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	315434	A. BUILDING _____ B. WING _____	03/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY OF CARING HEALTHCARE AT RIDGEWOOD	**304 S. VAN DIEN AVE RIDGEWOOD, NJ 07450**

(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 Survey: 3/4/21 CENSUS: 76 SAMPLE: 18 (plus 3 closed records) 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 not 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=E	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 follow a physician's order and document the amount of a supplement intake for 1 of 18 residents (Resident #43) for three months, according to the standards of clinical practice. This deficient practice was evidenced by the following:	F 658	The nurses and dietician assigned to resident #43 were re-educated regarding following physician orders and appropriate documentation of supplement intake. Resident charts were audited to verify supplement intake is properly documented. Residents who receive supplements have	3/18/21

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

Electronically Signed | 03/19/2021

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F 658	Continued From page 1 Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as case-finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." On Executive Order 26 at 11:21 AM, the surveyor observed Resident Executive laying on an Executive Order 26, 4.b. with eyes closed. On 3/1/21 at 11:04 AM, the Certified Nursing Aide (CNA) informed the surveyor that the resident was Executive Order 26, 4.b.. The CNA stated that the resident had a variable appetite. She further noted that the resident consumes at least 50% of the supplement shake.	F 658	the potential to be affected by the concern identified. Licensed nurses and dieticians were re-educated regarding following physician orders and proper documentation of supplement intake. They were instructed that should they have a question or need assistance at any time, to contact the Director of Nursing. The Director of Nursing or unit manager will audit three charts a week for the next twelve weeks to verify that supplement intake is being documented appropriately. Areas of concern will be addressed. Results of these audits will be reviewed at the monthly Quality Assurance and Performance Improvement Committee meeting for the next three months. Follow up will be provided as needed.	

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F 658	Continued From page 2	F 658		

On that same date at 11:25 AM, the Licensed Practical Nurse (LPN) informed the surveyor that the resident Executive Order 26, 4.b., Executive Order 26, 4.b. but the resident's appetite depended on the resident's behavior. The LPN further stated that Resident #43 "enjoys" the Executive Order Executive Order that the doctor ordered Executive Order 26, 4.b.

A review of the resident's Face Sheet (an admission summary) reflected that the resident was admitted Executive Order 26, 4.b. Executive Order 26, 4.b.

A review of the Executive Order Quarterly Minimum Data Set, an assessment tool used to facilitate care management, indicated a Brief Interview for Mental Status Executive Order 26, 4.b., which reflected that the resident's Executive Order 26, 4.b.

A review of the Executive Order 26, 4.b., and Executive Order Executive Order Order Summary Report with a Physician's Orders dated Executive Order revealed an order for Mighty Executive Order 26, 4.b. Executive Order 26, 4.b. chart amount taken.

The corresponding physician order was transcribed into the Executive Order 26, 4.b., and Executive Order 26, 4.b. electronic Medication Administration Record (eMAR). Further review of the January, February, and March 2021 eMAR's, revealed that the PO dated Executive Order for Executive Order 26, 4.b. was plotted at Executive Order 26, 4.b. Executive Order 26, 4.b. and signed by the nurses as

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administered with no amount documented.

A review of the Executive Orde Nutrition/Dietary Note showed that the resident's weight was obtained this date and was noted with Executive Order 26, 4.b. Executive Order 26, 4.b. since last week.

On Executive Orde at 10:55 AM, the LPN informed the surveyor that the Executive Order 26, 4.b. was transcribed on the eMAR and the amount should be documented in the eMAR according to the physician's order. The LPN then showed the surveyor the eMAR order for the mighty health shake and stated, "I don't know what happened," why the amount consumed was not documented even though the order was there.

On Executive Orde at 11:05 AM, the Dietician informed the surveyor that the resident was monitored for weight trending. She stated that the resident had an order for a Executive Order 26, 4.b. due to variable appetite. She further noted that the amount consumed for the mighty shake should be documented in the eMAR to evaluate the resident's intake. The Dietician indicated that she checks the eMAR for the amount of consumption of the supplement, and if the amount of intake were not documented, "I would talk to the nurse and the DON" to discuss the problem.

On that same date and time, the surveyor informed the Dietician of the above concerns. The Dietician could not speak to why she didn't notice that there was no documented consumption amount for the past three months.

