STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315083	A. BUILDING _____ B. WING _____	06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALARIS HEALTH AT JERSEY CITY	198 STEVENS AVE JERSEY CITY, NJ 07305

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Standard Survey: 6/10/21 Census: 106 Sample Size: 25 The facility is not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for long term care facilities.	F 000		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release	F 583		6/21/21

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

Electronically Signed | 06/21/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315083	A. BUILDING _____ B. WING _____	06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALARIS HEALTH AT JERSEY CITY	198 STEVENS AVE JERSEY CITY, NJ 07305

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 583	Continued From page 1 of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility policies, it was determined that the facility failed to provide full visual privacy during medication administration and during a physical examination for 2 of 22 residents reviewed, Resident # 14 and Resident # 81. The deficient practice was evidenced by the following: 1. On 6/2/21 at 10:21 AM, the surveyor observed the Registered Nurse (RN) lift the [redacted] of resident #14 and apply a [redacted] patch on the [redacted] in the hallway while residents and staff were walking around the area. On 6/4/21 at 10:56 AM, the surveyor spoke with the resident about the observation of the nurse putting the [redacted] patch on their [redacted] in the hallway. The resident stated "[redacted]." The surveyor asked the resident if the nurse always put the [redacted] patch on in the hallway. The resident said [redacted]." The surveyor asked the resident if it bothered [the resident] to have the [redacted] patch put on their [redacted] in the hallway. The resident said "No, it's ok, they don't do it all the time."	F 583	F583 SS=D Corrective action taken: On 6/8/21 the policy and procedure for resident's rights to privacy was reviewed with the RN and the attending physician by the Director of Nurses. Identification of residents that may be affected by the same practice : All residents have the potential to be affected by the same deficient practice. Systemic measures that were put in place: The nurse on 6/9/21 was immediately educated by the RN staff educator on resident privacy and proper procedure to administer medication. Policy for medication administration was revised on 6/11/21 to include offering privacy to resident during all medication administrations. All licensed nursing staff were educated on the revised policy and procedure on residents' privacy rights by RN nurse educator. Policies for privacy and medications are reviewed and educated during new nurse orientation by RN nurse educator. This practice will continue and will also be reviewed and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315083	A. BUILDING _____ B. WING _____	06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALARIS HEALTH AT JERSEY CITY	198 STEVENS AVE JERSEY CITY, NJ 07305

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 583	Continued From page 2 On 6/4/21 at 12:00 PM, the surveyor reviewed the medical record of Resident #14 which revealed the following: The current Physician's Order Sheet with an order that read [redacted]) Apply to [redacted] one time a day for [redacted] and remove per schedule." The order date was [redacted] The annual Minimum Data Set assessment tool dated [redacted], revealed the resident scored [redacted] out of a possible [redacted] when the Brief Interview for Mental Status was done which indicated the resident was [redacted] The current Medication Administration Record revealed that the nurse signed for the application of the patch on [redacted] On 6/4/21 at 1:21 PM, the surveyor spoke with the Director of Nursing (DON), the Licensed Nursing Home Administrator, the Regional VP and the Quality Assurance Nurse who were present about the observation of the nurse not offering physical privacy when applying the pain patch. The surveyor asked "Would you expect that the nurse would apply the [redacted] patch in the hallway?" The DON replied "No." 2. On 6/3/21 at 12:16 PM, the surveyor observed a physician on the observation unit. The physician went into the room of Resident # 81, and with the resident's door opened, the surveyor observed the physician lift the resident's [redacted] to the [redacted] and examine the resident's [redacted]. At 12:25 PM, the surveyor asked the physician about providing privacy during an examination	F 583	re-educate with all licensed nursing staff on a quarterly basis by the staff RN educator. The RN educator/or the Director of Nurses will do a minimum of 5 medication administration competencies with licensed nurses per quarter to ensure compliance with the resident privacy during medication administration. The attending physician was immediately re-educated on the policy for privacy by the RN staff educator. the Medical Director contacted all facility licensed medical practitioners and re-educated them on the facility policy on privacy during examination and care. The Medical Director and the Director of Nursing will provide inservice on facility policy for resident right to privacy to all licensed medical practitioners quarterly How Corrective action will be monitored to ensure deficient practice is being corrected and will not recur. Unit managers will audit licensed nurses compliance with privacy by observing licensed nruse care of 5 residents per unit weekly and reporting findings of privacy compliance to the administrator weekly for review and monitoring. Results of these audits will be presented to the Quarterly Quality Assurance committee meeting for review for the next two quarters. The Director of Nursing and or the RN supervisors will audit licensed medical practitioners compliance with privacy by	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315083	A. BUILDING _____ B. WING _____	06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALARIS HEALTH AT JERSEY CITY	198 STEVENS AVE JERSEY CITY, NJ 07305

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 583	Continued From page 3 and the physician stated that she should have closed the resident's door during the examination for privacy. At 1:30 PM, the surveyor discussed the concerns with the Administrator and DON. The DON stated that the physician should have provided privacy when examining the resident. The surveyor reviewed the facility's policy and procedure titled "Resident Rights to Privacy and Confidentiality" which was revised 11/2020. The policy and procedure indicated that "every nursing home resident has the right to personal privacy of not only his/her own physical body, but also of his/her personal space, including accommodations and personal care." The surveyor also reviewed the facility's policy and procedure titled "Medication Administration" which was updated 10/2020. It did not address the issue of providing physical privacy during the administration of medication. NJAC 8:39: 4.1 (a) 16	F 583	observing licensed physician interaction with 5 residents per unit weekly and report findings to the DON weekly. The Director of Nursing will provide weekly audits to the administrator weekly for review and monitoring. Results of these audits will be presented by the DON to the Quarterly Quality Assurance committee meeting for review for the next two quarters.	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record	F 689	F689 SS=D	6/21/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315083	A. BUILDING _____ B. WING _____	06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALARIS HEALTH AT JERSEY CITY	198 STEVENS AVE JERSEY CITY, NJ 07305

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 4 review, it was determined that the facility failed to provide a safe environment to prevent a fall during the repositioning and care of a resident. The deficient practice occurred for 1 of 2 residents (Resident #62) reviewed for [redacted] and evidenced by the following: On 6/2/21 at 12:23 PM, the surveyor observed Resident #62 in bed with eyes closed. The resident had a [redacted] and was receiving [redacted] There was a [redacted] on either side of the bed. The surveyor reviewed Resident #62's medical records that revealed the following: According to the Admission Record, Resident #62 was admitted to the facility with diagnoses that included [redacted]. The Admission Minimum Data Set (MDS) dated [redacted] and recent Quarterly MDS dated [redacted] indicated that the resident was unable to express oneself or understand others. The facility determined that the resident was [redacted] The facility assessed the resident's functional abilities in both the Admission MDS and Quarterly MDS as total assistance by two people for bed mobility, transfer, dressing, toilet use, which would consist of incontinent care, personal hygiene, and bathing. The resident had a [redacted] care plan that was initiated on [redacted] Included on the care plan was a notation that the resident had a [redacted] on [redacted]. Under Interventions dated [redacted],	F 689	Corrective action taken for those residents affected by the deficient practice: Policy on turning and repositioning reviewed with the CNA on 6/8/21 by the Director of Nurses. Identification of residents that may be affected by the same practice: All residents have the potential to be affected by the same deficient practice. Systemic measures put in place: All licensed nurses and nursing assistants were immediately re-educated with inservice on procedure on turning and repositioning based on resident level of assist by the RN Nurse Educator prior to the survey exit on 6/10/21. Policy on Turning and repositioning based on the level of assist required will be reviewed and educated during the general nursing orientation by the RN nurse educator. The RN nurse educator will also educate and review with all licensed nursing staff on a quarterly basis. The Director of Nursing (DON) and or the Administrator will review all fall incidents with the members of the interdisciplinary care team (IDCP) to prevent further occurrences. The DON will print data reports from the MDS assessments of which residents were coded as two person assist for bed mobility and transfers. This report was reviewed with the(IDCP) team at morning meeting on 6/18/21 and all care plans for those residents were reviewed to determine if included into the care plan. The DON will continue to this on a	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315083	A. BUILDING _____ B. WING _____	06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALARIS HEALTH AT JERSEY CITY	198 STEVENS AVE JERSEY CITY, NJ 07305

