and other persons such as delivery and maintenance persons and pesticide applicators entering the food preparation, food storage, and warewashing areas comply with this chapter ...." Reference: NJAC 8:24-2.4 Hygienic practices read, "...(c) The following requirements shall apply to hair restraints: 1. Except as provided in (c)2 below, food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food, clean equipment, utensils, linens; and unwrapped single-service and single-use articles ...." During the initial tour of the kitchen on 02/02/2022 at 2:25 PM, the surveyor observed the Food Services Director (FSD) in the kitchen not wearing a hair net. When interviewed, the FSD stated he would only wear one if he was in direct contact with food. However, the FSD had to cross through a food preparation area to get to his office. On 02/02/2022 at 2:30 PM, the surveyor observed the Director of Maintenance (DM) in the kitchen without wearing a hair net. He was in the dry food storage area as well as a food preparation area. Kitchen staff did offer nor ask the DM to put on a hair net while in the kitchen.	A 891		

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A 891	Continued From page 16 During the interview with the FSD, he stated that the MD came into the kitchen all the time, but he was not in direct contact with food, so he had never been asked to put on a hair net. On 02/02/2022 at 3:30 PM, an unidentified dietary aide was observed entering the kitchen. She was standing in a food preparation area talking with the cooks. She was not wearing a hair net, nor was she asked by kitchen staff to put one on. The FSD was interviewed and stated they had never required hair nets while in the kitchen, just when preparing food. On 02/03/2022 at 10:36 AM, the FSD stated he did not have any policies regarding the wearing of hair nets. On 02/04/2022 at 1:05 PM, the surveyor interviewed the Executive Director (ED). He stated that he was not aware of the hair net issue and deferred to the FSD for knowing the proper policy. The ED stated he would defer to the FSD to correct the issue of hair nets not being worn in the kitchen. On 02/04/2022 at approximately 6:00 PM, the FSD provided the survey team with an undated policy titled, "Hair Restraint." The policy read, "The Food Code requires that food employees wear hair restraints that are designed and worn to effectively keep their hair from contacting exposed food; clean equipment, utensils, and linens ...The purpose of this provision is both to prevent hair from contacting food and food-contact surfaces and to deter food employees from touching their hair." 2. Food Temperatures Reference: NJAC 8:24-2.1 Supervision, indicates,	A 891		

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A 891	Continued From page 17 " ...(c) The person in charge shall ensure the following: 3. That employees and other persons such as delivery and maintenance persons and pesticide applicators entering the food preparation, food storage, and warewashing areas comply with this chapter; iii. Through daily oversight of the employees' routine monitoring of the cooking temperatures using appropriate temperature measuring devices properly scaled and calibrated, that employees are properly cooking potentially hazardous food, being particularly careful in cooking those foods known to cause severe foodborne illness and death, such as eggs and comminuted meats ...." Reference: NJAC 8:24-3.5 Limitation of growth of organisms of public health concern, indicates, " ... (f) Except during preparation, cooking, or cooling, or when time is used as the public health control as specified under (g) below, potentially hazardous food shall be maintained ... 1. At 135°F or above, except that roasts cooked to safe cooking temperatures or reheated as specified under N.J.A.C. 8:24-3.4(g)5 may be held at a temperature of 130°F; or 2. At refrigeration temperatures ...." During the surveyor's initial tour of the kitchen on 02/02/2022 at 3:30 PM, the food temperature logs were reviewed for January 2022 and February 2022. The log revealed that the facility was taking the temperature of one hot item on the steam table per meal. Cold foods were not being temperature checked at all. The temperature log form being used by the facility was titled, "Hot Holding Food Temperature Log." There was no cold food holding temperature log form was not being used. The FSD stated that they only checked the temperature of one item on the steam table and did not understand why cold food	A 891		

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A 891	Continued From page 18	A 891		

needed to be temped if it was coming out of the refrigerator. Portioned cold foods observed in the refrigerator included milk, tartar sauce, cocktail sauce, and pudding.

On 02/03/2022 at 10:36 AM, the FSD stated he did not have any policies regarding the taking of food temperatures.

On 02/04/2022 at 1:05 PM, the ED was interviewed. He stated that he was not aware of the food temperature concern and deferred to the FSD for knowing the proper policy. The ED stated he would defer to the FSD to correct the issue of food temperatures not being taken.

On 02/04/2022 at approximately 6:00 PM, the FSD provided the survey team with an undated policy titled, "Service Temperatures." The policy revealed, "Policy: Temperatures of all hot and cold foods are taken during services to assure that foods are maintained at appropriate temperatures to ensure safety of food served to residents ...3. Take temperatures of all hot potentially hazardous foods as soon as they are put on the serving line or just before service. Take temperatures of all cold potentially hazardous foods as soon as they are put on the serving line (or salad bar). Take temperature of milk before serving begins...4. Record Temperatures on the Service Temperature Log and initial."

3. Dishwasher Machine
Reference: 8:24-4.9 Mechanical ware washing equipment, indicates, " ...(j) The temperature of the wash solution in spray-type ware washers that use chemicals to sanitize shall not be less than 120°F ...."

During a tour of the kitchen on 02/02/2022 at 3:16

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A 891	Continued From page 19 PM, several cycles of the low temperature dish machine were run. During the first run, the wash cycle water temperature that ranged between 94 degrees F and 100 degrees Fahrenheit (F), and the rinse cycle water temperature was at 110 degrees F. During the second run, the wash cycle water temperature remained the same and ranged between 94 degrees F and 100 degrees F and the rinse cycle water temperature at 110 F. A third run was conducted that showed that temperatures did not reach 120 degrees F, the wash cycle water temperature was at 110 degrees F and the rinse cycle water temperature at 116 degrees F. The surveyor interviewed the FSD regarding a low temperature machine, the water was supposed to wash and rinse at 120 degrees F. He stated that the facility was using NJ Ex Order 26.4b1 detergent. The FSD acknowledged that the water temperature was too low but stated that he did not know why. He stated it had been running at 120 degrees F and presented the dish machine log for review. The January 2022 dish machine log revealed temperatures of 120 degrees F or greater. During a final interview on 02/04/2022 at approximately 6:05 PM, the FSD stated he would need to call in a serviceman to analyze why the temperature was not reaching 120 degrees F. On 02/04/2022 at approximately 6:00 PM, the FSD provided the survey team with an undated policy titled, "Machine Warewashing - Low Temperature." The policy read,, "7. Record the temperatures for the wash, rinse and final rinse cycles and the water pressure in the Temperature Monitoring Form. Temperatures and pressure should be at least: Wash - Minimum of 120 [degrees] F and run for a minimum of 2 [two] minutes. Rinse - Minimum of 120 [degrees] F. Final rinse - Minimum of 120 [degrees] F ...."	A 891		

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A 891	Continued From page 20 4. Rag sanitizer bucket During the surveyor's initial tour of the kitchen on 02/02/2022 at 2:31 PM, the quaternary ammonium compounds sanitizer (QUAT) bucket was tested by the Food Service Director (FSD) to ensure prescribed levels of sanitizer of parts per million (PPM) was being used for sanitation. The first bucket tested was located next to the microwave in the food preparation area and was tested with a test strip. By default, the test strip was orange in color and was represented by zero (0) per the manufacturer's calibration. To be within the manufacturer's recommended concentration, the strip was expected to change from orange to other colors which were calibrated at varying concentrations. The test strip that was dipped into the bucket showed there was no sanitizer present in the water. The test strip did not change color. At 3:10 PM, the second bucket, located on the three-compartment sink, was tested with a test strip. The test strip that was dipped into the bucket showed there was no sanitizer present in the water. The test strip did not change color. A third container was filled with the QUAT solution straight from the dispenser, and the test strip read 200 PPM. During an interview, the FSD stated his expectation was that all QUAT buckets would read 200 PPM. A review of the Retail Food Inspection Report, completed on 12/31/2021, revealed a QUAT rag bucket was found without sanitizer during the inspection. On 02/04/2022 at 1:05 PM, the ED was interviewed. He stated he was not aware of the concern regarding the QUAT sanitizer bucket and	A 891		

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A 891	Continued From page 21 deferred to the FSD for knowing the proper policy. The ED stated he would defer to the FSD to correct the issue of the QUAT buckets without sanitizer. A policy regarding the QUAT sanitizer was not provided. 5. Refrigerator and Freezer temperatures - logging and monitoring Reference: NJAC 8:24-4.2 Design and construction, read, " ...8. In a mechanically refrigerated or hot food storage unit, the sensor of a temperature measuring device shall be located to measure the air temperature in the warmest part of a mechanically refrigerated unit and in the coolest part of a hot food storage unit. "Refrigeration temperatures" mean: 1. 41°F or less, except as specified under 2 below. 2. 45°F or less in refrigeration equipment in use as of January 2, 2007, that is not capable of maintaining the food at 41°F or less if: i. The equipment is in place and in use in the retail food establishment; and ii. As of January 2, 2012, the equipment is upgraded or replaced to maintain food at a temperature of 41°F or less ...." During the surveyor's initial tour of the kitchen on 02/02/2022 at 2:27 PM, the reach-in refrigerator temperature read 40 degrees Fahrenheit (F) on the outside thermometer. There was no thermometer located on the inside of the refrigerator and no temperature log. The FSD stated that they only kept temperature logs for the walk-in refrigerator and walk-in freezer. The walk-in refrigerator and the walk-in freezer did not have thermometers located inside. The facility was relying on the external thermometers for temperature accuracy. The FSD stated that to the best of his knowledge, there had not been an issue with temperatures.	A 891		

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A 891	Continued From page 22 On 02/03/2022 at 10:36 AM, the FSD stated he did not have any policies regarding the monitoring and logging of refrigerator and freezer temperatures. On 02/03/2022 at 11:44 AM, on the 400 Unit of the facility, the surveyor observed that the dining services refrigerator external thermometer read 43 degrees F. A thermometer inside the refrigerator could not be located. The FSD stated they did not keep a log of the refrigerators located on the resident special care units. On 02/04/2022 at 4:10 PM, in the pantry area for the facility's 500 and 600 Units, the refrigerator temperature was 44 degrees F per the external thermometer. A thermometer on the inside of the fridge could not be located. There was no temperature log for the fridge. On 02/04/2022 at 1:05 PM, the ED was interviewed. He stated he was not aware of the temperature logging issue and deferred to the FSD for knowing the proper policy. The ED stated he would defer to the FSD to correct the issue of refrigerator temperatures being logged and monitored. On 02/04/2022 at approximately 6:00 PM, the FSD provided the survey team with an undated policy titled, "Storage." The policy read, "Temperature Control: 1. Check the temperature of all refrigerators, freezers and dry storerooms at the beginning of each shift. This includes both internal and external thermometers, where appropriate. Refrigerator temperatures should be between 36 [degrees] F and 41 [degrees] F ... .2. Record temperatures on the appropriate temperature log and initial ... The food service manager will: ... 2. Review logs to make sure	A 891		

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there are no temperature deviations ...."

6. Unpasteurized Shelled Eggs
Reference: NJAC 8:24-3.2 Sources, specifications, and original containers and records indicates," ...(i) The following requirements shall apply to eggs and milk products: 1. Liquid, frozen, and dry eggs and egg products shall be obtained pasteurized ...."

Reference: NJAC 8:24-3.3 Protection from contamination after receiving, indicates, " ...(e) Pasteurized eggs or egg products shall be substituted for raw shell eggs in the preparation of foods such as Caesar salad, hollandaise or Bearnaise sauce, mayonnaise, meringue, eggnog, tiramisu and egg-fortified beverages that are not cooked to safe cooking temperatures ...."

Reference: NJAC 8:24-3.7 Special requirements for highly susceptible populations, indicates, "(a) In a retail food establishment that serves a highly susceptible population the following requirements must be met: 3. The following foods shall not be served or offered for sale in a ready-to-eat form: ii. Partially cooked food such as lightly cooked fish, rare meat; soft-cooked eggs that are made from raw shell eggs, and meringue ...."

On 02/02/2022 at 2:55 PM, in the facility's kitchen, the surveyor observed that there were approximately eight dozens of shelled eggs inside the walk-in refrigerator that were not stamped with "P" on them. The surveyor interviewed the FSD who confirmed that he did not order pasteurized eggs and was unable to state how many residents ordered "runny yolk" type eggs for breakfast. The FSD stated that since most of the residents had room trays, most residents received scrambled eggs for breakfast. The FSD

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A 891	Continued From page 24 stated that he was going to gather a list of residents who ordered and enjoyed "runny yolk" eggs. On 02/03/2022 at 11:34 AM, the surveyor interviewed the FSD regarding the unpasteurized eggs and residents who enjoyed their "runny yolk" eggs. The FSD stated he did not have a policy about using unpasteurized eggs. He stated that at that point, he was unable to obtain a list of residents who enjoyed "runny yolk" eggs. On 02/04/2022 at 10:30 AM, on the 400 Unit of the facility, the surveyor observed two bowls with two poached eggs in each bowl in the hot box (a food warming device used to transport meal trays and keep the food at the preferred temperature). On 02/04/2022 at 10:34 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) #9 who stated that she was the [redacted] NJ Ex Order 26.4b1 Unit. LPN #9 stated there were two residents who loved getting their "runny yolk" eggs daily. LPN #9 stated that dipping their toast in the yolks was their favorite thing to do and that the kitchen knew to send two poached eggs for each resident daily. The two residents who liked "runny yolk" eggs were not interviewable. On 02/04/2022 at 10:40 AM, the surveyor interviewed the FSD. When asked about the two residents on the 400 Unit who enjoyed their eggs with "runny yolks," the FSD stated, "I guess I misunderstood what you meant by runny yolks. Guess I better stop serving residents runny yolk eggs until I can start buying pasteurized shelled eggs."	A 891		

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A 891	Continued From page 25 When asked, the facility could not provide a policy regarding the use of pasteurized eggs. 7. Food items not labeled and dated. On 02/02/2022 at 2:27 PM, the surveyor observed multiple two-ounce plastic cups with either cocktail sauce or tartar sauce in the reach-in refrigerator. The tray of cups was covered loosely with plastic wrap, however, they were not labeled or dated. The FSD was unable to state how long the cups had been in the reach-in refrigerator. Below the cups was a half pan of gelatin covered with plastic wrap that was not labeled or dated. The FSD was unable to state how long that had been in the reach-in refrigerator. Above the main food prep area, the surveyor observed a loaf of French bread wrapped in plastic wrap. The loaf of bread was not labeled or dated. On 02/02/2022 at 2:40 PM, surveyor observed that the dry storage area appeared to be well stocked. However, nothing was dated to say how long it had been on the shelf. The surveyor interviewed the FSD who stated that his staff rotated the items when new shipments arrived so that it was "first in, first out." The FSD was unable to confirm and ensure that was truly happening. On 02/02/2022 at 2:54 PM, a rack was observed with loaves of bread in the dry food storage area. Several loaves had been opened that were not dated to state when the loaves of bread had been opened. No expiration date could be located on the unopened loaves of bread. The FSD stated it was his expectation that the loaves of bread would be dated when they were opened. On 02/03/2022 at 11:44 AM, the following were discovered in the 400 Unit pantry area:	A 891		

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A 891	Continued From page 26 - Two opened packages of cookies. Each package contained approximately 18 cookies (if full, in a 3 columned plastic tray). There were approximately 8 to 10 cookies in each opened package. - Two English muffins in a plastic bag with a bag that was not labeled or dated. - Two pieces of rye bread in plastic wrap that was not labeled or dated. - Three and a half loaves of sliced white bread on bags that were opened and not labeled or dated. - One package of English muffins with five muffins in the package. The package was not labeled or dated. - One opened bag of [redacted] potato chips wrapped in plastic wrap and not labeled or dated. - One unopened pack of cookies that was not dated. - A half loaf of sliced white bread with green fuzz covering the bread - Two pieces of rye bread wrapped in plastic wrap. The bread was very hard and not labeled or dated. At that time (11:44 AM on 2/3/22), the surveyor interviewed the FSD who stated that he did not have a dietary aide to oversee the pantries. On 02/04/2022 at 4:10 PM, the surveyor conducted observations of the pantry and refrigerator on the 500 and 600 Units. The surveyor observed one gallon of mayonnaise in the refrigerator that was half full and had an expiration date of 10/21/2021. There was a one-gallon jar of French dressing that was half full and had expired on 08/10/2021. There was a one-gallon jar of ranch dressing. It was half full and had expired on 12/02/2021. Also observed were five opened packages of English muffins that were not dated when opened. There were two loaves of sliced white bread that were not	A 891		

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A 891	Continued From page 27 labeled and dated. Additionally, the surveyor observed that there was no hot water to the hand washing sink, and no paper towels in the dispenser. On 02/04/2022 at 1:05 PM, the surveyor interviewed the ED who stated he was not aware of the labeling and dating issue and deferred to the FSD for knowing the proper policy. The ED stated he would defer to the FSD to correct the issue of labeling and dating. When requested, the facility could not provide a policy for labeling and dating of food.	A 891		
A 975	8:36-11.7(a)(1) Pharmaceutical Services (a) The administrator shall provide an appropriate and safe medication storage area, either in a common area or in the resident's unit, for the storage of medications that are not self-administered by the residents. The storage area requirement may be satisfied through the use of a locked medication cart. 1. The storage area shall be kept locked when not in use. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to keep 1 of 7 medication carts locked to ensure the safe storage and integrity of residents' medications.	A 975		

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A 975	Continued From page 28 Findings included: During the surveyor's tour of the 600 Unit of the facility on 2/4/22 at 8:29 AM, the surveyor observed an unlocked medication administration cart in front of a resident room with no staff visible in the hallway. At 8:30 AM (on 2/4/22), the surveyor observed Licensed Practical Nurse (LPN) #7 exit a resident room and walked up to the cart. The surveyor interviewed LPN #7 who confirmed that the cart was left in the hallway unlocked and unattended. LPN #7 stated, "I thought I locked it" and further stated that all medication carts were to be locked when staff members administering medications were not near the medication carts. LPN # acknowledged that the facility policy was not followed. At 10:30 AM (on 2/4/22), the surveyor interviewed the Assistant Director of Nursing (ADON) who stated that the facility policy was that all medication carts were to be locked when not directly attended by staff. The ADON acknowledged that the facility was not following its policy. When asked for a policy, the facility was unable to provide a written policy regarding medication storage.	A 975		
A1011	8:36-11.7(k) Pharmaceutical Services (k) Controlled dangerous substances shall be stored, and records shall be maintained, in accordance with the Controlled Dangerous Substances Acts, N.J.S.A. 24:21-1 et seq. and all	A1011		

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A1011	Continued From page 29	A1011		

other Federal and State laws and regulations concerning the procurement, storage, dispensation, administration, and disposition of same.

This REQUIREMENT is not met as evidenced by:
Based on observation and interview, it was determined that the facility failed to ensure that a NJ Ex Order 26.4(b)(1)) was securely and safely stored at the facility. NJ Ex Order 26.4(b)(1) (NJ Ex Order 26.4(b)(1) was found in a basket in an unsecured and unlocked area of the nursing office, under a chair. This had the potential to affect all residents.

Findings included:

On 02/04/2022 at 2:26 PM, in the nursing office and in the presence of the Director of Nursing (DON), four medication cards containing a total of NJ Ex Order 26.4(b)(1) (for a resident in Room NJ Ex Order 2) were observed in a rattan (a type of material that is used in wicker weaves, usually from palm tree) basket placed under a chair in the nursing office. At that time at 2:26 PM, the surveyor interviewed the Assistant Director of Nursing (ADON). During the interview, the ADON confirmed that the medication in the basket was NJ Ex Order 26.4(b)(1) The ADON stated that the facility expectation was that the NJ Ex Order 26.4(b)(1) was to be kept in double locked (locked behind two locks) storage. The ADON acknowledged that the facility was not following its policy. However,

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A1011	Continued From page 30 when asked for their policy on NJ Ex Order 26.4(b)(1) [redacted] and its storage, the facility was unable to provide a written policy.	A1011		
A1041	8:36-14.3(a) Emergency Services and Procedures (a) The facility shall conduct at least one drill of the emergency plans every month. The 12 drills shall be conducted on a rotating basis, to ensure that four drills occur during each working shift on an annual basis. The facility shall maintain documentation of all drills, including the date, hour, description of the drill, participating staff, and signature of the person in charge. In addition to drills for emergencies due to fire, the facility shall conduct at least one drill per year for emergencies due to a disaster other than fire, such as storm, flood, other natural disaster, bomb threat, or nuclear accident (a total of 12 drills). All staff shall participate in at least one drill annually, and selected residents may participate in drills. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record review, it was determined that the facility failed to perform the minimum required 12 emergency drills on an annual basis and failed to perform an annual disaster drill. This affected all residents of the facility. Findings included: On 2/3/2022, the surveyor reviewed the records	A1041		

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A1041	Continued From page 31 for drills conducted at the facility for 2021. On 2/3/2022 at 4:10 PM, the surveyor interviewed the Director of Maintenance (DM). He stated that he was looking for conducted drill records and could only produce a handful of records. The DM provided five fire drill records for 03/09/2021 on the 7:00 AM to 3:00 PM shift, 04/29/2021 on the 3:00 PM to 11:00 PM shift, 06/28/2021 on the 11:00 PM to 7:00 AM shift, 06/28/2021 on the 7:00 AM to 3:00 PM shift, and 07/25/2021 on the 7:00 AM to 3:00 PM shift. The DM stated that he was still looking for the rest of the records. On 02/04/2022 at 1:07 PM, the surveyor interviewed the Executive Director (ED). The ED stated that it was his expectation that fire drills would be completed monthly, and he was unaware of a requirement to do an annual disaster drill. During a follow-up interview with the DM on 02/04/2022 at 2:09 PM, the DM stated that he could not provide any evidence that fire drills had been completed as required. He stated it was an outside company that provided the fire drills, and that he was not aware why they had not been done. The DM also stated that he had been employed at the facility for NJ Ex Order 26.4b1 and that during his employment time at the facility, he had never been a part of a disaster drill. He said that to the best of his knowledge, a disaster drill had not been completed.	A1041		
A1047	8:36-14.3(d) Emergency Services and Procedures (d) Fire extinguishers shall be conspicuously hung, kept easily accessible, shall be visually examined monthly and the examination shall be	A1047		

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A1047	Continued From page 32 recorded on a tag which is attached to the fire extinguisher. Fire extinguishers shall also be inspected and maintained in accordance with manufacturers' and applicable NFPA requirements and N.J.A.C. 5:70. Each fire extinguisher shall be labeled to show the date of such inspection and maintenance. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to complete the monthly check of all fire extinguishers within the facility. This deficient practice affected the entire facility and a fire safety hazard to the facility. Findings included: On 2/2/2022 at 4:32 PM, during the surveyor's initial tour of the kitchen, the surveyor observed a fire extinguisher located by the kitchen door closest to the entrance to the dining room and another fire extinguisher located near the time clock. Upon inspection, the surveyor noted that the two fire extinguishers were serviced in 08/2021. The monthly check tag had not been signed for 09/2021 or 10/2021. The fire extinguishers were signed on 11/08/2021 and 12/18/2021, respectively, however, there were no signatures to indicate that the fire extinguishers were checked or inspected for 01/2022. On 02/02/2022 at 4:40 PM, fire extinguisher #1 in the dining room, had a tag that indicated the fire extinguisher had been serviced in 08/2021. The monthly check tag had also not been signed for	A1047		

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A1047	Continued From page 33 09/2021 or 10/2021. Fire extinguisher #1 was signed on 11/08/2021 and 12/18/2021, however, there was no signature for 01/2022. On 02/03/2022 at 2:28 PM, the surveyor continued the tour of the building which revealed that fire extinguisher #1 had been signed off for 1/15/2022. The DM stated he signed off for rounds he made on 01/15/2022. He stated he signed off all the tags on 02/02/2022. All inspected fire extinguishers read the same throughout the facility. They were not signed for September 2021 and October 2021. On 02/04/2022 at 1:07 PM, during an interview with the Executive Director (ED), the ED stated it was his expectation that all facility fire extinguishers would be checked and signed off monthly. On 02/04/2022 at 2:09 PM, during a follow-up interview, the DM stated, "I got lost in the COVID shuffle and forgot to sign off on the fire extinguishers for September 2021, October 2021, and January 2022." The DM stated he marked the date of 01/15/2022 on all fire extinguishers on 02/02/2022.	A1047		
A1089	8:36-16.3(b) Physical Plant (b) Means of ventilation shall be provided for every bathroom or water closet (toilet) compartment. Ventilation shall be provided either by a window with an openable area or by mechanical ventilation.	A1089		

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A1089	Continued From page 34	A1089		

This REQUIREMENT is not met as evidenced by:
Based on observation and interviews, it was determined that the facility failed to ensure resident apartment bathrooms with no openable windows were provided a ventilation fans that were in working order. This affected 9 out of 12 apartments tested in the main assisted living building.

Findings included:

On 02/03/2022 at 2:28 PM. The surveyor conducted a tour and inspection that focused on the main Assisted Living buildings (the campus was comprised of four buildings). Random apartments were selected based on residents' permission to enter their apartment. The following apartments were found with bathroom ventilation fans that did not working when tested: Apartment #'s 106, 210, 219, 225, 220, 311, 321, 325, and 316.

On 02/03/2022 at 4:00 PM, during the surveyor's interview with the Director of Maintenance (DM), he stated he was not aware that some bathroom ventilation fans were not working. The DM stated that it was not a part of the check list used to prepare an apartment for a move-in. The DM stated the ventilation fans were not routinely tested. The DM stated he would need to find out the cause, and that he would test the special care units too to see if the same problem existed in

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A1089	Continued From page 35 those buildings. When asked, the facility was unable to provide a policy regarding maintenance of the bathroom ventilation fans.	A1089		
A1249	8:36-17.7 Housekeeping-Sanitation-Safety-Maintenance The building and grounds shall be well maintained at all times. The interior and exterior of the building shall be kept in good condition to ensure an attractive appearance, provide a pleasant atmosphere, and safeguard against deterioration. The building and grounds shall be kept free from fire hazards and other hazards to resident's health and safety. This REQUIREMENT is not met as evidenced by: Based on observation and interviews, it was determined that the facility failed to provide a a safe and fire hazard free environment and ensure fire/smoke compartment doors were not held open with a wedge, fire doors closed all the way into the frame and latch, and that fire exit doors were not barricaded. These deficient practices and non-compliance with one or more requirements placed all residents' safety at risk and likely to cause serious injury, harm, impairment, or death to residents. Findings included: 1. On 02/03/2022 at 12:32 PM, on the 400 Unit, the surveyor observed the Emergency Fire Exit	A1249		

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A1249	Continued From page 36 Door #14 barricaded by a 2 x 4-inch piece of wood approximately 8 feet in length. The 2 x 4-inch piece of wood was horizontal to the floor, approximately 34 inches above the floor and stretched across the door. The wood was tied to the emergency exit push bar with a rope, leaving the emergency push bar inoperable. The piece of wood was placed on top of planters that were located on either side of the door's frame. Above the door was a lighted exit sign. On 02/04/2022 at 10:17 AM, on the 400 Unit, the surveyor observed that the 2 x 4-inch piece of wood had been removed and the magnetic locking mechanism for the door was not functional. The door was unlocked, and the 400 Unit was a secured dementia unit. On 02/04/2022 at 10:18 AM, Housekeeper #1 was interviewed. She stated the door had been tied "like that" for a while but could not say how long. She stated, "Maybe a couple of weeks?" On 02/04/2022 at 10:19 AM, the surveyor interviewed Licensed Practical Nurse (LPN) #9. LPN #9 stated she was the NJ Ex Order 26.4b1 [redacted]. LPN #9 stated not knowing why the door was tied shut, but it had been that way for a couple of weeks. On 02/04/2022 at 10:25 AM, the surveyor interviewed Director of Maintenance (DM). The DM stated that the door kept popping open and so the barricade was put up to ensure residents did not wander out. He stated the magnet did not work. He did not know who put up the barricade, but recalled the barricade being up for about a week. He stated that he had not had time to address the issue.	A1249		

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A1249	Continued From page 37 On 02/04/2022 at 10:30 AM, a Maintenance Assistant (MA) was interviewed. The MA stated it had been barricaded for several weeks. He knew about it and was working with the alarm company to get the magnet fixed. He stated the parts were on order. On 02/04/2022 at 12:25 PM, the Executive Director (ED) was informed of the immediate threat of having a fire door barricaded. A removal plan was requested. During a follow-up interview with the ED on 02/04/2022 at 1:12 PM, the ED stated, "I thought the rule of thumb was there needed to be two means of egress and there is a second fire exit (close by to Door #14) on the other side of the room." He stated he would reach out to the Fire Marshall to see if that door really needed to be a designated fire exit. The ED acknowledged the door had been barricaded, but assumed it was "OK" since there was another fire door in the same room. He stated, NJ Ex Order 26.4b1 [redacted] he facility did not provide a policy related to fire doors. On 02/04/2022 at 6:42 PM, a Removal Plan for the immediacy situation was submitted by the facility and accepted by the state agency. The Removal Plan had a completion date of 02/04/2022, read as follows: "Effective 02-4-2022 the exit door is fully accessible. The resident area of security is not affected as there is a key code doorway to enter the living area. The exit door leads to a secure courtyard. The facility will routinely on each shift check all other exit doors for obstruction. The shift supervisor will make necessary repairs and changes to any of the exit doors devices as necessary. All above will be documented."	A1249		

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A1249	Continued From page 38 On 02/04/2022 at 6:50 PM, the survey team observed and verified the immediacy of the blockade at Fire Exit Door #14 had been removed and the key coded doorway into the living area was secured and functional. On 2/19/2022, an onsite revisit was conducted and upon entering the facility at 10:45 AM, the surveyor proceeded directly to the 400 Unit. Fire Exit Door #14 was inspected and appeared to be in working order and was not barricaded. 2. Reference: Both a fire compartment and a smoke compartment are defined by National Fire Protection Association (NFPA) 101: Life Safety Code, as "a space within a building that is enclosed by fire or smoke barriers on all sides, including the top and bottom ...." On 02/03/2022 at 3:18 PM, the surveyor observed one set of internal compartment fire doors on the second floor of the assisted living building. The two doors were held open with magnets that were designed to release if the fire alarm was activated. If activated, the doors would not have been able to close because there were wedges holding the doors open. Additionally, when the doors were allowed to close, there was no latching mechanism present to ensure a proper fire/smoke seal. During the surveyor's interview with the Director of Maintenance (DM), he stated that he did not know who put the wedges in the doors and the reason for it. The DM stated he did not realize that the doors did not latch. The DM stated that fire doors should not be held open with wedges and that these doors should latch closed. On 02/03/2022 at 4:07 PM, the surveyor	A1249		

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A1249	Continued From page 39 observed one set of internal compartment fire doors on the third floor of the assisted living building with the two doors that were held open with wedges and if activated, the doors would not be able to close. Additionally, when the doors were allowed to close, there was no latching mechanism present to ensure a proper fire/smoke seal. During the interview with the DM, again stated that he did not know who put the wedges in the doors and that he was not aware that the doors did not latch. He stated that fire doors should not be held open with wedges and they should latch closed. On 02/04/2022 at 4:09 PM, on the 600 Unit, the set of internal compartment fire doors was observed. The two doors were held open with magnets that were designed to release if the fire alarm was activated. If activated, the doors would not have been able to close because there were wedges holding the doors open. Additionally, when the doors were allowed to close, one of the doors was unable to latch because the latching mechanism on the door was pulling away from the door. The doors failed to ensure a proper fire/smoke seal. 3. During concurrent observations and interview with the Maintenance Director (MD) on 02/03/2022 at 2:32 PM, Exit Door #5, located in the main floor library, was a single door with a keypad and magnet. If the fire alarm was activated, the magnet would release. However, the levered door handle had a bathroom lock that would prevent the easy egress to exit. The DM confirmed that it was a levered door handle and not a push bar. He stated that someone trying to get out the door may have to unlock the bathroom-type lock to egress.	A1249		

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A1249	Continued From page 40 On 02/03/2022 at 2:35 PM, Exit Door #4, located in the main floor TV room, was a single door with a keypad and magnet. If the fire alarm was activated, the magnet would release. However, the surveyor observed that the levered door handle had a bathroom-type lock that would prevent an easy egress to exit. Additionally, there was a chair on the outside of the door, blocking the exit route. The DM confirmed that it was a levered door handle and not a push bar. He stated that someone trying to get out the door may have to unlock the bathroom-type lock to egress. The DM confirmed that there was also a chair outside the exit and it should not be blocking a fire exit door. On 02/04/2022 at 4:40 PM, Fire Exit Door #16, on the 400 Unit, was observed for proper functioning. The single door was held closed with a magnet and keypad that was designed to unlock if the fire alarm system was activated. The door was swung open to see if it would close into the frame and latch. The door did not fully return to the frame and did not latch. The door handle was a round doorknob with a bathroom lock. The door was not equipped with a push bar for emergency egress. On 02/04/2022 at 4:43 PM, Fire Exit Door #15, on the 400 Unit, was also observed for proper functioning. The single door was held closed with a magnet and keypad that was designed to unlock if the fire alarm system was activated. The door was swung open to see if it would close into the frame and latch. The door returned to the frame but did not latch. The door handle was a round doorknob with a bathroom lock. The door was not equipped with a push bar for emergency egress.	A1249		

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A1249	Continued From page 41 On 02/04/2022 at 4:47 PM, the surveyor observed the Director of Nursing (DON) tried to check both doors, Door #15 and #16. The DON confirmed to the surveyor that the doors did not latch and that Door #16 was not returning to the frame. The DON stated it was her expectation the doors would have a secure closure for both the safety of the residents on Unit 400 who were at risk for wandering and to ensure fire safety. The DON could not explain why the doors had doorknobs and not a push bar for emergency egress. The DON tried each door three times and could not get the doors to close and/or latch to it frame.	A1249		
A1299	8:36-18.3(a)(5) Infection Prevention and Control Services (a) Written policies and procedures shall be established and implemented regarding infection prevention and control, including, but not limited to, policies and procedures for the following: 5. Techniques to be used during each resident contact, including handwashing before and after caring for a resident; This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and policy reviews, it was determined that the facility failed to implement an effective infection and prevention control progrm and techniques that were in accordance with the Centers for Disease Control (CDC) guidelines and recommendations when the facility	A1299		

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A1299	Continued From page 42 1) failed to screen all staff entering the building for NJ Ex Order 26.4(b)(1); 2) failed to ensure that staff changed disposable gloves between patient; 3) failed to ensure that staff performed hand hygiene (washing or sanitizing hands) after removing disposable gloves; 4) failed to ensure that staff wore appropriate personal protective equipment (PPE - protective clothing) when in patient NJ Ex Order 26.4(rooms; 5) failed to ensure that staff donned (put on) and doffed (removed) PPE correctly; 6) failed to ensure that all staff wore N95 masks (masks that offer greater protection from infectious diseases) over their nose and mouth when interacting with residents or in resident hallways; 7) failed to ensure that staff maintained a closed door on a NJ Ex Order 26.4(b)(1) resident's room as part of the facility's NJ Ex Order 26.4(b cohort plan (a plan designed to limit NJ Ex Order 26.4(b)(1) of NJ Ex Order 26.4(b)(1)); and 8) failed to ensure that a newly admitted resident was NJ Ex Order 26.4(b)(1) for NJ Ex days after the resident's admission. These deficient practices and the non-compliance with the requirements placed all residents' health and safety at risks, and likely to cause serious harm, injury, impairment, or death to its residents. This occurred during NJ Ex Order 26.4(b)(1). Findings included: Reference: A review of the Centers for Disease Control and Prevention (CDC) Hand Hygiene Guidance, retrieved from https://www.cdc.gov/handhygiene/providers/guideline.html, (updated 1/30/2020, read, "... Multiple opportunities for hand hygiene may occur during a single care episode. Following are the clinical indications for hand hygiene: Use an alcohol-based hand sanitizer immediately before touching a patient, before performing an aseptic	A1299		

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A1299	Continued From page 43 task (e.g., placing an indwelling device) or handling invasive medical devices, before moving from work on a soiled body site to a clean body site on the same patient, after touching a patient or the patient's immediate environment, after contact with blood, body fluids or contaminated surfaces, and immediately after glove removal. Wash with soap and water when hands are visibly soiled, after caring for a person with known or suspected infectious diarrhea, and after known or suspected exposure to spores...." Reference: A review of the CDC Updated Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, updated 09/10/2021, indicated, "...Source control and physical distancing (when physical distancing is feasible and will not interfere with provision of care) are recommended for everyone in a healthcare setting. This is particularly important for individuals, regardless of their vaccination status, who live or work in counties with substantial to high community transmission...." Reference: CDC's Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, updated 02/02/2022, read, " ... Implement Universal Use of Personal Protective Equipment for HCP ... If SARS-CoV-2 infection is not suspected in a patient presenting for care (based on symptom and exposure history), HCP should follow Standard Precautions (and Transmission-Based Precautions if required based on the suspected diagnosis). Additionally, HCP working in facilities located in counties with substantial or high transmission should also use PPE as described below:	A1299		

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A1299	Continued From page 44 ... NIOSH-approved N95 or equivalent or higher-level respirators can also be used by HCP working in other situations where additional risk factors for transmission are present such as the patient is not up to date with all recommended COVID-19 vaccine doses, unable to use source control, and the area is poorly ventilated. They may also be considered if healthcare-associated SARS-CoV-2 transmission is identified and universal respirator use by HCP working in affected areas is not already in place ... To simplify implementation, facilities in counties with substantial or high transmission may consider implementing universal use of NIOSH-approved N95 or equivalent or higher-level respirators for HCP during all patient care encounters or in specific units or areas of the facility at higher risk for SARS-CoV-2 transmission. Eye protection (i.e., goggles or a face shield that covers the front and sides of the face) should be worn during all patient care encounters ...." Reference: CDC guidelines, Interim Infection Prevention and Control Recommendations for Healthcare Personnel [HCP] During the Coronavirus Disease 2019 (COVID-19) Pandemic, last updated on 02/23/2021, indicated, "... HCP [healthcare personnel] should wear well-fitting source control at all times while they are in the healthcare facility, including in breakrooms or other spaces where they might encounter co-workers...." Infection Control 1. On 2/3/22 at 8:36 AM, the surveyor observed Certified Medication Aide (CMA) #5 from the hallway of the [redacted] Unit of the facility. CMA #5 was not wearing a mask while escorting a resident out of resident Room #[redacted] CMA #5	A1299		

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confirmed that she was not wearing a mask and stated that the facility expectation was that staff were to wear masks when in resident areas.

2. On 02/03/2022 at 9:05 AM, in the entranceway of the facility, the surveyor observed the Executive Director (ED) entering the facility, self-checking the temperature with a thermometer located on the entranceway wall, and then walked into the facility.

A surveyor's review of a facility document titled, "COVID-19 Screening Roster - Staff," dated 02/03/2022, indicated that employees were to respond to screening questions and document their temperatures when reporting to work. The surveyor also reviewed the facility policy titled, "Infection Prevention Readiness for COVID-19" undated, which revealed that all employees were to be screened for signs and symptoms of COVID-19 when they report to work.

The surveyor did not observe the ED complete the [redacted] screening questions nor documented the [redacted] reading before reporting for work and entering the facility on [redacted].

On 02/04/2022 at 12:25 PM, the surveyor interviewed the ED. During the interview, the ED was unable to describe the screening process, including the facility's policy to complete the screening questions when entering the facility to report for work. The ED acknowledged that the facility policy was not followed.

3. On 02/03/2022 at 9:31 AM, the surveyor conducted an observation at the [redacted] Unit of the facility and observed a precaution sign posted at the door of Room #[redacted]. The [redacted] precaution

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sign indicated that staff were to wear gloves, a NJ Ex Order 2 and a face mask when entering Room NJ Ex Ord CMA #3 was observed to enter the room to provide the resident medication wearing only an NJ Ex Or mask. During an interview with the surveyor, Certified Medication Aide (CMA #3) stated that she thought the resident might be on NJ Ex Order 26.4(b)(1)) due to having NJ Ex Order 26.4(b)(1).

On 02/03/22 at 12:25 PM, the surveyor interviewed the Assistant Director of Nursing (ADON) who stated that the resident in Room # NJ Ex O was on NJ Ex Ord due to suspected NJ Ex Order 26.4(b)(1) based on the resident's symptoms.

On 2/03/2022 at 12:41 PM, the surveyor interviewed the Director of Nursing (DON). The DON stated that the facility expectation was that staff would wear the PPE indicated on signs posted outside of residents' rooms. The DON acknowledged that the facility was not following its policy.

Surveyor's review of a facility policy titled, "Infection Prevention Readiness for COVID-19," undated, revealed that if a resident was suspected or known to have COVID-19, any staff entering those resident rooms should wear a gown, gloves, face shield, and N95 mask (a mask that provides a higher level of protection from infectious disease transmission).

A review of a facility policy titled, "Outbreak Plan," undated, revealed that staff were to follow transmission-based precautions (TBP - additional protective measure used to prevent the spread of infectious diseases) when indicated to provide safe resident care. Further review showed that staff were to implement TBP when entering a

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resident's room based on signage posted at the door of the resident's room.

4. On 02/03/2022 at 12:00 PM, observations on the [NJ Ex O] Unit revealed NJ Ex Order 26.4(b)(1) signs on Room #[NJ Ex Ord] The door to the room was open to the common area of the unit. During an interview conducted on 02/04/2022 with the DON, the DON stated that staff were to close the bottom portion of the room doors for any residents who were on NJ Ex Order 26.4(b)(1). The DON stated that if doors were left open on the NJ Ex Order 26.4(b)(1) rooms, the facility was not following its policy.

5. On 2/3/22 at 12:02 PM, during an observation conducted on the [NJ Ex O] Unit, CMA #3 was observed wearing an [NJ Ex Or] mask under the tip of her nose. CMA #3 stated that it was a facility-provided mask and that CMA #3 had not been fit tested (a test done to ensure that a mask fits an individual's face in a way to ensure optimum protection from respiratory particles) for that mask. CMA #3 stated that the mask made her hot and nauseated, and that CMA #3 preferred to wear the mask below her nose. CMA #3 acknowledged that was not the correct way to wear a mask.

6. On 2/3/22 at 12:10 p.m., on [NJ Ex O] Unit of the facility, the surveyor observed Home Health Aide (HHA) #1 delivering a meal tray to resident at Room #[NJ Ex Ord] a NJ Ex Order 26.4(b)(1) room, wearing gloves upon entering the room and exiting the room. The surveyor did not observe HHA #1 don nor doff any personal protective equipment (PPE) prior to entering the [NJ Ex Order 26.4(] room. HHA #1 was picking up another food tray for delivery when the surveyor interviewed her. HHA #1 stated that she should have changed her gloves and washed her

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hands before delivering another tray. She stated she should have put on full PPE prior to entering the room to deliver the lunch tray.

7. On 02/03/2022 at 12:12 PM, the surveyor observed HHA #2 carrying a lunch tray into Room #[redacted] a NJ Ex Order 26.4(b)(1) room, without wearing PPE. Upon surveyor's interview, HHA #2 stated that she did not wear the correct PPE into Room #[redacted] and that she was supposed to put on a gown, gloves face shield, and get a new mask. HHA #2 stated, "No, I did not do that right. We are just trying to get the food out." At 12:16 PM, HHA #2 was again observed entering another NJ Ex Order 26.4(b)(1) room, Room #[redacted] without donning any PPE.

At 12:25 PM, the surveyor interviewed the Assistant Director of Nursing (ADON). The ADON stated that the staff had received numerous trainings regarding changing gloves, hand washing, and donning and doffing of PPE. The ADON stated that the expectation was that staff should have been donning and doffing full PPE when entering and exiting any room with a resident on NJ Ex Order 26.4(precautions.

The facility did not provide a policy regarding PPE. However, a review of facility policy titled, "Infection Control," dated 03/08/2007, revealed that staff were to perform hand hygiene after removing gloves.

8. On 02/03/2022 at 12:27 PM, during an observation on the [redacted] Unit, the surveyor observed HHA #3 donning PPE to enter an NJ Ex Order 26.4(room. HHA #3 was observed dragging the [redacted] on the floor while trying to tie the neck so she could slip it over her head. After donning the [redacted] she put on her NJ Ex Order 26.4(b)(1) and gloves.

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HHA #3 was already wearing an [NJ Ex Or] mask with a surgical mask over it. HHA #3 exited the room wearing full PPE. HHA #3 removed the [NJ Ex Or] and dropped it onto the floor, potentially contaminating the floor, removed her [NJ Ex Order] failed to roll it inside out, and proceeded to shake the [NJ Ex Order] out, before placing the [NJ Ex Order] in the soiled linen bin. She then removed her gloves and threw them away. HHA #3 was not observed to change her mask(s). HHA #3 then picked the [NJ Ex Order 26.4(b)(1)] up off the floor and proceeded to carry the contaminated [NJ Ex Order 26.4(b)(1)] approximately 15 feet to the nurse's station. HHA #3 was not observed performing hand hygiene.

On 02/03/2022 at 12:41 PM, the surveyor conducted an interview with the ADON. During the interview, the ADON confirmed that HHA #3 did not follow the correct donning and doffing PPE procedures and acknowledged that the facility policy was not followed.

9. On 2/3/2022 at 4:41 PM, while on the 500 Unit of the facility, the surveyor observed an [NJ Ex Order 26.4(b)] cart with PPE that was outside of Room #[NJ Ex Or] No signage was at the door of Room #[NJ Ex O] to indicate PPE was to be used when entering the room, and three family members were in the room. During an interview conducted at 4:44 PM with the three family members in Room #[NJ Ex Or] they stated the resident in Room #[NJ Ex O] had been admitted on [NJ Ex Order 26.4(b)(1)] and was currently visiting with other residents in the facility's day room. The family members further stated that the resident in Room #[NJ Ex O] had not been NJ Ex Order 26.4(b)(1) and had recently recovered from NJ Ex Order 26.4(b)(1). One family member stated that when they had met with the facility ED, it was shared that the NJ Ex Order 26.4b1 resident would have to be on [NJ Ex Order 26.4(b)] upon admission due to [NJ Ex Order 26.4(b)]

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A1299	Continued From page 50 NJ Ex Order 26.4(b)(1) The family member then stated that when they arrived on NJ Ex Order 26.4(b)(1), nothing was mentioned about NJ Ex Order 26.4(b) and the NJ Ex Order 2 resident was welcomed into the day room. On 2/04/2022 at 12:47 PM, during an interview with the ED, the ED confirmed that the newly admitted resident in Room # NJ Ex O should have been placed NJ Ex Order 26.4(b)(1) upon admission and that the facility was not following its policy. A review of a policy titled, "Infection Prevention Readiness for COVID-19," undated, revealed that all newly admitted residents should be placed in a private room under isolation precautions for 14 days. On 02/04/2022 at 7:00 PM, the ED provided the surveyors with an acceptable Removal Plan with a completion date 2/4/2022. The surveyor reviewed the Removal Plan which read, "Reeducation on Proper handwashing while caring for a resident, touching infected areas and other hygiene opportunities and with regards to proper Ppe [PPE] wear for contact/droplet precautions in isolation and following signage accordingly. Will have return demonstration given on handwashing & Donning/Doffing Ppe [PPE] correctly. Reeducation with regards to selections of proper PPE precautions as ordered, to include review of precaution signage & Return quiz on proper isolation wear. Nursing RN [Registered Nurse] or DON will also do random pop ups on every shift for a demonstration of handwashing and PPE donning/doffing to prevent spread of infection. A pop-up review form will be completed and any deficient practice shall be immediately reported to	A1299		

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A1299	Continued From page 51 Admin [Administrator] and employee shall be counseled with RN, DON, and Administrator. Reeducation of all staff for handwashing to prevent spread of any infection to all areas in paragraph 1, will be done by 2/21/22. Random pop-ups will be done daily for 30 days, then quarterly ... An in-service with all staff shall be completed by 2-7-2022. The in-service will include but not be limited to, temperature checks, proper screening paperwork, correct mask wearing and contact tracing for residents leaving the facility. The facility will identify any other entrances and take the necessary precautions for entering the facility with the proper screening. On-going inspections from the facility administration will continue to observe the visiting for and screening format established." On 2/19/22, an onsite revisit was conducted to determine compliance and implementation of the Removal Plan provided to the surveyor on 2/4/22. During the revisit, it was determined that the imminent danger situation was still present. Surveyors observed the facility staff entering [redacted] rooms without wearing the proper personal protective equipment (PPE) required. In addition, surveyors observed staff failed to wear fit tested [redacted] masks or wear them properly to ensure masks' good fit. Surveyors then requested for another Removal Plan for the facility's ongoing infection control issues. On 02/19/2022 at 9:25 PM, the Removal Plan with a completion date of 02/19/2022 was provided the surveyors. The Removal Plan read as follows: "Employees failed to follow facility protocol by failing to wear the facility assigned N95/or not	A1299		

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A1299	Continued From page 52	A1299		

wearing their N95 mask correctly.
- Bayside Manor requires that when in an outbreak, all employees wear 3M Model 8210 N95 mask. Employees at Bayside Manor have been fit tested for 3M Model 8210 N95 mask, no other N95 masks shall be worn.
- The Director of Nursing or designee will see that all other masks supplied by Bayside Manor shall be removed and placed in emergency storage until out of outbreak status by February 22nd, 2022. The Director, Assistant Director/designee will ensure that only 3M Model 8210 N95 masks are supplied to Bayside Manor.
- The Director, Assistant Director or designee will review all personal protective equipment (PPE) orders prior to ordering N95 masks.
- Documented education with our supply personnel will be conducted by February 21, 2022, to ensure that only 3M Model 8210 N95 masks are distributed to Bayside Manor personnel. Education will be completed by the Director of Nursing or designee.
- All employees will be in-serviced on the proper protocol for the type of N95 to wear and on the correct way to wear the N95 mask. Inservice shall be completed by February 23, 2022. Employee(s) who fail to attend training by February 23, 2022, shall be suspended until such in service education has been completed. Education will be conducted to the Director of Nursing or designee.
- After all in-services have been completed, the Director of Nursing or designee will conduct random audits on all shifts for 3 times a week for 4 weeks, then once week for 4 weeks, then quarterly. Audit findings will be reported at the quarterly Q&A meetings.
- The Administrator/Owner will be responsible for the implementation of the Removal Plan.

Employee Failure to follow isolation precautions
- All employees will be in-serviced on the different

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A1299	Continued From page 53 types of isolation. All employees will be educated on what personal protective equipment (PPE) is used for the different types of isolation, and when to use the PPE. Training will include the facility's requirement to wear PPE that is designated per isolation sign. Employees will follow the required PPE and must don PPE prior to entering any room with an isolation sign. This would include, but not limited to delivering a meal tray, housekeeping and/or to provide care. Training will include the policy and procedure for handwashing, infection control, mask use, wearing gloves, donning & doffing of gowns, and review of the different PPE signage usage. All in-services require employee signatures and time and date training occurred. - Inservice(s) shall be completed by February 23rd, 2022. Education will be provided by the Director of Nursing or designee. Employee(s) who fail to attend training by February 23, 2022, shall be suspended until such in-service education has been completed. - After all in-services have been completed, the Director of Nursing or designee will conduct random audits on all shifts for 3 times a week for 4 weeks, then once week for 4 weeks, then quarterly. Audit findings will be reported at the quarterly Q&A meetings. - The Administrator/Owner will be responsible for the implementation of the Removal Plan." On 02/19/2022, an on-site revisit was conducted to determine implantation of the Removal Plan. During the revisit, the survey team determined that the immediacy situation was still present due to staff entering isolation rooms without wearing personal protective equipment. (PPE) and staff failing to wear fit tested N95 masks or wear them properly so that the mask ensured a good fit, as evidenced by the following:	A1299		

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A1299	Continued From page 54 On 02/19/2022 at 11:42 AM, on the 500 Unit, the surveyor interviewed LPN #10 who stated that she had attended training on NJ Ex Order 26.4b1 about donning and doffing of PPE, hand washing, and wearing NJ Ex Or masks. The surveyor observed LPN #10 wearing an NJ Ex Or mask that was not the approved and fit-tested mask of the facility. LPN #10 had on a headband that had buttons that secured the ear loops of her mask. LPN #10 stated that she was not wearing the type of mask that she was fit tested for, but instead was wearing one she brought in, and it had ear loops that worked with her headband. LPN #10 stated that she was under the impression that once they were fit tested for an NJ Ex Or mask, they could wear any type they wanted to wear. On 02/19/2022 at 12:00 PM, surveyor observed Housekeeper #11 wearing an NJ Ex Or mask that was not approved by the facility. Housekeeper #11 stated that she had not been fit tested for the mask she was wearing. She stated that the mask she was wearing was provided by her housekeeping department head. Housekeeper #11 stated she had just cleaned Apartment # NJ Ex Orc an apartment that had signage and PPE outside the room as a designated room for NJ Ex Order 26.4 . Housekeeper #11 stated that she did not put on any PPE prior to cleaning Apartment # NJ Ex Orc She reported being told that the resident NJ Ex Order 26.4(b)(1) , and that she did not feel she had to wear all of the PPE if the resident only NJ Ex Order Housekeeper #11 then walked over to the NJ Ex Order 26.4(b)(1) signage outside of Apartment # NJ Ex Orc read the sign, and stated that she should have worn the PPE required. On 2/19/2022 at 12:08 PM, the surveyor interviewed HHA #12 who stated that having recently attended in-service training for hand	A1299		

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A1299	Continued From page 55	A1299		

washing, PPE donning and doffing, mask wearing, and wearing the NJ Ex Or mask. The surveyor observed HHA #12 wearing an NJ Ex Or mask with a surgical mask over it. HHA #12 had the NJ Ex Or mask straps dangling down and a surgical mask over it loosely holding the NJ Ex Or in place. HHA #12 stated the strap had broken, and she was on her way to get a new mask. HHA #12 was walking away from the surveyor and was observed placing the straps of the NJ Ex Or mask over her head. The straps to the NJ Ex Or mask were still intact; therefore, HHA #12 did not wear the mask properly.

On 2/19/2022 at 12:13 PM, on the second floor of the assisted living building, the surveyor observed Medication Technician (Med Tech) #13 wearing an NJ Ex Or mask with a surgical mask over it. The NJ Ex Or mask straps were hanging to the sides. Med Tech #13 stated she told the Director of Nursing (DON) that the mask was disturbing to her. She indicated that the DON told her that she needed a physician note in order to be excused from wearing the NJ Ex Ord Med Tech #13 stated she had been fit tested and approved to wear the facility tested NJ Ex Or masks. Med tech #13 stated she had recently attended training regarding PPE donning and doffing, mask wearing, hand washing, and NJ Ex Order 26.4(rooms.

On 2/19/2022 at 12:19 PM, on the 2nd floor of the assisted living building, the surveyor interviewed Dietary Aide (DA) #14 who stated that he had not been fit tested for the type of NJ Ex Or mask he had on. He stated it was the mask that was provided to him to wear.

On 02/19/2022 at 12:20 PM, the surveyor observed LPN #15 coming out of a resident apartment. Her NJ Ex Or mask was up to her face

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without the straps secured. She was wearing a surgical mask over the [redacted] to keep it in place. LPN #15 stated she had recently attended training on donning and doffing PPE, hand washing, and wearing the fit-tested [redacted] mask. She initially stated she would take down the straps when she was not in contact with a resident, however, acknowledged that this surveyor had just observed her exiting a resident apartment with the straps down.

On 02/19/2022 at 12:25 PM, on the second floor, the surveyor observed CNA #16 was wearing an [redacted] mask but that the bottom strap was hanging down. During an interview with CNA #16, she stated that she did not feel as though she needed to have the second strap on to give her a secure fit. She stated that the bottom strap hurt to wear. She stated she had not been fit tested for an [redacted] mask. CNA #16 stated that she had recently attended training for hand washing and isolation precautions.

On 02/19/2022 at 12:57 PM, the DON and Assistant Director of Nursing (ADON) were interviewed. The DON stated she needed to go back through her records to see who had attended the in-service training. She could not confirm if all staff had attended training on infection control. She stated, "I still have staff that need to attend training, but not sure who."

On 02/19/2022 at 1:03 PM, the surveyor interviewed the DON who stated that it was her expectation that everyone would be wearing the fit-tested [redacted] mask, which was the [redacted] Model 8210. She stated that it was wrong to wear an [redacted] without the straps and to wear a surgical mask over it; it would not provide a secure fit. The DON and ADON stated they had been making

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A1299	Continued From page 57	A1299		

random observations around the facility and still constantly had to remind staff what the expectation was for wearing the proper mask and wearing it properly.

On 02/19/2022 at 2:30 PM, during an interview with the surveyor, the ADON stated that during the in-service training, the DON stated that the [redacted] Model 8210 [redacted] mask was the only approved and fit-tested mask for the facility.

On 02/19/2022 at 3:07 PM, the DON was interviewed about how she was monitoring the compliance of the recent training. The DON stated that they had a staff member who ordered the supplies for the facility, so she was not sure how other types of [redacted] masks were getting into the facility. She stated that the random walk-throughs by the DON and ADON were the only source of monitoring compliance at the current time. The DON stated she would take responsibility for monitoring the compliance of the nursing staff, but that the other department heads would have to be responsible for their own employees.

On 02/19/2022 at 4:00 PM, the Administrator, Owner, DON, and ADON were notified of the need to provide a Removal Plan due to the immediacy situation still being present.

A Removal Plan was requested and provided to the surveyor at on 02/19/2022 at 9:25 PM for the ongoing infection control issues. The Removal Plan, with a completion date of 02/19/2022, read as follows:
"Employees failed to follow facility protocol by failing to wear the facility assigned N95/or not wearing their N95 mask correctly.
- Bayside Manor requires that when in an

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A1299	Continued From page 58 outbreak, all employees wear 3M Model 8210 N95 mask. Employees at Bayside Manor have been fit tested for 3M Model 8210 N95 mask, no other N95 masks shall be worn. - The Director of Nursing or designee will see that all other masks supplied by Bayside Manor shall be removed and placed in emergency storage until out of outbreak status by February 22nd, 2022. The Director, Assistant Director/designee will ensure that only 3M Model 8210 N95 masks are supplied to Bayside Manor. - The Director, Assistant Director or designee will review all personal protective equipment (PPE) orders prior to ordering N95 masks. - Documented education with our supply personnel will be conducted by February 21, 2022, to ensure that only 3M Model 8210 N95 masks are distributed to Bayside Manor personnel. Education will be completed by the Director of Nursing or designee. - All employees will be in-serviced on the proper protocol for the type of N95 to wear and on the correct way to wear the N95 mask. Inservice shall be completed by February 23rd, 2022. Employee(s) who fail to attend training by February 23rd, 2022, shall be suspended until such in service education has been completed. Education will be conducted to the Director of Nursing or designee - After all in-services have been completed, the Director of Nursing or designee will conduct random audits on all shifts for 3 times a week for 4 weeks, then once week for 4 weeks, then quarterly. Audit findings will be reported at the quarterly Q&A meetings. - The Administrator/Owner will be responsible for the implementation of the Removal Plan. Employee Failure to follow isolation precautions - All employees will be in-serviced on the different	A1299		

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types of isolation. All employees will be educated on what personal protective equipment (PPE) is used for the different types of isolation, and when to use the PPE. Training will include the facility's requirement to wear PPE that is designated per isolation sign. Employees will follow the required PPE and must don PPE prior to entering any room with an isolation sign. This would include, but not limited to delivering a meal tray, housekeeping and/or to provide care. Training will include the policy and procedure for handwashing, infection control, mask use, wearing gloves, donning & doffing of gowns, and review of the different PPE signage usage. All in-services require employee signatures and time and date training occurred.
- Inservice(s) shall be completed by February 23rd, 2022. Education will be provided by the Director of Nursing or designee. Employee(s) who fail to attend training by February 23rd, 2022 shall be suspended until such in-service education has been completed.
- After all in-services have been completed, the Director of Nursing or designee will conduct random audits on all shifts for 3 times a week for 4 weeks, then once week for 4 weeks, then quarterly. Audit findings will be reported at the quarterly Q&A meetings.
- The Administrator/Owner will be responsible for the implementation of the Removal Plan."

On 03/13/2022, an on-site revisit was conducted to determine compliance for the Removal Plan. Upon entering the facility, the surveyor was screened appropriately for [redacted]. Staff were observed being screened appropriately as well. All staff were observed to wear the [redacted] Model 8210 [redacted] mask. Staff interviews verified that staff had been fit tested and had been in-serviced on wearing the [redacted] mask, as well as wearing the

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A1299	Continued From page 60 appropriate PPE. Surveyor's review of a fit testing log revealed all staff employed at the facility had been fit tested and completed on 02/21/2022. A review of in-services, dated 02/22/2022, revealed all employees had been in-serviced on the type of [NJ Ex Or] mask to wear, the correct way to wear an [NJ Ex Or] mask, the different types of [NJ Ex Order 26.4(b)] the appropriate PPE and the facility's requirement to wear PPE designated per the [NJ Ex Order 26.4(] signage. Based on these observations, interviews with staff, and review of the in-service documentation, the surveyor determined that the facility implemented its Removal Plan and the imminent danger was removed.	A1299		
A1307	8:36-18.4(a)(1) Infection Prevention and Control Services (a) Each new employee upon employment shall receive a two-step Mantoux tuberculin skin test with five tuberculin units of purified protein derivative. The only exceptions shall be employees with documented negative two-step Mantoux skin test results (zero to nine millimeters of induration) within the last year, employees with a documented positive Mantoux skin test result (10 or more millimeters of induration), employees who have received appropriate medical treatment for tuberculosis, or when medically contraindicated. Results of the Mantoux tuberculin skin tests administered to new employees shall be acted upon as follows: 1. If the first step of the Mantoux tuberculin skin test result is less than 10 millimeters of induration, the second step of the two-step Mantoux test shall be administered one to three weeks later.	A1307		

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A1307	Continued From page 61 This REQUIREMENT is not met as evidenced by: Based on interview and employee record reviews, it was determined that the facility failed to ensure that one of six employees received a [NJ Ex Order 26.4(b)(1) redacted] test upon employment with the facility, Licensed Practical Nurse [LPN] #8. Findings included: On 02/03/2022 at 3:30 PM, the surveyor conducted an employee record of LPN #8. During surveyor's interview with the Payroll Clerk (PC), the PC confirmed that LPN #8 was hired on [NJ Ex Order 26.4(b)(1) redacted] and currently employed at the facility. During an interview with the Director of Nursing (DON) on 02/04/2022 at 10:40 AM, the DON stated that the facility policy was to complete [NJ Ex redacted] testing on every employee when the employee started working at the facility. The facility was unable to provide documentation that a [NJ Ex redacted] test was completed on LPN #8 from [NJ Ex Order 26.4(b)(1) redacted] through [NJ Ex Order 26.4b1 redacted]. The DON acknowledged that the facility was not following its policy. When asked for a policy, no written policy regarding [NJ Ex redacted] testing was provided.	A1307		

BAYSIDE MANOR
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A310

8.36-3.4(a)(1) Administration/ Infection Control Completion date- 3/14/2022

1. The Administrator has enforced new policies, procedures, and hands-on training for [redacted] Administrator has hired an ICP consultant to monitor and advise [redacted] compliance on a monthly basis. The Administrator along with the Director of Nursing, Assistant Director of Nursing, Administrator consultant and Nursing consultant has met with all staff during a 5 day mandatory meeting to enforce all new policies.

1. All residents have been affected by this deficient practice. All residents not in sample have the potential to be affected by the same deficient practice.

1. Hands-on training has been conducted by Administrator / DON / ADON and ICP consultant with ALL current and new employees. Employees listed in citations (CMA #5, Executive Director, CMA #3, HHA #1, HHA#2, and HHA#3) were all present and verbalized understanding of new policies and procedures. New policies have been created for infection control. Such policies and in-services include:
    . Covid screening for all staff and visitors entering the community
    a. Proper use of gloves
    b. Demonstration of proper hand hygiene
    c. Hands on training for proper use of correct PPE in resident isolation rooms; removal of PPE / donning and doffing.
    d. Proper use of N95 masks during Covid19 outbreak. Each current and new employee has been properly fitted for an N95 mask.
    e. Administrator has ensured all employees have been trained on isolation protocol and proper use of doors in isolation rooms.
    f. New policies have been created to reflect proper Covid19 testing and time frame of quarantined new admissions and readmissions into the community. All staff have been in-serviced on new admission and readmission policy.

1. Administrator has met with DON/ADON to implement a new monitoring schedule for infection control compliance. Administrator will review that pop audits have been completed by DON/ADON in accordance. Administrator has implemented daily meetings to include admission and readmission quarantining as well as Covid19 testing results. Administrator will meet with the ICP consultant on a monthly basis to review infection control compliance. A quality assurance evaluation of all departments pertaining to infection control will be conducted quarterly. During this quarterly quality assurance evaluation, the evaluator will ensure proper safe precautions are being maintained in ALL departments to reduce the risk of infection. Proper screening, use of PPE, proper isolation protocols, Covid 19 testing as well as the practicing of basic infection

control policies will be assessed at this time. During this time the quality assurance form will be completed. The form will be assessed during the morning meeting with all department heads once completed. The quality assurance form will also be reviewed by the ICP consultant for any recommendations. Any areas of concern or areas out of standard compliance will be addressed immediately by the administrator.

A310
8.36-3.4(a)(1) Administration / Fire Safety Completion date- 3/14/2022

1. The Administrator removed blocking device from emergency fire exit door #14 on the 400 Unit immediately after the conclusion of the survey. The Administrator and director of maintenance immediately ensured that the magnetic locking mechanism for the emergency fire exit door #14 is functional and working properly. Fire door #14 is fully accessible in the event of an emergency. The Administrator has enforced that no fire door shall be barricaded in the event of malfunction.

1. All residents have been affected by this deficient practice. All residents not in sample have the potential to be affected by the same deficient practice.

1. Administrator has implemented a new policy for monitoring fire doors monthly, checking for proper keypad functioning and proper closing. Administrator has enforced a new policy with DON and all staff to institute a 30 minute census check in the event of a resident access fire door not functioning properly. A new form has been created for a 30 minute resident census check.

1. Administrator has created a new tracking and monitoring system for the proper operation of all fire doors. Director of maintenance will document such findings on a monthly basis after inspection has been completed. The Director of Maintenance will report any malfunctioning fire safety doors immediately to the administrator. Administrator will oversee those monthly inspections have been completed. The Administrator will continue to hold daily meetings with department heads, at this time any concerns with functioning of fire doors will be addressed. A quality assurance evaluation of the maintenance department pertaining to fire safety, as well as evaluation of the completion of monthly fire drills will be conducted quarterly. The fire doors and extinguishers will be assessed for proper functioning at this time. During this time the quality assurance form will be completed. The form will be assessed during the morning meeting with all department heads. Any areas of concern or areas out of standard compliance will be addressed immediately by the administrator.

A891

8.36-10.5(a) Dining Services Completion date- 5/10/2022

1. Since the visit on 2/2/22, all employees and those entering the kitchen have been wearing hair restraints at all times while in the kitchen. As of 5/1/22 temperatures of all food being served both hot and cold have been continually logged. The low temperature dishwasher water, freezer and refrigerator temperatures have been continually logged and checked for proper functioning, including the refrigerator on the 400 unit. A new element was repaired in the heating booster located in the warewasher to reach the desired water temperature of the warewasher. The rag sanitizer buckets have an adequate amount of sanitizer when tested and will continually be tested every 2 hours by the Director of Food Services or designee; including the sanitizing bucket by the 3-compartment sink. Unpasteurized eggs have not been served in runny yolk form to any resident. All food items are now being dated and labeled when opened. The dining services program is now in compliance with provisions of the New Jersey Administrative Code 8:24.

1. All residents have been affected by this deficient practice. All residents not in the sample have the potential to be affected by the same deficient practice.

1. Hands on training has been conducted by the Food Service Director with all current employees and new employees working in a food services capacity. All employees out of compliance during visit on 2/2/22 have been in-serviced on new policies. Employees listed in citations (Food Service Director, Director of Maintenance, all dietary aides, Dishwasher employees, and LPN#9) were all present and verbalized understanding of new policies and procedures. New policies have been created and new in-services conducted to ensure all employees follow the provisions outlined in NJAC 8:24. Such policies and in-services include:
    . The need for hair restraints of anyone entering the kitchen
    a. Logging temperatures of hot and cold foods while being prepared and being served, freezer and refrigerator temperatures
    b. Proper operation and parameters of low temperature warewashing machine
    c. Standard operating procedure for sanitizing buckets
    d. Proper time and place to use pasteurized and unpasteurized eggs
    e. The proper way to label food when it is opened

1. The Food Service Director will monitor that all individuals entering the kitchen are wearing a hair restraint. The Food Service Director will sign food temperature logs and thermometer calibration weekly. The Food Service Director will verify daily that temperatures are recorded daily in all kitchen refrigerators, freezers and the warewashing machine. The Food Service Director has now ordered both pasteurized and pasteurized eggs to be used while preparing foods for residents. The Food Service Director will review proper practices with any employee exhibiting unsafe practices. The Administrator will continue to hold daily meetings with department heads, at this time any concerns with dining services will be addressed. A quality assurance evaluation of all the dining service programs pertaining to infection control and food and safety precautions

will be conducted quarterly. During this quarterly quality assurance evaluation, the use of hair restraints, proper food temperature checks, proper food storage and labeling, and the proper functioning of all warewashers will be assessed. During this time the quality assurance form will be completed. The form will be assessed during the morning meeting with all department heads. Any areas of concern or areas out of standard compliance will be addressed immediately by the administrator.

A975

8.36-11.7 (a)(1) Pharmaceutical Services Completion date- 5/11/2022

1. All mediation carts have been locked at all times when not in use or unattended since visit on 2/4/2022; including the medication cart on the [redacted] unit listed in citation. No resident was harmed when the stated medication cart was unlocked and unattended. A medication pass observation was completed on 5/2/2022 with LPN#7 noted in deficiency. LPN#7 has had a one-to-one training with a Nursing consultant to reeducate her on the importance of medication storage and best practices of a medication administration pass.

1. All residents in the sample have the potential to have been affected by this deficient practice. All residents not in sample have the potential to be affected by the same deficient practice.

1. A new policy on safe medication storage and maintaining privacy has been created. Such policy has been discussed with all CMAs/LPNs/RNs; including LPN#7. Director of Nursing / Assistant Director of Nursing and Nursing consultants have trained all CMAs/LPNs/RNs on 5/2/22 on:
    . Proper storage of all medications in a medication cart when in use and not in use
    a. Locking a medication cart and securing keys when a medication cart not in use
    b. HIPPA and the importance of covering medication administration records or shutting off electronic medical records when not in use
        . A self-locking timer has been added to all electronic medical record screens on all medication carts.
    c. Best practices of a medication pass

1. DON/ADON will continue to perform quarterly observations of all Certified Medication Aides to ensure safe practice is performed during medication passes. DON/ ADON will continue to implement monthly nursing meetings to discuss areas of safe practice of medications, medication passes and resident safety. DON/ADON continue to make rounds during medication passes. DON /ADON will spot train and educate any CMA/ LPN / or RN not in accordance with safe practices of medication administration and storage. ICP consultant will perform monthly rounds and survey medication carts. DON/ADON will meet with ICP consultant to discuss any areas of concern on a monthly basis. A quality assurance evaluation of the nursing department pertaining to safe practices of medication administration and safe practices of medication storage will be conducted quarterly. During the quality assurance quarterly evaluation, the quarterly CMA medication pass observation will be assessed for completion. LPNs and RNs will also be given

training on safe practices of medication in an assisted living facility. During this time the quality assurance form will be completed. The form will be assessed during the morning meeting with all department heads. Any areas of concern or areas out of standard compliance will be addressed immediately by the administrator.

A1011

8.36-11.7(k) Pharmaceutical Services Completion date- 5/11/2022

1. All NJ Ex Order 26.4(b)(1) requiring a double lock listed upon inspection on 2/4/22 have been safely secured and safely stored in the facility. All NJ Ex Order 26.4(b)(1) with the potential of the drug NJ Ex Order 26.4(b)(1) that are no longer in use have been destroyed as per NJ Ex Order 26.4(b)(1) Act and all other Federal and State laws. All NJ Ex Order 26.4(b)(1) with the potential of the drug being abused that are still in use are properly stored with a double lock in medication carts. A lock safe has been installed in the Nursing office to safely secure NJ Ex Order 26.4(b)(1) until proper destruction of medication.

1. All residents have been affected by this deficient practice. All resident's not in the sample have the potential to be affected by the same deficient practice.

1. A new policy has been created for the Registered Nurse to conduct weekly medication cart audits. A new policy has been created for proper and safe storage and removal of all controlled substances no longer in use. An in-service has been conducted and will continue by the Director of Nursing and Assistant Director of Nursing to all CMAs/LPNs/ RNs on proper removal of controlled substances no longer in use and proper and safe storage of all controlled medications.

1. The Registered Nurse in the facility will conduct weekly medication cart audits on all medication carts in the facility. Upon audits, the Registered Nurse will remove all expired or discontinued controlled substances. Such controlled substances will be double locked in the nursing office in a properly secured lock safe until destruction. Proper destruction will be conducted within 30 days of such medication no longer in use. Prior to the removal by the Registered Nurse of controlled substances from the medication cart, the LPN/CMAs will continue to count such controlled medication during each shift change. This will ensure the narcotic count is accurate until destruction. The pharmacy consultant will continue to visit the facility quarterly to ensure proper storage of all controlled substances and medication review. A quality assurance evaluation of the nursing department pertaining to safe practices of medication administration and safe practices of medication storage will be conducted quarterly. During the quality assurance quarterly evaluation the quarterly CMA medication pass observation will be assessed for completion. LPNs and RNs will also be given training on safe practices of medication in an assisted living facility. During this quarterly quality assurance evaluation all medication carts and refrigerators storing medications will be evaluated to ensure all locks are properly functioning. During this time the quality assurance form will be completed. The form will be assessed during the morning meeting with all

department heads. Any areas of concern or areas out of standard compliance will be addressed immediately by the administrator.

A1041

8.36-14.3(a) Emergency Services and Procedures Completion date- 5/11/2022

1. A mandated monthly fire drill was conducted since the visit on 2/24/22. All staff that was present at the time of the drill was in-serviced on proper and safe evacuation in the event of a fire. Fire Drills have been and will continue to be conducted monthly and on-going since visit on 2/4/22.

1. All residents have been affected by this deficient practice. All resident's not in the sample have the potential to be affected by the same deficient practice

1. A policy has been created that requires the facility to conduct at least one drill of the emergency plans every month. The drills will be conducted on a rotating basis to ensure that each working shift receives four drills on an annual basis The facility shall also conduct at least one drill per year for emergencies due to a disaster other than fire. All drills will contain proper documentation in accordance with the licensure of Assisted Living Residences. Bayside Manor will conduct a monthly in-house fire drill in the event of an outside service not conducting such mandatory monthly fire drill. An in-service has been performed with the Director of Maintenance (DM) and the Administrator on new stated policies.

1. The Director of Maintenance will use the newly created tracking system to ensure that a monthly fire drill has been conducted along with the annual disaster drill. The Executive Director will monitor the fire drill tracking system monthly. A quality assurance evaluation of the maintenance department pertaining to fire safety, as well as evaluation of the completion of monthly fire drills will be conducted quarterly. The fire doors and extinguishers will be assessed for proper functioning at this time. During this time the quality assurance form will be completed. The form will be assessed during the morning meeting with all department heads. Any areas of concern or areas out of standard compliance will be addressed immediately by the administrator.

A1047

8.36-14.3(d) Emergency Services and Procedures Completion date- 5/11/2022

1. All extinguishers located in the facility have been inspected by the Director of Maintenance and documented on tags located on each extinguisher; including the fire extinguishers located by the time clock, kitchen door, and fire extinguisher #1 listed in citation. All extinguishers are in working order with adequate pressure. All extinguishers are properly functioning and properly stored in accordance with the National Fire Protection Association.

1. All residents have been affected by this deficient practice. All resident's not in the sample have the potential to be affected by the same deficient practice

1. A policy has been created that requires the facility to conduct at least one inspection of fire extinguishers on a monthly basis. Such policy includes proper inspection, proper storage and proper documentation of extinguishers. One to one training has been conducted with the Administrator and Director of Maintenance on new policies and new tracking systems put in place.

1. The Director of Maintenance will use the newly created tracking system to ensure that a monthly inspection of all fire extinguishers has been conducted. The Administrator will monitor the fire extinguisher inspection tracking system monthly, as well as randomly checking the signature of completion on fire extinguishers throughout the facility. The Administrator will continue to hold daily meetings with department heads, at this time any extinguishers not in working order will be addressed. A quality assurance evaluation of the maintenance department pertaining to fire safety, as well as evaluation of the completion of monthly fire drills will be conducted quarterly. The fire doors and extinguishers will be assessed for proper functioning at this time. During this time the quality assurance form will be completed. The form will be assessed during the morning meeting with all department heads. Any areas of concern or areas out of standard compliance will be addressed immediately by the administrator.

A1089

8.36-16.3(B) Physical Plant Completion date- 5/1/2022

1. All Apartments listed during inspection on 2/3/2022 that did not have proper ventilation fans located in resident bathrooms have been repaired and are in working order; including bathrooms in resident rooms 106, 210, 219, 225, 220, 311, 321, 325, and 316. Such fans in every bathroom in the listed violation now have proper functioning mechanical ventilation.

1. All residents have been affected by this deficient practice. All resident's not in the sample have the potential to be affected by the same deficient practice.

1. A policy has been created to ensure inspections of all resident's bathroom mechanical ventilation fans are checked weekly by housekeeping during room cleaning and by maintenance upon move-

in of a new resident. The Director of Maintenance has been in-serviced on proper inspection to ensure a ventilation fan is in working order. The Director of Maintenance will continue to train all maintenance staff on such policy. Director of housekeeping has been in-serviced on the following below and will continue to train her staff on such new policy and procedure

. The proper way to check the exhaust ventilation system to ensure it is working properly.
a. If an exhaust ventilation system is found to not be working properly by the housekeeping personnel, they will fill out a work order to have it fixed or replaced by the Maintenance Department

2. Checking the proper functioning of a bathroom exhaust ventilation system has now been added to the maintenance department's checklist used to prepare an apartment for a move in . Checking all resident bathroom ventilation systems, has been added to the housekeeping room cleaning checklist. The Director of housekeeping will review the weekly room checklist filled out by her staff and will report any deficient exhaust fans to the maintenance department immediately. Any exhaust systems found to be deficient will be repaired or replaced. The Administrator will continue to hold daily meetings with department heads, at this time any concerns with mechanical ventilation fans not in working order will be addressed. A quality assurance evaluation of the maintenance department and housekeeping department will be conducted quarterly. During this quarterly quality assurance evaluation rooms currently occupied and rooms currently vacant will be assessed for proper functioning of ventilation fans. During this time the quality assurance form will be completed. The form will be assessed during the morning meeting with all department heads. Any areas of concern or areas out of standard compliance will be addressed immediately by the administrator.

A1249
8:36-17.7 (Housekeeping - Sanitation- Safety- Maintenance) Completion date- 5/1/2022

1. All emergency fire exits are properly functioning and repaired. In the event of a fire, all fire doors will be unlocked and all keypads will be released. There are no exits in the facility that are barricaded to prevent exiting or entering the facility. A revisit was conducted on 2/19 and determined the cited barricaded door fire door #14 on the 400 unit is now in working order with no blocking device present. Fire door #14 and all fire doors are easily accessible in the event of an emergency. At no time are the fire or smoke doors propped open with a wedge or magnet including compartment doors on the 600 unit. Compartment doors on the 600 unit listed in the citation are properly fire/smoke sealed in accordance with National Fire Protection Association. Exit door #5 located in the main library, exit door #4 in the main TV room and fire exit door #15 are properly functioning in the event of an emergency with a keypad and magnet. Door #16 stated in the citation is properly latching to ensure fire safety. A new push bar has been ordered for all cited doors and will be installed by the end of the month, until then all doors are properly functioning in accordance with fire safety evaluation by local and state fire inspections.

1. All residents have been affected by this deficient practice. All resident's not in the sample have the potential to be affected by the same deficient practice.

1. A new policy has been created for the Director of Maintenance to check on all fire doors and smoke doors monthly. At this time the DM will be checking proper functioning and proper sealing

of doors when closed. New push bar mechanisms have been ordered to be installed on all fire doors that exit the facility. New double push bar mechanisms have been ordered to be installed on smoke doors on the 2nd and 3rd floor dividing each floor.

1. The Director of Maintenance or designee will continue to conduct monthly fire and smoke door inspections. During this time proper functioning and proper latching will be assessed and addressed if out of compliance. In the event of a door not properly functioning the Administrator will be notified immediately, and a 30 min census check of residents able to access such a door will be initiated. The Administrator will continue to coordinate daily morning meetings, at this time all fire and smoke doors out of compliance will be addressed. The Administrator will continue to make daily rounds and check that the buildings and grounds are kept free from fire hazards and other hazards to resident's health and safety. A quality assurance evaluation of the maintenance department pertaining to fire safety, as well as evaluation of the completion of monthly fire drills will be conducted quarterly. The fire doors and extinguishers will be assessed for proper functioning at this time. All fire doors will be assessed for proper functioning in the need of exiting the facility in an emergency. During this quality assurance evaluation, the fire doors will also be assessed for any blocking device that may impede immediate evacuation. During this time the quality assurance form will be completed. The form will be assessed during the morning meeting with all department heads. Any areas of concern or areas out of standard compliance will be addressed immediately by the administrator.

A1299

8.36-18.3(a)(5) Infection Prevention and Control Services Completion date- 3/15/2022

1. All staff and visitors are now being screened and will continue to be screened before entering the facility. Such screening processes include NJ Ex Order 26.4(b)(1) checks and NJ Ex Order 26.4(b)(1) symptom questionnaires. Proper NJ Ex Order 26.4(b) precautions are now in place when NJ Ex Order 26.4(b)(1) with all residents. All new admissions and readmissions are NJ Ex Order 26.4(b)(1) and will continue to be NJ Ex Order 26.4(b)(1) in accordance with CDC guidelines to reduce the risks of infection. Infection control precautions were put into effect immediately after the conclusion of survey.

1. All residents have been affected by this deficient practice. All residents not in sample have the potential to be affected by the same deficient practice.

1. Written policies and procedures have been established and implemented for infection prevention and control. New techniques are now being used when in contact with a resident. Only the front main entrance is being used for entering the facility. All staff must check their temperature and record findings before entering. All staff must answer COVID 19 questionnaire. All visitors must check their temperature and record findings before entering. All visitors must answer COVID 19 questionnaire. All concierges have been trained to properly screen all staff and visitors entering the facility. All vendors and deliveries are instructed to use the main entrance for proper screening

before entering the facility. All employees have been trained and re-trained during a 5 day mandatory meeting held through 2/17/22 - 2/23/22 to enforce all new policies. All employees have been trained and educated on proper use and disposal of gloves, proper handwashing and implementation, proper use of PPE and donning and doffing. During this 5 day training all attendees were educated and correctly returned demonstration of new procedures. During this 5 day training all employees were properly mask fitted for N95 masks, they have been educated for proper wearing of masks. New policies have been created to enforce all new procedures. The Director of Nursing, Administrator, Administrator consultant and nursing consultant have created new policies for proper time frame of quarantine and proper testing for new admissions and readmissions. Admissions and readmissions are quarantined to their rooms in accordance with CDC guidelines. Such rooms are using proper signage for isolation protocols; as well as proper closure of doors entering such rooms. All staff has been trained on isolation precautions and proper use of PPE when entering and exiting isolation. CMAs, LPNs, and RNs have been trained and educated on adequate timing needed to test quarantine residents in order to remove isolation status. Since the visit on 2/4/2022 a new designated PPE storage room has been put in place. The room includes clean isolation room set-ups, as well as an area for disposal of soiled PPE equipment. During this 5 day training held through 2/17/22 - 2/23/2 cited employees CMA #5, CMA #3, HHA #1, HHA #2, HHA #3, LPN #10, housekeeper #11, HHA #12, CMA #13, Dietary aide #15, LPN #15, CNA #16 were in attendance. Employees listed in citations (CMA #5, Executive Director, CMA #3, HHA #1, HHA#2, and HHA#3) were all present and verbalized understanding of new policies and procedures as well. Upon daily rounds made by Administrator consultant, and Nursing consultant all employees are in compliance with PPE, and are properly wearing their face masks to reduce the risk of infection. All isolation rooms are using proper signage to inform staff and visitors of possible risk of infection and PPE needed before entering.

1. The front main entrance is the only entrance continuing to be used to ensure proper screening is done to reduce the risk of infection. The Director of Nursing and Assistant Director of Nursing are continuing to make daily rounds to each unit to ensure proper use of PPE and infection control. The Director of Nursing or designee will conduct random audits on all three shifts three times a week for 4 weeks, then once a week for 4 weeks, then quarterly. Audits findings will be reported at the quarterly Q & A meetings. Administrator has implemented daily meetings to include admission and readmission quarantining as well as Covid19 testing results. An ICP consultant has been hired to monitor and advise infection control compliance on a monthly basis. The Director of nursing and Administrator will meet with the ICP consultant on a monthly basis to review infection control compliance. A quality assurance evaluation of all departments pertaining to infection control will be conducted quarterly. During this quarterly quality assurance evaluation, the evaluator will ensure proper safe precautions are being maintained in ALL departments to reduce the risk of infection. Proper screening, use of PPE, proper isolation protocols, Covid 19 testing as well as the practicing of basic infection control policies will be assessed at this time. New employees that have been hired since the last quarterly quality assurance evaluation will be assessed for completion of mandatory infection control training and proper N95 mask fitting. During this time the quality assurance form will be completed. The form will be assessed during the morning meeting with all department heads once completed. The quality assurance form will also be reviewed by the ICP consultant for any recommendations. Any areas of concern or areas out of standard compliance will be addressed immediately by the administrator.

A1307
8:36-18.4 (a)(1) Infection Prevention and Control Services Completion date- 5/1/2022

1. All employees, current and new, have received a proper NJ Ex Order 26.4(b)(1) or have been screened for [redacted] in accordance with the Department of Health and CDC; including stated LPN#8. All employees have such documentation and will be tracked annually for proper screening. All employees that are currently working are exhibiting no signs and symptoms of tuberculosis and serve no harm to all residents in the facility.

1. All residents have been affected by this deficient practice. All resident's not in the sample have the potential to be affected by the same deficient practice.

1. A policy has been created to ensure the initial and annual TB screening is completed and documented. The DON and ADON have been in-serviced on such a new policy. All new employees who have not received a TST within the last year will receive an initial first step TST (Tuberculosis Skin Test) and within 1-3 weeks will receive the 2nd step. An annual individual risk assessment and symptom evaluation screening form will be completed annually on all employees. All employees will receive TB information annually. The staffing coordinator has added the initial TST and / or screening form to her new hire checklist.

4. The Director of Nursing or appointed designee will ensure all new employees will receive an initial TST (Tuberculosis Skin Test) and / or individual risk assessment and symptom evaluation screening form. The Director of Nursing or appointed designee will track that all employees receive annual TB information on an annual basis. The TST (Tuberculosis Skin Test) has been added to the new hire checklist. The Director of Nursing and the staffing coordinator will ensure all new employees receive proper TB testing and/or screening as per guidelines before starting a new shift. A quality assurance evaluation of the nursing department pertaining to initial and annual TB screening will be conducted quarterly. During the quality assurance quarterly evaluation, the PPD/TB tracking will be assessed. Any new or current employee out of compliance will be given the Tuberculosis Skin Test or TB questionnaire immediately. During this time the quality assurance form will be completed. The form will be assessed during the morning meeting with all department heads. Any areas of concern or areas out of standard compliance will be addressed immediately by the administrator.