STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	11A018	A. BUILDING: _____ B. WING _____	02/07/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDING OF HAMILTON, THE	1750 YARDVILLE-HAMILTON SQUARE ROAD HAMILTON, NJ 08690

(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) COMPLETE DATE
A 000	Initial Comments Initial Comments: Type of Survey: Covid-19 Focused Infection Control Census: 68 A COVID-19 Focused Infection Control Survey was conducted by the State Agency on 02/07/2022. The facility was found not to be in compliance with the New Jersey Administrative CODE 8:36 infection control regulations standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. 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.	A 000		
A1271	8:36-18.1(a) Infection Prevention and Control Services (a) The facility shall develop and implement an infection prevention and control program. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record	A1271		

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

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A1271	Continued From page 1 review, it was determined the facility failed to implement an effective Infection Control and Prevention Program, in accordance with the Centers for Disease Control (CDC) Guidelines, to ensure one of one activity staff wore a mask and encouraged residents to wear masks during group activities when the facility was in high Covid-19 transmission status. This deficient practice had the potential to affect all residents of the facility and occurred during the COVID-19 pandemic. Findings included: Reference: A surveyor's review of the CDC's "Updated Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic" (updated 09/10/2021 and retrieved 02/08/2022) revealed, " ...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 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.	A1271		

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A1271	Continued From page 2 On 02/07/2022 at 11:56 AM, the surveyor observed the Assistant Activities Director (AAD) coordinated a group activity with 15 random residents in an open common area located across the stairway landing on the second floor of the facility. The surveyor observed the residents in the group were not wearing masks and were in seating arrangement that did not provide six feet of social distancing, as residents sat shoulder to shoulder. The residents did not receive redirection from staff to address the need to exercise social distancing or wear their masks over their mouth and nose. The surveyor observed the AAD stood facing the group of residents and had her mask below her jaw. On 02/07/2022 at 12:20 PM, the AAD told the surveyor that she knew to wear her mask over her nose and to encourage the residents to do the same. The AAD stated she pulled her mask down to better communicate with the residents during the group activity. On 02/07/2022 at 1:56 PM, the surveyor interviewed the Health and Wellness Director (HWD) who confirmed that the facility had no active COVID-19 cases in the building. However, the HWD stated that the facility was still considered to be in a COVID-19 outbreak based on their last reported case on 01/21/2022. The HWD added that the facility was in a community with high transmission for COVID-19 infection. The HWD told the surveyor that it was important for staff to wear masks at all times and to encourage residents to do the same. The HWD stated that staff should also encourage social distancing with residents whenever practicable. The HWD stated that all staff were trained to wear masks, regardless of their vaccination status.	A1271		

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A1271	Continued From page 3 On 02/07/2022 at 2:10 PM, the surveyor interiewed the Certified Assisted Living Administrator (CALA) who stated that all staff had to wear masks for staff-to-staff and staff-to-resident interactions. The CALA stated that proper use of source control (wearing mask over the nose and mouth) was important because it helped prevent the transmission and spread of infection between residents and staff. Surveyor's review of the facility's policy, titled, "Exposure Control Plan" last revised in March 2021, revealed, "..In the event of a suspected or confirmed SARS-CoV-2 Virus outbreak ...or other airborne transmissible disease hazard to which employees may be exposed, the use of National Institute for Occupational Safety and Health (NIOSH) approved respirators (i.e., N95 respirators) may be required for employees identified in the Employee Exposure Determination table ...based on OSHA and Centers for Disease Control (CDC) guidance and in accordance with SARS-CoV-2, COVID-19 Respiratory Protection Program Supplement ...."	A1271		
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;	A1299		

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	11A018	A. BUILDING: _____ B. WING _____	02/07/2022

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A1299	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure that two of two dietary staff performed appropriate hand hygiene during meal service and between resident's contact and failed to ensure dietary staff offered or encouraged residents to perform hand hygiene during meal service, in accordance with the facility policy and the Centers for Disease Control (CDC) Guidelines. Findings included: Reference: A review of the CDC Hand Hygiene Guidance, retrieved from https://www.cdc.gov/handhygiene/providers/guideline.html, updated 1/30/2020, retrieved on 02/08/2022), 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 task ... or handling ... devices, before moving from ... 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 ... and after known or suspected exposure to spores ...." On 02/07/2022 at 12:20 PM, the surveyor observed residents as they made their way into the dining area on the first floor of the facility. The	A1299		

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A1299	Continued From page 5	A1299		

dining area had two entry ways with hand sanitizers mounted to the walls on each entry way. The surveyor's observation revealed that some of the residents walked into the dining room independently, some walked with assistive walking devices, and others propelled themselves in their wheelchairs. The surveyor observed that none of the 19 residents who walked into the dining room utilized the mounted hand sanitizer on the entry way.

As the residents settled in the dining room, Dietary Aide (DA) #1 proceeded to serve drinks to the residents. DA #2 and DA #3 were observed taking the residents' meal orders. The surveyor observed that the dietary aides adjusted the residents' wheelchairs and chairs such that the residents sat closer to the table. DA #2 and DA #3 proceeded to retrieve each resident's meal from the kitchen and placed the meals on the table.

During the meal service, DA #1, DA #2, and DA #3 intermittently adjusted their facemasks and made contacts with the residents as they continue to adjust and assisted residents with their seats and served their meals. In addition, the surveyor observed the dietary staff patted the residents backs and shoulders, as they served each resident their meal. The surveyor did not observed DA #1, DA #2, and DA #3 perform hand hygiene between each resident's contact nor offered or perform hand hygiene to the residents.

On 02/07/2022 at 12:45 PM, surveyor's interview with DA #3 revealed that she had been trained on the need to perform hand hygiene prior to serving meals to residents and the importance of performing or offering hand hygiene to residents during meal delivery. DA #3 stated she sometimes forgot to perform hand hygiene or to

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A1299	Continued From page 6	A1299		

offer/encourage the residents to do the same. DA #3 acknowledged that she was not carrying a portable hand sanitizer on her and was unable to perform hand hygiene in-between resident's contact.

On 02/07/2022 at 12:52 PM, DA #2 told the surveyor that the facility trained staff on indications for hand hygiene which included, but not limited to, before donning and after doffing gloves, after going to the bathroom, and after touching any body part, etc. She stated that she simply forgot to perform hand hygiene and that she did not know that she had to encourage residents with hand hygiene before their meals.

On 02/07/2022, at 1:11 PM, the surveyor interviewed Food Service Director (FSD) who stated that he expected dietary staff to perform hand hygiene whenever it was indicated. The FSD stated that dietary staff should perform hand hygiene before and during meal service. He stated that dietary staff should offer residents hand hygiene prior to meal service. The FSD concluded that he would retrain dietary staff on indications for hand hygiene.

On 02/07/2022 at 2:10 PM, the Certified Assisted Living Administrator (CALA) stated that training on infection control practices had been ongoing with all staff across the facility. The CALA stated that proper hand hygiene was the number one way of combating the spread of infection in any healthcare environment. The CALA stated that it was important for staff to perform hand hygiene between resident contacts, as well as for residents to be provided and/or encouraged to perform hand hygiene before meals.

The surveyor reviewed the facility's Handwashing

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A1299	Continued From page 7 Facilities and Practices policy, revised in March 2021, and read, "Employees shall wash their hands vigorously for 20 seconds before starting work, after leaving and returning to their work and frequently during the employees shift including: ...immediately before and after each contact with a person ... Community staff will encourage residents and visitors to wash their hands and will assist residents in licensed apartments with handwashing as a component of service provision." This policy was not consistently implemented.	A1299		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
11A018	A. Building B. Wing	7/7/2022

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LANDING OF HAMILTON, THE	1750 YARDVILLE-HAMILTON SQUARE ROAD HAMILTON, NJ 08690

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (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 A1271 Reg. # 8:36-18.1(a) LSC	Correction Completed 04/11/2022	ID Prefix A1299 Reg. # 8:36-18.3(a)(5) LSC	Correction Completed 04/11/2022	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	
2/7/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

THE LANDING OF HAMILTON

Plan of Correction for 5/9/22 Visit

A1271

- In order to accomplish the corrective action, The community conducted a root cause analysis related to the Department's findings that the community failed to provide a safe environment for residents to ambulate freely and failed to develop a security policy for the exit doors allowing for safe passage for coming and going.

  It was determined that the Plant Operations Supervisor was not aware that the community did have an established security policy which had been approved as part of the community's initial licensing and was in place and applied properly at the time of the incident.

  It was also determined that the Health and Wellness Director's (HWD) statement that residents were "free to come and go" was not clarified to explain that, while residents in the non-secured assisted living neighborhood are free to come and go, each resident's care plan identifies the resident's needs and preferences. Resident #4's mutually agreed on service plan identified that the resident was able to safely leave the community without supervision. Resident #4 had a wireless personal emergency pendant and was assessed as being independent with the community's call system operation.

  When the HWD encountered Resident #4 at 3:00 am on the date of the incident, she texted a Resident Assistant and requested Resident #4 be checked on. At 3:30 am, Resident #4 was located outside and had evidently fallen. Resident #4 was wearing the pendant when located outside but had not activated the device to summon assistance for re-entry to the community or for assistance after falling.

  The root cause analysis indicates that the community did not fail to provide a safe environment for ambulating or fail to have a policy for exit doors allowing for safe coming and going. As it was unusual for Resident #4 to be walking the hallways at approximately 1:50 am and again at 3:00 am, additional communication between staff at 1:50 am and additional intervention by the HWD at the time of her encounter with Resident #4 at 3 am or an expedited safety check by the RA at 3 am may have prevented the incident from occurring. Unfortunately, as this event occurred in the past, those actions cannot be accomplished to change or prevent the affected resident's incident.

  Entered in POC following the receipt of unacceptance letter dated 8/17/22:
  - In accordance with 8:36-16.16, self-locking doors used at the main entrance and other entrances are equipped with notification devices that are integrated into the community's sounding device system.
  - The department has asked "What corrective action is in place to secure the whereabouts of a resident who becomes unable to activate the pendant due to a fall or injury"
    - A corrective action for this scenario is outside of the scope of licensing expectations. Call systems, either stationary or wireless, are not a licensing requirement. Call devices are made available as an additional support and are not intended to replace mutually agreed upon safety checks. However, it should be noted that residents who do not feel they are a fall risk or have other concerns, may not choose to have safety checks. Unless electronic monitoring systems are installed (cameras, motion detection, audio activated devices), it is not possible to entirely secure the whereabouts of a resident who becomes unable to activate a manual pull station or pendant. Use of such monitoring systems is a violation or resident privacy rights and would not be consistent with the "homelike setting" of an assisted living residence.

- In order to identify other residents who may be affected, The community has provided training to all staff regarding the community's Policy and Procedure Manual that is required to be established and maintained in accordance with §8:36-5.7.

  Staff have received additional training regarding observing for and responding to behaviors/circumstances that may indicate a sudden or significant change of resident condition and that such situation must be verbally

reported to the designated supervisor on duty immediately to ensure immediate interventions are enacted and a temporary care plan is established to monitor the resident.

- To ensure the deficient practice will not occur, the General Manager or their designee, will utilize the community's electronic "dashboards" to review recurring incident trends, unscheduled services, temporary care plans and other metrics that may indicate a gradual or sudden change of resident condition. This is in addition to evaluating individual incidents as they occur.

- In order to monitor the effectiveness of this plan, the General Manager will review the dashboard as part of their quarterly review.