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 5 there was documentation for "2 people assist at all times during care." The Progress Notes dated [redacted] revealed the nurse documentated on [redacted] at 10:15 AM, she was called to the resident's room by the Certified Nursing Assistant (CNA). The nurse entered the resident's room and observed Resident #62 lying on the floor faced down next to the bed. The nurse documented that she inquired of the CNA what happened, and the CNA told the nurse that the resident "rolled out of bed when trying to position resident in bed." The nurse documented that the resident had a [redacted] to the [redacted] and was provided first aide. On 6/7/21 at 10:30 AM, the surveyor interviewed the Registered Nurse Unit Manager (RNUM) who stated the resident did have a [redacted] on [redacted] and informed the surveyor that of what occurred. The surveyor asked the RNUM if the resident was a one or two person assist with positioning and she stated the resident was always a two person assist during care and positioning. The surveyor requested to review the [redacted] investigation. At 1:29 PM, the Director of Nursing (DON) provided the [redacted] investigation report. According to the investigation report dated [redacted], the CNA assigned to the resident wrote in her statement the following; "while I was turning [the resident] to clean [the resident] back, I slightly pull [redacted] toward me and [the resident] had an involuntary movement causing [the resident] to roll off the [redacted] into the floor mat." The IDT (Interdisciplinary Team) Meeting	F 689	monthly basis as well as review the point of care charting by licensed nursing assistants. How corrective action will be monitored: The unit managers and or RN nursing supervisors will do direct care observation weekly of residents on each unit and audit that correct level of assist is being provided during care for 5 residents weekly and report findings of audits to DON weekly. The DON will audit the point of care certified nursing assistant documentation of residents who require two person assist for transfers or bed mobility weekly to verify compliance with the level of care required. The DON will review audits with the administrator weekly for further review and monitoring. The results of these audits will be presented by the DON at the QAA meeting for review for the next three quarters.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315083	A. BUILDING _____ B. WING _____	06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALARIS HEALTH AT JERSEY CITY	198 STEVENS AVE JERSEY CITY, NJ 07305

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 6	F 689		

Note-Fall Incident notes indicated under New Interventions the following; "[redacted] next to bed, two person assist with all care, and rehab post fall screen." Under Conclusion the following was documented; " ...for the safety of the resident and staff, [the resident] will be two person assist for all care ..."

There were additional IDT notes dated [redacted] and [redacted] reviewed that indicated the following: IDT Meeting Note - Care Plan Review dated [redacted] under #4 ADL's "Bed Mobility, Dressing, Eating, Toileting, Hygiene - Total x2." The IDT Meeting Note - General dated [redacted], the team discussed Resident #62 current ADL status, and included in the documentation following ADL's: Total assist x2 in bed mobility, dressing, eating, toileting, hygiene and bathing."

According to the form Rehab-General dated 3/25/21 under #44 and #44a; "Bed mobility and Support Provided - dependent and 2+people."

On 6/9/21 at 10:25 AM, the surveyor interviewed the CNA who was assigned to Resident #62 on [redacted]. The CNA stated that she always calls another CNA to help her with the resident. She stated while she was waiting for the CNA to come into the room, she started to "prepare to move [the resident] a little." She stated she "pulled the sheet under [the resident] towards me and then [the resident] started to move like a spasm and fell to the floor mat."

The surveyor asked the CNA if the resident was to be assisted by two people during care. Initially she said "no" and then changed her answer to "yes." The surveyor and the CNA reviewed the MDS Kardex Report that CNAs use as a plan of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315083	A. BUILDING _____ B. WING _____	06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALARIS HEALTH AT JERSEY CITY	198 STEVENS AVE JERSEY CITY, NJ 07305

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 7 care for the resident which indicated under ADL-Bed Mobility, total assistance, two + person's physical assist. The CNA stated she should have waited for the other CNA to assist her when she repositioned the resident. On 6/9/21 at 1:07 PM, the surveyor discussed the above concern with the Administrator and DON. The DON confirmed that the resident has been a two person's assistance since admission. A review of the facility's policy titled Repositioning Program dated 3/3/19 and revised 5/16/21, under Procedure for Bed Repositioning #3 indicated the following; "Certified Nursing Assistant(s) will assist/provide residents on turning and repositioning program to reposition every two hours and as needed while in bed based on level of assist required (1 person or 2 person assist). NJAC 8:39-27.1(a)	F 689		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.	F 755		6/21/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315083	A. BUILDING _____ B. WING _____	06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALARIS HEALTH AT JERSEY CITY	198 STEVENS AVE JERSEY CITY, NJ 07305

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 8 §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility records, it was determined that the facility failed to ensure an accurate inventory of controlled medications (narcotic medications) was dispensed from the facility's narcotic back up cabinet. The deficient practice occurred in 1 of 1 back up narcotic boxes inspected and evidenced by the following: On 6/3/21 at 11:17 AM, the surveyor checked the back-up narcotic cabinet located in the Supervisor's office, in the presence of the Director of Nursing (DON). The package labeled [redacted] mg (a combination narcotic [redacted]) had [redacted] tablets in the package. When compared to the declining inventory sheet, a discrepancy was observed. The declining inventory showed [redacted] mg tablets remaining in the package.	F 755	F 755 SS=D: Corrective action taken for these residents who were affected by the deficient practice: No residents were affected by the deficient practice. Identification of residents that may be affected by the same practice: All residents who are on narcotic medications have the potential to be affected by the deficient practice. Systemic measures put into place: Narcotic discrepancy was immediately resolved and corrected prior to survey exit. The RN nursing supervisor signed dose given on declining sheet. All licensed nursing staff were immediately re-educated with re-inservice on policy and procedure for narcotic	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315083	A. BUILDING _____ B. WING _____	06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALARIS HEALTH AT JERSEY CITY	198 STEVENS AVE JERSEY CITY, NJ 07305

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 9 The surveyor asked the DON to recount the tablets and she confirmed the same discrepancy. The DON stated the oncoming and outgoing shift Supervisors are responsible to count the controlled medications in the narcotic back up cabinet. The last date that was documented on the declining inventory sheet was [redacted] at 5 PM which indicated one [redacted] mg tablet was removed from inventory. The declining inventory sheet showed from [redacted] to [redacted] the last count remained at [redacted] tablets. On 6/3/21 at 11:53 AM, the surveyor interviewed the 7-3 Registered Nurse Supervisor (RN/S) and 11-7 Registered Nurse Unit Manager (RN/UM), who was supervising during the 11-7 shift on 6/3/21. The RN/UM stated that the two nurses started the control medication count at 7:30 AM on 6/3/21. The RN/UM stated that the RN/S counted controlled medications in the separate packages, while the RN/UM compared the tablets counted to the declining inventory sheet. The RN/S stated she did not notice the discrepancy. The RN/S confirmed with the surveyor that only the Supervisor has the keys for the back up narcotic cabinet. The RN/UM stated she did not notice the discrepancy when she counted with the evening shift Supervisor. On 6/3/21 at 12:31 PM, according to the DON, the 11-7 Supervisor who worked on [redacted] gave [redacted] mg to a resident at 6 AM. The 11-7 Supervisor informed the DON that she forgot to document on the declining inventory sheet.	F 755	inventor and policy of resolving narcotic discrepancy prior to survey exit by the RN nurse educator. RN Nurse Educator will review policy and procedure for Narcotic inventory and the discrepancy resolution wit all new licensed nursing staff during general nursing orientation and re-educate with in-services to all licensed nursing staff on a quarterly basis. Director of Nurses (DON) will do a minimum of 5 random audits of narcotic back up box per month to verify compliance with policy. Unit managers will do weekly narcotic declining sheet audit to verify compliance with policy. How corrective action will be monitored : The Director of Nursing (DON) will complete a minimum of 5 audits counts of narcotic back up box monthly to verify compliance with inventory policy and accuracy of narcotics. Unit managers and /or the RN nursing supervisors will observe a minimum of three narcotic inventory counts done at change of shift on each nursing unit to verify count, findings, of audits will be submitted to the DON for weekly review. The DON will provide weekly audits of all findings to narcotic compliance to the administrator for weekly reviewing and monitoring. the DON will review these audits at the QAA comittee meeting for the next two quarters.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315083	A. BUILDING _____ B. WING _____	06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALARIS HEALTH AT JERSEY CITY	198 STEVENS AVE JERSEY CITY, NJ 07305

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 10 At 1:42 PM, the surveyor discussed the above concern with the Administrator, Regional VP, Quality Assurance Nurse and the DON. The facility's policy titled Inventory Control of Drugs without a date indicated under Policy- "Controlled drugs are inventoried and documented under the proper conditions with regard to security and state/federal regulations." And under Procedure #A-2 "Schedule 11 medications are counted by the oncoming nurse and outgoing nurse at least once (1) a day or at the change of shift and documented on a Controlled Drug Count Verification (Shift Count Sheet for Narcotics)." NJAC 8:39-29.7(c)	F 755		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents,	F 880		6/24/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315083	A. BUILDING _____ B. WING _____	06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALARIS HEALTH AT JERSEY CITY	198 STEVENS AVE JERSEY CITY, NJ 07305

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 11 staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment 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.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315083	A. BUILDING _____ B. WING _____	06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALARIS HEALTH AT JERSEY CITY	198 STEVENS AVE JERSEY CITY, NJ 07305

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 12 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of 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, interview, and record review, it was determined that the facility failed to follow appropriate measures to prevent and control the spread of infection. This deficient practice was observed for 2 of 22 residents reviewed, Resident #81 and #103, as evidenced by the following: On 6/2/21 at 11:20 AM, the surveyor observed personal protective equipment (PPE) hanging on the door of Resident #81. There was also a STOP sign and a sequence for putting on and taking off PPE sign on the door which read "droplet precautions, everyone must: clean their hands, including before entering and when leaving the room, make sure their eyes, nose and mouth are fully covered before room entry, wear N95 mask, put on gown and gloves, and remove face protection before room exit." The surveyor interviewed the Registered Nurse, Unit Manager, Infection Preventionist (RN/UM/IP) who stated that the resident was readmitted to the facility and was on contact and droplet precautions in the observation unit (A unit where residents were quarantined for 14 days upon admission or re-admission to observe for signs and symptoms of [redacted]. Resident #81 was in the bed, located inside the resident's room.	F 880	F 880 ss=D Corrective action taken for those residents affected by the deficient practice: Policy on Infection Control transmission based droplet precautions were reviewed with the attending physician and the laundry aide. A Directed Plan of Correction was also written. it includes the three inservice modules and the Root cause analysis of this issue. The RCA for the attending physician was ; physician not aware that she was on an observation floor and was suppose to wear her N95. She stated that the protocol of the hospital was different. The attending also does not visit frequently and visits only once every 30 days to see her resident. since she visits infrequently she had a memory lapse as what mask to wear on the floor. The RCA of the laundry worker not wearing the appropriate mask: she infrequently goes up to the at unit and had a memory lapse on what mask to use. She also did not ask nursing what mask to wear. She became nervous when the surveyor was looking at her. All Front line staff viewed the video; Keep Covid out. All facility staff viewed; USE	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315083	A. BUILDING _____ B. WING _____	06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALARIS HEALTH AT JERSEY CITY	198 STEVENS AVE JERSEY CITY, NJ 07305

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 13 The surveyor reviewed the medical record of Resident #81 which revealed the following: An Admission Record, which indicated that Resident #81 was admitted to the facility with diagnoses that included [redacted] A Physician's Order Sheet that included a physician's order dated [redacted] which read "transmission-based droplet precautions." On 6/3/21 at 12:16 PM, the surveyor observed a Physician on the observation unit. The RN/UM/IP explained to the Physician that the unit was an observation unit and all the residents were on contact and droplet precautions. The Physician went to Resident # 81's room with a blue surgical mask on and no N95 respirator mask, she donned gloves, gown, and a face shield. With the resident's door opened, the surveyor observed the Physician lift the resident's [redacted] to examine both of the resident's [redacted]. The surveyor observed the Physician doff her face shield, gloves, and gown and place in the appropriate bins. At 12:25 PM, the surveyor asked the Physician why she was not wearing an N95 mask. The Physician stated that she was not aware that she needed an N95 mask to enter the resident's room and did not have one with her. The Physician stated that she was only at the facility to visit that one resident. At 12:30 PM, the surveyor interviewed the RN/UM/IP who stated that the Physician should have worn an N95 mask and she did not realize	F 880	PPE correctly. Identification of residents that may be affected by the same practice: All residents have the potential to be affected by the same deficient practice. Systemic measures put in place: The physician and laundry aide observed not wearing the N95 mask, were immediately inserviced by the administrator and the infection control preventionist on the facility policy regarding personal protective equipment required when entering resident rooms on transmission based droplet precautions prior to survey exit on 6/10/21. All facility staff in all departments were immediately re-educated by the Director of Nursing (DON) and the infection preventionist regarding infection control and use of appropriate personal protective equipment including use of N95 mask when entering rooms on transmission based droplet precautions. All facility staff including all licensed medical practitioners will receive inservice on the use of personal protective equipment quarterly by the infection control preventionist. Infection Control guidelines and policy on personal protective equipment will be reviewed with all staff quarterly by the staff RN educator and /or when guidance changes. The infection control preventionist and or the DON will conduct audit evaluations on staff donning and doffing personal protective equipment including the N95 Mask on a quarterly basis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315083	A. BUILDING _____ B. WING _____	06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALARIS HEALTH AT JERSEY CITY	198 STEVENS AVE JERSEY CITY, NJ 07305

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 14 that the Physician was not wearing one. At 1:30 PM, the surveyor discussed the concerns with the Administrator and Director of Nursing (DON). The DON stated that the Physician should have worn an N95 mask per the facility policy and procedure. On 6/6/21 at 9:22 AM, the surveyor observed a Laundry Aide (LA) on the observation unit. The LA entered Resident # 103's room wearing two surgical masks, face shield, gloves and gown. The LA did not don an N95 mask. The surveyor observed PPE hanging on Resident #103's door. There was also a STOP sign and sequence for putting on and taking off PPE sign on the door which indicated "droplet precautions, everyone must: clean their hands, including before entering and when leaving the room, make sure their eyes, nose and mouth are fully covered before room entry, wear N95 mask, put on gown and gloves, and remove face protection before room exit." The surveyor observed the LA doff her gloves, gown, surgical mask and face shield and place them in the appropriate bins as she exited the resident's room. The LA was observed performing appropriate hand hygiene. At 9:27AM, the surveyor interviewed the LA who stated that she recently received an in-service (a training session) provided by the DON which indicated that she only needed to wear a surgical mask if entering a resident's room who was on droplet precautions, as long as there was no close contact. The LA stated that she only worked on that unit and was done with her resident assignment at that time. At 9:40 AM, in the presence of the DON, the LA	F 880	How corrective action will be monitored: the DON and or the infection control preventionist and or the RN supervisors will do infection control rounds and audits daily on all three shifts to ensure staff compliance with infection control guidelines. The infection Control preventionist and or DON will complete minimum of 5 audits weekly on donning and doffing personal protective equipment including the N95 mask with he staff from different departments across all shifts including at least one audit of licensed medical practitioner donning and doffing personal protective equipment from the observation unit. The DON will provide weekly audits of all findings of personal protective equipment. The DON will provide protective equipment compliance audits to the administrator for weekly review and monitoring. The results of these audits will be presented to the QAA committee quarterly by the DON for review and discussion . This review will be presented for the next two quarters.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315083	A. BUILDING _____ B. WING _____	06/10/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALARIS HEALTH AT JERSEY CITY	198 STEVENS AVE JERSEY CITY, NJ 07305

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 15	F 880		

stated that she was in-serviced by the DON and that she only needed to wear a blue surgical if she was not to have close contact with the resident. The DON stated that if any staff entered the resident's room, whether it was close contact or not, the room of those resident's on quarantine were considered droplet precautions and an N95 mask must have been worn when entering the resident's room.

At 10:10 AM, the DON provided the surveyor with an in-service dated [redacted] signed by the LA, which revealed that laundry staff should don gown, gloves, N95 mask, and face shield when going into the resident rooms on the observation unit.

At 1:15 PM, the surveyor discussed the above concerns with the Administrator and DON, who stated that the LA should have worn an N95 mask when entering a resident's room who was on droplet precautions.

The surveyor reviewed the policy and procedure titled "PPE during the COVID-19 Public Health Emergency" which was revised 6/7/21. The policy and procedure indicated that the cohort for new or readmission (observation unit) required droplet precautions including N95 mask use.

N.J.A.C. 8:39-19.4(a)