STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315366	A. BUILDING _____ B. WING _____	05/18/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALARIS HEALTH AT BELGROVE	195 BELGROVE DRIVE KEARNY, NJ 07032

(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: 05/18/2021 Census: 67 Sample Size: 17 A Recertification Survey was Conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey. A COVID-19 Focused Infection Control Survey was conducted in conjunction with the recertification survey. The facility was found to be in compliance with 42 CFR 483.80 infection control regulations as it relates to the CMS and Centers for Disease Control and Prevention (CDC) recommended practices for COVID-19.	F 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to maintain professional standards of nursing practice in accurately documenting physician's orders for 1 of 20 residents reviewed; Resident [redacted]. The deficient practice was evidenced by the following:	F 658	1. * No Corrective action was accomplished for resident [redacted] as resident has [redacted]. * In-service on deficient practice was initiated for nurses. * All residents with insulin and oxygen orders were reviewed for proper	6/11/21

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

Electronically Signed | 05/28/2021

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F 658	Continued From page 1 On 05/17/21 at 02:16 PM, the surveyor reviewed the closed record of resident [redacted] who was no [redacted] of the facility. The surveyor reviewed the resident's paper and electronic chart. While reviewing Resident [redacted] electronic chart, the surveyor noted a documented Physician's order entered in the electronic medication administration record (EMAR) dated 4/12/21 for "[redacted]" (a once weekly medication that helps your body release it's own insulin) [redacted] The surveyor noted a nursing entry on the EMAR dated 4/12/21 at 9:00 AM, documenting that [redacted] was administered to Resident [redacted]. At that same time/date, the surveyor reviewed the hand written Nurse Practioner's order found on the Physician's Order Sheet dated 4/11/2021 that documented, "[redacted]." The surveyor noted that the EMAR had a documented Physician's order entered that read "[redacted] The AR had documented nurses signatures that [redacted] Resident [redacted] from 4/7-4/12 every shift, with the last entry time being 11:00 PM on 4/12/21 - 7:00 AM 4/13/21. The surveyor then reviewed the Nurses Progress Note dated 4/13/21 at 7:31 AM, which documented, "[redacted] via nasal cannula. Received at shift, in bed asleep, in no respiratory issues, Vital signs within normal limits." The surveyor reviewed the Face Sheet (a	F 658	documentation. 2. * All residents with physician's orders are potentially affected. 3. * 11-7 nurse on duty will review all new orders from the day daily to check for completion and accuracy of transcription of physician or nurse practitioner's orders. * In-service by Assistant Director of Nursing (ADON)or designee on 24 hour chart check to the 11-7 nurses. * In-service by ADON or designee on Transcribing Physician's Orders, which includes the nurse to read back and verify the physician's order to the Doctor or Nurse Practitioner. * In-service by ADON or designee on accurately documenting physician's orders which includes nurse's notes. 4. * 5 residents physician orders will be reviewed by Director of nursing (DON) or designee for proper physician order transcription weekly for 3 months the re-evaluate. * 5 residents chart will be reviewed by DON or designee for compliance with daily 24 hour chart check weekly for 3 months then re-evaluate.	

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F 658	Continued From page 2 document that gives a patient's information at a quick glance) for Resident [redacted] who was [redacted] and [redacted] Executive Order 26, 4.b. On 5/17/21 at 9:43 AM, the surveyor met with the Director of Nursing (DON), Administrator and Quality Assurance Regional Nurse. The DON could not explain any of the discrepancies found and assured the surveyor that the correct amount of [redacted] was administered as well as the correct [redacted] level. On 5/17/21 at 10:20 AM, the surveyor interviewed the facility Nurse Practitioner (NP) who could not explain why the documentation did not match the orders written by the NP or the Physician. On 5/17/21 at 12:38 PM, the surveyor was informed by the DON that the pharmacy only delivered Executive Order 26, 4.b. The DON supplied evidence in the form of a pharmacy packing slip documenting, Executive Order 26, 4.b. that were delivered from the pharmacy on 4/12/21 at 4:15:31 AM. The surveyor reviewed the Policy and Procedure for "Transcribing Physician's Orders" revised on 2/2021. The "Policy Interpretation and Implementation" which documented "1. The licensed nurse receives the order from the physician via written, verbal or telephone order. Verbal and telephone orders are verified by the licensed nurse by reading it back to the physician to verify accuracy. 2. Orders are transcribed to	F 658	* 5 residents chart will be reviewed by DON or designee for nursing documentation on physician orders weekly for 3 months the re-evaluate. * All findings will be reported and reviewed monthly and reported quarterly during the QAPI meeting for the next 3 quarters by ADON or designee to the QAPI committee. Evaluation by the committee to determine continuing frequency of audits.	

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F 658	Continued From page 3 the electronic medical record, reviewed, acknowledged and saved by the transcriber (licensed nurse) and automatically generates an electronic Physician's Order Sheet (POS), Medication Administration Record (MAR) and Treatment Administration Record (TAR)." On 5/18/21 at 1:30 PM, the surveyor met with the DON, Administrator and Vice President of Operations who could not present any further information as to why there were multiple documentation errors for Resident #58. NJAC 8:39-27.1(a)	F 658		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following	F 880		6/11/21

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F 880	Continued From page 4 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 infection.	F 880		

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F 880	Continued From page 5 §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 ensure that the visiting Physiatrist and the nurse performing wound care adhered to CDC guidelines and the facility's policy put in place to maintain proper infection control practices preventing infection spread for 4 of 20 residents observed; Residents [redacted] and [redacted]. This deficient practice was identified and as evidenced by the following: 1. On 5/10/21 at 11:59 AM, the surveyor was touring on the unit occupied by Residents [redacted] Executive Order 26, 4.b. [redacted] The surveyor observed signage posted on each resident's door prior to entering their room which stated, "Transmission Based Precaution; Droplet Precaution for observation. Before entering room, the following Personal Protective Equipment (PPE) must be worn: N95 mask, gloves, gown, eye protection." The surveyor observed Personal Protective Equipment (PPE) carts placed outside of every door prior to entering the resident's room that contained hand sanitizer, gloves, disinfecting wipes, surgical masks, N95 masks and reusable gowns. On 5/10/21 at 12:01 PM, the surveyor observed the Physiatrist leave Resident [redacted] room wearing a KN95 mask (a less protective mask	F 880	1. * Resident#260 and #261 and #262 were monitored for symptoms which may had affected them for the deficient infection control practice observed. * Clean field for [redacted] treatment for resident [redacted] was redone and disinfected as the field was contaminated with dirty gloves prior to the treatment. * The physiatrist and Registered Nurse (RN) was immediately re-in-serviced on proper infection control practice. 2. * All residents are potentially affected. 3. * Receptionist or supervisor will check all staff, visitors and vendors upon entry of the facility to ensure the individual has required Personal Protective Equipment (PPE)otherwise will be given the proper PPE prior to going on the units. * Infection Preventionist (IP)or designee will observe physicians, nurse Practitioners (NP)and vendors while on the units for proper PPE and	

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F 880	Continued From page 6 than N95). The surveyor observed the Physiatrist leave Resident [Executive Order] room without performing handwashing or utilizing an alcohol-based hand rub (ABHR) to sanitize her hands. After leaving Resident [Executive Order] room, the Physiatrist proceeded to enter Resident [Executive Order] room only wearing the same KN95 mask. The surveyor observed the Physiatrist leave Resident [Executive Order]s room without performing handwashing or utilizing ABHR to sanitize her hands. After leaving Resident [Executive Order] room, the surveyor then observed the Physiatrist enter Resident #[Executive Order] room, wearing the same KN95 mask and the same disposable gloves. The surveyor observed that the Physiatrist removed her gloves and applied an ABHR after leaving the Resident [Executive Order] room. On 5/10/21 at 12:10 PM, the surveyor interviewed the Physiatrist. The surveyor asked the Physiatrist if she was familiar with proper infection control procedures and the proper PPE required to be worn in resident rooms on the Observation Unit she was visiting. The Physiatrist responded, "Yes, I am aware, but I forgot." On 5/11/21 at 2:00 PM, the surveyor discussed the above concern with the Administrator, Director of Nursing and Vice President of Operations who both agreed that the Physiatrist did not wear proper PPE prior to entering the resident's rooms. The surveyor reviewed the facility policy titled, "PPE during the COVID-19 Public Health Emergency" which documented under procedure, "All staff, visitors and vendors will be required to wear a facemask for the duration of their shift and at all times while in the facility to reduce the risk of potential exposure and transmission of COVID-19." Under Cohort COVID-19 Observation, "Type of Precaution and	F 880	handwashing. * In-service by IP or designee to all physicians and vendors on proper required PPE when on the units and resident rooms. * In-service by IP or designee on Infection Control Practice during [Executive Order] care for all nurses. * In-service by IP or designee on handwashing with physicians and vendors. * Root Cause Analysis was completed on each staff involved: a. Physiatrist was familiar with proper infection control procedures and the proper PPE required to be worn in the resident rooms on the observation Unit she was visiting. The Physiatrist stated she was aware and forgot. b. Registered Nurse acknowledged that she should have removed her gloves, washed her hands and put a new gloves before touching the treatment cart and the clean plastic barrier. RN stated that she got very nervous at the beginning and she was sweating since both the surveyor and the [Executive Order] Doctor observed her. She added that it was her first time being observed by the state surveyor and felt a lot of pressure. * Directed In-service training by Infection Preventionist or designee on the following: - Nursing Home Infection	

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F 880	Continued From page 7 PPE needed: Droplet Precautions. N95 mask (must be fit-tested) for staff in High Risk (that included Medical Staff); gloves, gown, goggles or shield." 2. On 5/12/21 at 1:53 PM, the surveyor observed the Registered Nurse (RN) perform a [Executive Order] for Resident [Executive] s [Executive Order 26, 4.b.]. A Certified Nursing Assistant (CNA) assisted the RN with the positioning of Resident [Executive] during the treatment. The [Executive Order 26] physician assessed and measured the [EExecutive Order] during the treatment. The surveyor reviewed the May 2021 Physician Order Summary (PO), which reflected a Physicians' order (PO) to [Executive Order 26, 4.b.] [Executive Order 26, 4.b.] The PO was noted on the May 2021 Electronic Treatment Administration Record. During the [Executive Order 2] observation, the surveyor observed the RN wash her hands, put on gloves, and disinfect the over-bed table with Sani-Cloth Germicidal Disposable Wipes, which have a recommended 2 minute dwell time (the amount of time it takes for the product to disinfect the surface properly). The RN opened the treatment cart outside of the room using the same contaminated gloves, used to disinfect the over-bed table. The RN obtained the plastic barrier stored in the treatment cart and immediately covered the over-bed table without waiting the 2 minute dwell time. At that time, the surveyor asked the RN to step out of the room and discussed the breaks in technique. The RN acknowledged that she should have removed her gloves, washed her hands and put on new gloves before touching the treatment cart and the	F 880	Preventionist training course Module 1: Infection Prevention and Control Program for Topline staff and IP. - CDC COVID-19 Prevention messages for front line Long-Term Care staff: keep COVID-19 out for Frontline staff. - Nursing Home Infection Preventionist Training Course Module 6B: Principle of Transmission Based Precautions for all staff including Topline staff and IP. 4. * 3 resident [Executive Order] treatments will be observed for infection control practice weekly for 3 months the re-evaluate. * The IP or designee will observe at least 3 physician, NP, or vendors weekly entering rooms of and/or performing tasks for residents on droplet precautions on the observation unit for 1 month then re-evaluate. * All findings will be reported and reviewed monthly and reported quarterly during the QAPI meeting for the next 3 quarters by IP or designee to the QAPI committee. Evaluation by the committee to determine continuing frequency of audits.	

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F 880	Continued From page 8 clean plastic barrier. The [Executive Order 2] Physician was interviewed after the treatment and acknowledged that the RN should have removed her gloves and washed her hands before setting up the clean field. The [Executive Order 2] Physician further acknowledged that the RN should wait 2 minutes for the table to dry before applying the clean barrier, to guarantee that the over-bed table was properly disinfected. At that time the RN stated that she would, "start over." The [Executive Order 2] physician stated that the RN should start over as she had contaminated the clean field. The RN then washed her hands, put on a clean set of gloves, removed the soiled dressing, washed her hands, and cleansed the [Executive Order] with NSS. The [Executive Order 2] Physician assessed and measured the [Executive Order 26, 4.b.], The RN cleansed the [Executive Order 26, 4.b.] [Executive Order 26, 4.b.] and covered with a dated initialed dressing. The RN failed to sanitize the over-bed table after post treatment but stated, "I should have." The surveyor reviewed the Admission Minimum Data Set (MDS), an assessment tool dated 3/14/21 with a Brief Interview for Mental Status score of 15, which reflected the resident was cognitively intact. The surveyor reviewed the facility's "Wound Treatment" policy dated as revised 1/20/21. The policy's statement reflected, Policy : To prevent and treat pressure sores Procedure: 1. Check Physician's Order 2. Wash hands 6. Gather supplies 11. Clean table with proper	F 880		

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F 880	Continued From page 9 disinfectant 12. Remove gloves and wash hands 13. Place barrier on table On 5/12/21 at 3:02 PM, the survey team met with the Administrator, Director of Nursing, Quality Assurance Registered Nurse and Vice President of Operations to discuss the above observations and concerns. The facility provided no further information. NJAC 8-39-19.4 (a)	F 880		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315366	A. Building B. Wing	7/16/2021

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ALARIS HEALTH AT BELGROVE	195 BELGROVE DRIVE KEARNY, NJ 07032

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0658 Reg. # 483.21(b)(3)(i) LSC	Correction Completed 06/11/2021	ID Prefix F0880 Reg. # 483.80(a)(1)(2)(4)(e)(f) LSC	Correction Completed 06/11/2021	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
5/18/2021	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO