STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315245	A. BUILDING _____ B. WING _____	07/12/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT CHERRY HILL	1399 CHAPEL AVE WEST CHERRY HILL, NJ 08002

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F 000	INITIAL COMMENTS Survey Date: 7/12/22 Census: 104 Sample: 7 A COVID-19 Focused Infection Control Survey was conducted by the New Jersey Department of Health. The facility was found to be not in compliance with 42 CFR §483.80 infection control regulations as it relates to the implementation of the CMS and Centers for Disease Control and Prevention (CDC) recommended practices for COVID-19.	F 000		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment	F 880		10/12/22

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

Electronically Signed | 08/12/2022

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F 880	Continued From page 1	F 880		

conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of

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F 880	Continued From page 2 infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and review of facility documentation, it was determined that the facility failed to a) perform appropriate monitoring of all residents for signs and symptoms of COVID-19 as well as perform complete contact tracing to identify residents and staff potentially exposed to COVID-19, a deadly virus, and b) perform appropriate screening and education of visitors to address the risk for infection transmission, in accordance with the facility policy and acceptable standards of infection control practice during a COVID-19 Focused Survey. The deficient practice was evidenced as follows: 1. During entrance conference with the surveyors, the Assistant Administrator (AA), the Director of Nursing (DON), and the Infection Preventionist (IP) on 07/12/22 at 10:02 AM, the AA stated that the facility's outbreak started [redacted] due to positive residents and staff members. He further stated that at that time, communal activities and dining was stopped, and residents were encouraged to stay in their room. He stated that facility wide COVID testing was completed for all staff and residents and continued to be done twice a week. The IP stated that all staff were required to wear a N95 mask (a respiratory protective device designed to achieve a very close facial fit and very efficient filtration of airborne particles) and a face shield.	F 880	1. " Contact tracing completed " Coverage for reception was updated " Signs and symptoms for residents were completed 2. " All residents have the potential to be affected. 3. " Receptionist was immediately re-inserviced and educated on procedure of screening " A facility wide inservice was conducted on screening process all visitors, vendors and employees. " Scanning process was developed to ensure reception desk will be covered during scanning time " All clinical staff were inserviced to the requirement of documentation required for all resident with possible exposure in addition to positive COVID-19 residents " A comprehensive contact tracing form was created that incorporated all information required to perform an adequate comprehensive contact tracing. " All staff were inserviced to the importance of providing accurate details during contact tracing.	

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F 880	Continued From page 3 During an interview with the surveyors on 07/12/22 at 10:13 AM, the IP stated that the facility started facility wide testing for residents and staff and residents were placed on vital signs check daily on [redacted] She stated that COVID positive residents were moved to the COVID unit. If they had had a roommate, the roommate was placed on droplet precautions and vital signs were done every shift. While reviewing contact tracing (the process of identifying, assessing, and managing people who have been exposed to someone who has been infected with the COVID-19 virus), the IP stated that the facility did do contact tracing for the resident's and the staff members but did not determine the extent of the exposure. She stated that the purpose of contact tracing was to find a root cause to see where it all started. The facility provided, "Contact Tracing" forms for the four COVID-19 positive staff members. The Contact Tracing included the employee's name, date of possible exposure, date of last COVID test. Employee #1's form revealed unknown exposure, fully up to date on COVID-19 vaccinations, and wears personal protective equipment (PPE) at all times while in the facility. Employee #2's form revealed unknown exposure, EX. Order 26.(4) B1 on [redacted], fully up to date on COVID-19 vaccinations, and wears PPE at all times while in the facility. Employee #3's form revealed unknown exposure, fully up to date on COVID-19 vaccinations, and wears appropriate PPE at all times in the facility. Employee #4's form revealed unknown exposure, fully up to date on COVID-19 vaccinations, and wears appropriate PPE while in the facility. During an interview with the surveyors on	F 880	" A facility wide inservice for all nurses was conducted to educate on requirement of Q shift monitoring documentation for residents being monitored. " Infection Intervention and Prevention Plan was completed by facility Infection Prevention and Intervention Plan which includes tracking/screening procedures was completed Infection preventionist completed the CDC infection prevention training course modules. Infection preventionist will conduct daily audit to ensure documentation is completed and findings will be presented at QAPI monthly X 3 months then annually or as needed. A random audit will be performed once a Week for 3 months by Infection preventionist or designee to ensure all employees, vendors and visitors were checked in at reception / reception desk always has coverage and findings will be presented at QAPI monthly X 3 months then annually or as needed. 4. A Root Cause Analysis was conducted on why the staff did what they did " Infection Preventionist needs further training on the severity of performing appropriate monitoring of all residents for signs and symptoms of COVID-19 as well	

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F 880	Continued From page 4 07/12/22 at 11:56 AM, the IP stated that if a resident was positive for COVID, staff would complete a COVID assessment. If a resident was exposed to a positive roommate, they would be placed on droplet precautions and a Respiratory assessment would be completed. She stated that during the outbreak everyone in long term care was placed on daily vital sign and everyone on the subacute unit was placed on vital signs every shift. 2. On 07/11/22 at 08:50 AM, the surveyors entered the facility through the main entrance. There was no staff at the reception desk. There was no signage to alert people that they need to be screened prior to entry. The was a white board with COVID information and that a N95 mask and face shield were required in the facility. There were two staff members in the foyer that did not instruct the surveyors to screen. The surveyors walked onto the first-floor unit and asked a medication cart nurse where the DON's office was located. The nurse gave the surveyors the directions but did not ask any further questions. The surveyors went to the AA's office and introduced themselves. The AA took the surveyors to the conference room and did not ask any further questions in regard to the surveyor's entrance. During entrance conference with the surveyors on 07/11/22 at 10:06 AM, the DON stated that everyone entering the building should be stopped at the receptionist desk, screened, educated, and given PPE, if needed. She stated the purpose of the screening was early detection. At that time, the surveyors stated that they had not been screened or questioned upon entrance. The AA stated that he immediately went to the	F 880	as perform complete contract tracing. " Receptionist needs further training on the severity of performing the appropriate screening and provide education to visitors to address the risk for infection transmission. 5. Staff were in serviced utilizing the following videos: a. Module 1 - Infection Prevention & Control Program - Infection Preventist and Topline Staff b. Keep COVID-19 Out! - Frontline Staff c. Closely Monitor Residents - Frontline Staff d. Use PPE Correctly for COVID-19 - Frontline Staff e. Module 5 - Outbreaks - Topline and Infection Preventist f. Module 4 - Infection Surveillance - Topline and Infection Preventist g. Module 7 - Hand Hygiene - All staff including Topline Staff and Infection Preventist h. Module 6A - Principles of Standard Precautions - All staff including Topline Staff and Infection Preventist i. Module 6B - Principles of Transmission Based Precautions - All staff including Topline Staff and Infection Preventist	

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receptionist desk after leaving the surveyors in the conference room to see what had happened. The DON stated that the surveyors still should be screened. After the entrance conference at 10:40 AM, the surveyors informed the IP that they were going to tour the facility. The IP directed them back to the conference room.

At 10:42 AM, the DON took the surveyors temperature and gave them the Visitor/Vendor log to complete regarding signs, symptoms, and exposure to COVID-19.

During an interview with the surveyor on 07/11/22 at 11:05 AM, a resident's [redacted] stated that he/she would have to fill out a form at the reception desk and have his/her temperature taken.

During an interview with the surveyors on 07/12/22 at 11:57 AM, the IP stated that the facility policy for COVID-19 monitoring was to perform daily vital sign and everyone on the subacute unit was placed on vital signs every shift. She stated that COVID-19 signs and symptom monitoring was only done for residents who were already COVID-19 positive or considered exposed. At 12:10 PM, the IP again stated [COVID-19] symptom monitoring is not documented and only done for COVID-19 positive residents. She stated that the nurses "just know" to look for and report the signs and symptoms. She further stated that it was important to check for signs and symptoms of COVID-19 in residents for "early detection".

A review of the facility's policy, "Outbreak Plan" revised on 6/18/2022, Outbreak Phases: B. Outbreak Heightened Alert Phase: Identify and

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F 880	Continued From page 6 Screen residents, staff, and visitors, based on outbreak identified. Screening Protocol: B. Residents and Visitors: Facility will conduct active screening of all residents: when the building is in outbreak. Nursing staff will monitor resident's minimum of daily for symptoms of infectious disease including monitoring of vital signs; Residents will be monitored for signs and symptoms related to the infectious disease for those having confirmed close contact with someone that was infected. Visitors: Facility will conduct active screening of all visitors EXCEPT EMS personnel. The facility will advise everyone who enters the building to monitor for signs and symptoms of COVID 19 for at least 14 days after exiting the facility ...Screening Protocol to consist of a completion of a questionnaire about symptoms and potential exposure ... NJAC 8:39-19.4(a)(d)(f)(g)	F 880		

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S 000	Initial Comments THE FACILITY WAS NOT IN COMPLIANCE WITH THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE, CHAPTER 8:39, STANDARDS FOR LICENSURE OF LONG TERM CARE FACILITIES. 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 THE PROVISIONS OF THE NEW JERSEY ADMINISTRATIVE CODE, TITLE 8, CHAPTER 43E, ENFORCEMENT OF LICENSURE REGULATIONS.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff-to-shift ratios as mandated by the state of New Jersey for 10 of 14-day shifts reviewed. This deficient practice was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 1/28/21, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey	S 560	All residents could be potentially affected by this occurrence. The facility has entered into an agreement with a staffing agency which will boost the overall CNA numbers to ensure compliance with the staffing requirements. The facility will host recruitment and retention meetings with the staff to ensure their current staff want to continue employment. The facility will document all their staffing efforts in QAPI for 3 months then re-evaluate their staffing needs to ensure the staffing ratios are in	9/12/22

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

Electronically Signed | 08/12/22

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S 560	Continued From page 1 Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 2/01/21: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. The surveyor requested staffing for weeks of 6/26/22 and 7/3/22. Review of the New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report revealed the following: -06/26/22 had 8 CNAs for 103 residents on the day shift, required 13 CNAs. -06/27/22 had 12 CNAs for 102 residents on the day shift, required 13 CNAs. -06/30/22 had 12 CNAs for 102 residents on the day shift, required 13 CNAs. -07/01/22 had 12 CNAs for 102 residents on the day shift, required 13 CNAs. -07/02/22 had 10 CNAs for 102 residents on the day shift, required 13 CNAs. -07/03/22 had 9 CNAs for 102 residents on the	S 560	compliance. Director of Human Resources or designee weekly marketing open positions to local schools, mall and public areas. The facility just increased the rate of pay for RN's, LPN's and CNA's. The facility is also offering to pay for the schooling for any new hires that want to become a CNA.	

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S 560	Continued From page 2 day shift, required 13 CNAs. -07/05/22 had 12 CNAs for 103 residents on the day shift, required 13 CNAs. -07/07/22 had 11 CNAs for 103 residents on the day shift, required 13 CNAs. -07/08/22 had 12 CNAs for 103 residents on the day shift, required 13 CNAs. -07/09/22 had 9 CNAs for 103 residents on the day shift, required 13 CNAs. During an interview with the surveyors on 07/12/2022 at 11:15 AM, the staffing coordinator stated she was aware of the staffing ratios and that they "always" meet the ratios. She stated that the Human Resource Director or herself clocks in as a CNA when they fall short. During an interview with the surveyors on 07/12/2022 at 12:53 PM, the Assistant Administrator and the Director of Nursing both stated that they were aware of the staffing ratios but were unable to speak to them.	S 560		