On 3/3/21 at 10:14 AM, the surveyors met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), Dietician, and

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F 658	Continued From page 4 the wound doctor. The DON stated that the staff should have documented the intake amount of the supplement according to the physician's order. The Dietician further noted [redacted] Resident #43 had Executive Order 26, 4.b. since last week. On that same date and time, the LNHA stated that "the drop-down" for documenting the amount of intake was omitted in the electronic medical records when the order was entered on [redacted] by the nurse that was why the amount of intake was not recorded when it was given [redacted] according to the physician's order. A review of the facility Transcription of Orders Policy provided by the Assistant Administrator with a reviewed date of 9/20 indicated, "Medications and treatments ordered by physician, nurse practitioner, including telephone orders, may be taken by a licensed nurse and signed by physician based on State requirements. Copy the orders to the Medication Administration Record and Treatment Record if appropriate." NJ 8:39-11.2 (b)	F 658		
F 880 SS=E	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.	F 880		4/13/21

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F 880	Continued From page 5 §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 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	F 880		

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F 880	Continued From page 6 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. §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 review of pertinent facility documents, it was determined that the facility failed to: a) ensure proper use of personal protective equipment (PPE) for 3 of 7 staff; b) perform handwashing appropriately for 1 of 8 staff; and, c) ensure that workers were knowledgeable of the cleaning chemicals and process used in the workplace for 1 of 3 staff in accordance with the Centers for Disease Control and Prevention guidelines for infection control to mitigate the spread of COVID-19. This deficient practice was evidenced by the following: According to the U.S. CDC guidelines Responding to Coronavirus (COVID-19) in Nursing Homes, Considerations for the Public Health Response to COVID-19 in Nursing Homes, updated 4/30/2020 included, "All	F 880	The staff and vendors who were identified in this document were re-educated on the facility's Infection Prevention and Control Policy. This included proper use of PPE, appropriate handwashing, and review of cleaning chemicals and process used in the workplace. Facility residents have the potential to be affected by the identified concern. Current vendors have been provided with education/re-education regarding the facility's Infection Control policies and practices including proper use of PPE and handwashing. This education/re-education will be ongoing as changes are made to facility policy and procedure and/or vendors change or are added. Facility staff were re-educated on	

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F 880	Continued From page 7 recommended COVID-19 PPE should be worn during care of residents under observation, which includes the use of an N95 or higher-level respirator, eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown." According to the U.S. CDC guidelines Hand Hygiene in Healthcare Settings, Glove Use: When and How to Wear Gloves, reviewed 1/31/2020 included, "Wear gloves, according to Standard Precautions, when it can be reasonably anticipated that contact with blood or other potentially infectious materials, mucous membranes, non-intact skin, potentially contaminated skin or contaminated equipment could occur. Gloves are not a substitute for hand hygiene. Perform hand hygiene immediately after removing gloves. Change gloves and perform hand hygiene during patient care. If gloves become visibly soiled with blood or body fluids following a task, moving from work on a soiled body site to a clean body site on the same patient or if another clinical indication for hand hygiene occurs. Never wear the same pair of gloves in the care of more than one patient. Carefully remove gloves to prevent hand contamination." A review of the U.S. CDC's Cleaning and Disinfecting Your Facility, updated on 7/28/2020, included, "Practice routine cleaning of frequently touched surfaces. High touch surfaces include tables, doorknobs, light switches, countertops, handles, desks, phones, keyboards, toilets, faucets, sinks, etc. Disinfect with a List N: disinfectants for use against SARs-CoV, the virus that causes COVID 19. For electronics, such as tablets, touch screens, keyboards, remote controls, and ATMs, consider putting a wipeable	F 880	the facility' s Infection Prevention and Control Policy. This included proper use of PPE, appropriate handwashing, and review of cleaning chemicals and process used in the workplace. As part of the facility's Directed Plan of Correction a Root Cause Analysis was required to be completed as of 04/13/2021. The following root causes/contributory factors were identified with re-education completed by the Director of Nursing, Assistant Director of Nursing, Infection Preventionist and Regional Nurse as of 04/13/2021: Topline staff viewed CDC Module 1 (Infection Prevention & Control Program). This includes the Infection Preventionist (certified on 10/27/2020), the Regional Educator (certified on 11/25/2020), the Regional Nurse (certified on 11/27/2020), the Director of Nursing (certified on 01/22/2021), and the Assistant Director of Nursing (certified on 01/22/2021). All facility staff from all departments viewed CDC training videos on 04/02/2021, 04/05/2021, 04/07/2021, 04/08/2021, and 04/09/2021. These videos included “Use PPE Correctly for Covid-19” (www.youtube.com/watch?v=YYTATw9yav4), “Keep Covid-19 Out!” (www.youtube.com/watch?v=7swrF9MGdw), “Clean Hands” (www.youtube.com/watch?v=xmYMUly7qiE), and “Sparkling Surfaces” (www.youtube.com/watch?v=t7OH8ORr5lg).	

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F 880	Continued From page 8 cover on electronics. Follow the manufacturer's instructions for cleaning and disinfecting. If no guidance, use alcohol-based wipes or sprays containing at least 70% alcohol. Dry surface thoroughly and wear appropriate PPE when cleaning or disinfecting frequently touched surfaces and electronics." Additional considerations for employers: "Educate workers performing cleaning, laundry, and trash pick-up to recognize the symptoms of COVID-19. Develop policies for worker protection and provide training to all cleaning staff on-site prior to providing cleaning tasks. Ensure workers are trained on the hazards of the cleaning chemicals used in the workplace in accordance with OSHA's Hazard Communication Standard." 1. On 2/26/21 at 10:49 AM, the Registered Nurse/Supervisor (RN/S) of the [redacted] informed the surveyor that the unit was a combination of [redacted] residents who were on cohort (a group of people banded together) and maintained on observation; because the residents were a new admit or re-admitted to the facility, dialysis residents and residents who go out of the facility for a consult and returns to the facility under PUI (a person under investigation) for COVID-19. The RN/S further stated that staff should wear full PPE, which included a gown, gloves, an N95 mask, and eye protection when entering the PUI resident's room. On 2/26/21 at 11:14 AM, the surveyor, Director of Nursing (DON), and the Assistant Director of Nursing (ADON) toured the [redacted]. The surveyor, DON, and the ADON observed the Certified Nursing Aide (CNA) enter a PUI room with no eye protection. The ADON stated that the	F 880	CNA identified stated that she forgot to put on her face shield prior to entering a resident's room. She was wearing all other required PPE and did further state that she was aware that she was required to wear eye protection. She was re-educated and provided a face shield by the Assistant Director of Nursing on 02/26/2021. CNA watched CDC training videos on 04/08/2021. HK#1 stated that to the surveyor on 02/26/2021 that he was not aware that he needed to wear an N95 mask and eye protection when entering a resident room. The Assistant Director of Nursing provided HK#1 with the appropriate N95 mask and eye protection and did re-educate HK#1 regarding proper PPE use on 02/26/2021. HK#1 did state that he was previously educated that he became nervous during his interview and mistakenly answered the surveyor's inquiries incorrectly.HK #1 watched CDC training videos on 04/08/2021. [redacted] indicated that she failed to review required PPE and therefore was not compliant with PPE requirements. She also failed to perform proper hand hygiene after removing PPE and exiting the resident room. The [redacted] was provided with education regarding required PPE and hand hygiene by the Director of Nursing on 02/26/2021. HK#2 stated that he failed to check his cleaning cart to verify chemicals were	

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F 880	Continued From page 9 CNA should have eye protection like a face shield before entering the PUI room. On that same date and time, during the interview with the CNA in the presence of the DON and the ADON, the CNA stated that although she wore the other PPE, she forgot to wear her face shield. The ADON immediately provided the CNA with a face shield. 2. On 2/26/21 at 11:23 AM, during the tour, the surveyor, DON, and ADON observed Housekeeper#1 (HK#1) not wearing an N95 mask and eye protector inside a PUI room of Resident#225 while sweeping the floor near the doorframe. There were signs for Contact and Droplet Precaution and what PPE to wear before entering the PUI room noted; Resident#225's [redacted] dated [redacted], was [redacted] Simultaneously, HK#1 stated to the surveyor in the presence of the DON and the ADON, that he was not aware that he should be wearing an N95 mask and eye protection when entering the room. The ADON immediately provided HK#1 with an N95 mask and face shield. 3. On that same date and time, the surveyor observed the [redacted] noted inside the resident's PUI ([redacted]) room, wearing a gown, gloves, surgical mask, and goggles. The surveyor interviewed the [redacted] in the presence of the DON. The [redacted] stated, "I didn't know that I had to wear an N95 mask inside the room because the other facility was not implementing it." The [redacted] did not have an answer to why she did not perform hand hygiene after removing her gloves. Furthermore, the [redacted] indicated that "this was the first resident I saw today" in the facility. The DON	F 880	properly labeled. He also stated that he was nervous when interviewed by the surveyor and could not recall/provide information related to chemical contact times. He was re-educated regarding these items by the Director of Maintenance/Environmental Services and Director of Nursing on 03/01/2021. HK #2 watched CDC training videos on 04/05/2021. CNA, HK#1, [redacted] and HK#2 verbalized understanding of re-education and were able to successfully demonstrate competency. The Director of Nursing will complete a walk-through of the facility three times per week for the next twelve weeks to verify that the Infection Prevention and Control practices are being followed by staff and vendors. Areas of concern will be addressed. Results of the walk-throughs will be reviewed at the monthly Quality Assurance and Performance Improvement Committee meetings for the next three months. Follow up will be provided as needed.	

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F 880	Continued From page 10	F 880		

immediately educated the [Executive Order 26, 4.b] and provided an N95 mask to make sure to follow facility protocol before seeing other residents.

4. On 3/1/21 at 11:53 AM, the surveyor, observed HK#2 cleaning inside a PUI room. HK#2 sprayed a disinfectant chemical into the sink top, table and immediately wiped it down with a washcloth. Simultaneously, the surveyor interviewed HK#2, who could not state the contact time (the time the disinfectant needs to stay wet on a surface to ensure efficacy) for the disinfecting chemical.

On that same date and time, HK#2 showed the surveyor one of two disinfecting chemical sprays; Both were noted without a label. HK#2 informed the surveyor that the two disinfecting chemical sprays are used for disinfecting frequently touched surfaces like the sink and tables. HK#2 said that he knew what kind of disinfecting chemical was in the bottle and further stated, "I don't need to label it."

On 3/1/21 at 12:43 PM, the surveyor informed the Licensed Nursing Home Administrator (LNHA) and the Director of Maintenance and Environmental Services (DMES) of the above concerns. The DMES, in the presence of the LNHA, informed the surveyors that the chemicals that were transferred to a spray bottle should be labeled with the name of the chemicals, EPA (Environmental Protection Agency released registered disinfectant products that have qualified for use against COVID-19), and their contact time.

A review of the facility provided information about How to Properly Make and Use Sanitizers & Disinfectants dated 2011 provided by the DMES

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F 880	Continued From page 11	F 880		

included "All spray bottles must be clearly labeled with contents."

On 3/1/21 at 1:09 PM, the DMES stated that HK#2 should have waited for at least a minute to dry up before wiping the table and sink.

On 3/3/21 at 9:55 AM, the LNHA and DON met with the surveyors. The LNHA stated that the [Executive Order 26, 4.b] "normally" should have met with the floor nurse or DON before seeing the resident for treatments or consults. The LNHA further stated that the [Executive Order 26, 4.b], who was the facility vendor, did not talk to the nurse in the unit and went directly to the resident.

On that same date and time, the LNHA informed the surveyors that there was no documented protocol for vendors when they come to the facility with regards to PUI and PPE use. She further stated that "it is verbally communicated" only that vendors should go to the unit nurse or DON before going to the resident. Also, the LNHA indicated that staff should follow the contact time of the disinfecting chemicals.

A review of the undated facility's Personal Protective Equipment Use in Cohorts Policy that the Assistant Administrator provided included "Yellow Cohort (PUI): universal source control with the use of procedure masks throughout the common areas of the unit. Upon entering the room, staff should don full PPE use with gowns, gloves, face shields or goggles and N95."

A review of the facility's Handwashing/Hand Hygiene Policy that the Assistant Administrator provided with a revised date of November 2020 included, "Hand hygiene is the final step after

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315434	A. BUILDING _____ B. WING _____	03/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY OF CARING HEALTHCARE AT RIDGEWOOD	**304 S. VAN DIEN AVE RIDGEWOOD, NJ 07450**

(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 removing and disposing of personal protective equipment. The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections." A review of the facility's Equipment Cleaning Policy that the Assistant Administrator provided with a reviewed date of 9/20 included, "It is our policy to clean equipment, including high touch surfaces between resident use to prevent the spread of infection. Procedure: 2. Medical equipment and high touch surface areas will be cleaned utilizing bleach or EPA registered disinfectant between patient use and upon discharge." On 3/3/21 at 1:35 PM, the surveyor met with the LNHA, Assistant Administrator, and DON; There was no additional information provided. NJAC 8:39-19.4 (a) (1) (n) (2)	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 A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
315434		4/26/2021

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY OF CARING HEALTHCARE AT RIDGEWOOD	304 S. VAN DIEN AVE RIDGEWOOD, NJ 07450

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 03/18/2021	ID Prefix F0880 Reg. # 483.80(a)(1)(2)(4)(e)(f) LSC	Correction Completed 04/13/2021	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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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	
3/4/2021	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO