STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315207		C 11/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT KRESSON VIEW, LLC	2601 EVESHAM ROAD VOORHEES, NJ 08043

(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 Complaint #: NJ144984, NJ146175, NJ148578, NJ146923, NJ148191 Census: 172 Sample Size: 8 The facility is not in compliance with all the standards in the New Jersey Administrative Code 8:39, Standards for Licensure of Long-Term Care Facilities. A COVID-19 Focused Infection Control Survey was conducted by the New Jersey Department of Health. The facility was found to be not in compliance with 42 CRF 483.80 infection control regulations and has not implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Survey date: 11/20/2021 - 11/21/2021 Census: 172	F 000		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Complaint Intake NJ146923 Based on interviews, record reviews, and facility policy review, it was determined that the facility failed to follow the medication administration schedule as ordered by the physician for one (Resident [redacted]) of one resident reviewed for	F 760	F-760: SS=D Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) I. CORRECTIVE ACTIONS ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE:	12/29/21

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

Electronically Signed — 01/03/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 760	Continued From page 1 medication administration. This included the late administration of [redacted], [redacted] and [redacted], which are significant medications that are to be given at specific times. Findings included: 1. A review of Resident [redacted]'s face sheet indicated the facility admitted the resident with diagnoses that included major depressive disorder and anxiety disorder. A review of Resident [redacted]'s quarterly Minimum Data Set (MDS), dated [redacted] indicated the resident had a Brief Interview of Mental Status (BIMS) score of [redacted] out of [redacted] indicating that the resident was [redacted]. A review of Resident [redacted]'s order recap report, dated [redacted], indicated the resident was to have [redacted] ([redacted] medication) every [redacted] hours for [redacted]. The order recap indicated the resident was to have [redacted] (gm) packet daily at bedtime for [redacted]. The order recap indicated the resident was to have [redacted] milligram (mg) daily for [redacted]. The order recap indicated the resident was to have [redacted] mg daily for [redacted]. The order recap indicated the resident was to have [redacted] mg every [redacted] hours for [redacted] and [redacted] mg at bedtime to reset [redacted]. The order recap indicated the resident was to receive [redacted] mg twice a day for [redacted] During an interview on 11/20/2021 at 10:45 AM, Resident [redacted] stated that on [redacted] Licensed Practical Nurse (LPN) #5 purposely passed the resident's room during the 8:00 PM medication	F 760	¿ Involved LPN was counseled and re-educated on facility□s policy regarding Administration of Medications, with focus on the need to follow the medication administration schedule as ordered by the physician. ¿ The resident□s Attending Physician was notified regarding the late administration of the medications. No adverse effects or harm was identified on Resident [redacted] due to the late administration of the medications. II. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE ¿ All residents have the potential of being affected by the same deficient practice. The MARs (Medication Administration Records) of all residents were audited to identify if any other residents were affected by the same deficient practice, i.e., late administration of significant medications that are to be given at specific times. No other residents were affected. III. MEASURES PUT INTO PLACE OR SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: ¿ All nurses were in-serviced on the Facility□s Policy regarding Administration of Medications, with focus on the administration of medications within the prescribed time. Emphasis was also made on promptly communicating to the Unit Manager and/or Supervisor any	

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F 760	Continued From page 2 pass and did not administer the resident's medications. Resident [redacted] stated LPN #5 was getting back at the resident since the Resident [redacted] gave LPN #5 a hard time earlier about [redacted] medication. Resident [redacted] stated there was an incident earlier that day due to the resident's prescribed medication not being available. Resident [redacted] stated LPN #5 was an agency nurse and did not have access to obtain narcotics and told the resident to wait until the medication was brought up by the supervisor. Resident [redacted] stated the resident apologized to LPN #5 and received the medications at 10:00 AM. Resident [redacted] stated the resident then went downstairs to the lobby and told Registered Nurse Supervisor (RNS) #2 what happened and asked RNS #2 to get the resident's [redacted] medication. Resident [redacted] stated RNS #2 then took the [redacted] medication to LPN #5, who administered the medication around 11:00 PM. A review of Resident [redacted]'s Medication Administration Audit Report (MAAR), for 11/19/2021, indicated the resident had [redacted] due at 8:00 AM, and the [redacted] was administered at 10:00 AM. The MAAR indicated the resident had [redacted] and [redacted] due at 8:00 AM, and the clonazepam and [redacted]l were administered at 10:29 AM. The MAAR indicated Resident [redacted] had [redacted], [redacted], and [redacted] due at 8:00 PM. The MAAR indicated the resident received the [redacted], and [redacted] at 10:15 PM. The MAAR indicated the resident received [redacted], and [redacted] at 11:01 PM. During an interview on 11/20/2021 at 6:32 PM, LPN #5 stated that on [redacted] Resident [redacted] did	F 760	issues that may potentially result in late administration of medications so they can be addressed immediately. IV. MONITORING OF CORRECTIVE ACTIONS: ¿ Unit Manager or designee will review the MARs of 10 residents weekly x 4 weeks, then monthly x 3 months; to ensure that significant medications are administered within the prescribed time, in accordance with the Physician□s Orders. Any identified issues will be addressed immediately. ¿ Findings will be reported to the Director of Nursing and Administrator monthly and presented in the QAPI Meeting quarterly. The QAPI Committee will determine the need for further audits and/or action plan.	

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F 760	Continued From page 3 not have any more [redacted] upstairs, and since LPN #5 was agency, supervisors needed to pull the medication. LPN #5 stated Resident [redacted] received morning medications late on 11/19/2021 because the [redacted] was not available. LPN #5 did not want to go into the resident's room unprepared because the resident would be upset about [redacted] not being available. LPN #2 stated the resident did become upset and started yelling and screaming, demanding the [redacted]. LPN #5 admitted to not administering the resident's medications at 8:00 PM and admitted telling the resident, "Because you were upset earlier, I did not want to go through what you put me through this morning." LPN #5 was not aware the resident went to RNS #2 and asked for the medication. LPN #5 stated the resident received the [redacted] medication when RNS #2 brought it up. During a concurrent interview and record review on 11/21/2021 at 8:09 AM, the Director of Nursing (DON) stated she had not been able to reach RNS #2 but had gone and spoken to Resident [redacted] in the morning on 11/21/2021. The DON stated the resident did not have any [redacted] medication left in the resident's "bingo card," (packaged medication on a card that has a bubble for each pill; the nurse pops out the pill each time a pill is administered) and that meant a fingerprint needed to be retrieved from a locked medication dispensing machine downstairs. The DON stated Resident [redacted] "is reactive to things" and was just upset medication was not administered earlier. The DON stated Resident [redacted] "denied any injustices or misdoings." The DON reviewed Resident [redacted]'s medication administration audit report, dated 11/19/2021, and confirmed Resident [redacted] received the resident's medication beyond the medication administration window. The DON	F 760		

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F 760	Continued From page 4 stated medications could be given one hour before or one hour after they were due. The DON stated there was no reason Resident [redacted] should have received medications late, because supervisors were always available to get medications for nurses. A review of the facility's policy titled, "Administering Medications," dated 12/2012, indicated "Medications must be administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders)." New Jersey Administrative Code §8:39-29.2(d)	F 760		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and	F 761		12/29/21

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F 761	Continued From page 5 Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Complaint Intake NJ146923 Based on observations, interviews, and facility policy review, it was determined that the facility failed to ensure medication was safely stored and not dispensed prior to administration and not left on top of an unsupervised medication cart for one (med cart for Rooms [redacted] out of seven medication carts in the facility. Findings included: 1. During a concurrent observation and interview on 11/20/2021 at 11:00 AM, the medication cart for Rooms [redacted] was observed to be unattended. There was a medicine cup containing one pill, and a bottle of [redacted] on top of the cart. The cart remained unattended until 11:07 AM. Licensed Practical Nurse (LPN) #1 exited a resident room approximately 20 feet from the medication cart and approached the medication cart. LPN #1 stated the medication in the cup had been prepared earlier to administer to a resident, but LPN #1 was called away to give another medication. LPN #1 then reached into the medication cart and grabbed a medicine cup with medications in it and walked away. The medication cup with one pill and the bottle of eye drops remained on top of the medication cart. LPN #1 returned and stated the medication in the cup was [redacted]) and should not have been left unattended because a confused	F 761	F-761: SS=D Label/Store Drugs and Biologicals I. CORRECTIVE ACTION S ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: ¿ No residents were directly affected by the deficient practice. Involved Nursing Staff was immediately counseled and re-educated on the facility□s protocol re: Proper Storage of Drugs when left unattended. II. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE ¿ All residents have the potential to be affected by this deficient practice. III. MEASURES PUT INTO PLACE OR SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: ¿ All facility nurses were re-educated on facility□s policy re: Proper Storage of Medications. Emphasis was made on ensuring that medications are stored/secured when left unattended and inaccessible to residents. Education will be on-going for all new hires.	

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F 761	Continued From page 6 resident or anyone could walk by and take the medication. LPN #1 stated medication should only be dispensed at the time of administration because the nurse could get distracted or called away like she was, and a medication error could occur. During an interview on 11/21/2021 at 12:45 PM, the Director of Nursing (DON) stated medication carts contained routine medications and over-the-counter medications and were to remain locked when not in use by a nurse. The DON stated if a nurse walked away from a medication cart, the cart should be locked, and no medications should be left on top of the cart. The DON stated leaving medication unattended was unacceptable, and any resident or person could take the medication. The DON stated medications should be prepared at the time of administration. The DON stated if the medications were not given at the time they were dispensed, they should be discarded to avoid mistakes later, such as giving the wrong medication to the wrong resident. The DON stated LPN #1 was a seasoned nurse and knew not to pre-pour medications or leave them unattended. The DON stated that was not an acceptable practice. A review of the facility's policy titled, "Administering Medications," dated 12/2012, indicated, "During administration of medications, the medication cart will be kept closed and locked when out of sight of the medication nurse or aide. It may be kept in the doorway of the residents' room, with open drawers facing inward and all other sides closed. No medication is kept on top of the cart. The cart must be clearly visible to the personnel administering medications, and all	F 761	IV. MONITORING OF CORRECTIVE ACTIONS: ¿ The Unit Manager/Nursing Supervisor or Designee will conduct Medication Storage Observation Audits per unit weekly x 4 weeks; then monthly x 3 months. Audit will focus on ensuring that that medications are stored/secured when left unattended and inaccessible to residents. Identified issues will be rectified immediately. ¿ Findings will be reported to the Director of Nursing and Administrator monthly and presented in the QAPI Meeting quarterly. The QAPI Committee will determine the need for further audits and/or action plan.	

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F 761	Continued From page 7 outward sides must be inaccessible to residents or other passing by."	F 761		
F 880 SS=E	New Jersey Administrative Code §8:39-29.4 (h) 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 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	F 880		2/8/22

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F 880	Continued From page 8 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. §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 observations, interviews, facility document review, and facility policy review, it was determined the facility failed to ensure employees entering the facility were screened for signs and symptoms of [redacted] prior to entering common	F 880	F-880: SS=E Infection Prevention & Control CFR(s): 483.80{a)(1)(2)(4)(e)(f) I. CORRECTIVE ACTION S ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY	

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F 880	Continued From page 9 areas and patient care areas. This deficient practice had the potential to affect all residents and occurred during the COVID-19 pandemic. Findings included: 1. During an observation on 11/20/2021 at 7:05 AM, five unidentified employees were observed in the lobby of the facility, lined up awaiting screening. Registered Nurse Supervisor (RNS) #1 was at the front desk informing the employees of their assignments for the day after each employee was screened. During an observation on 11/20/2021 at 7:20 AM, Certified Nursing Assistant (CNA) #3 was observed entering the facility, walking past the front desk and screening kiosk. RNS #1 asked CNA #3 to return, and CNA #3 continued to walk through the double doors which led to a second set of double doors leading to the quarantine unit. CNA #3 was then observed walking back to the main lobby and out the front door. During an interview on 11/20/2021 at 7:22 AM, RNS #1 stated CNA #3 went to the clock-in room, which was just before the quarantine unit. RNS #1 then observed CNA #3 walking back to the main lobby and out the front door. RNS #1 stated the employees knew they needed to screen first, but the RNS could not make them. During an interview on 11/20/2021 at 7:24 AM, CNA #3 returned and proceeded to walk towards the elevator. CNA #3 was asked about the screening process for the facility and stated the process was to screen then clock in. CNA #3 stated he did not screen because he was late for work and needed to clock in. CNA #3 stated the	F 880	THE DEFICIENT PRACTICE: ¿ Involved Staff were immediately counseled and re-educated on the facility□s Policy re: Completing the Screening questionnaire for signs and symptoms of COVID-19 and completing temperature checks upon entry into the facility prior to entering common areas and patient care areas. None of the involved staff exhibited any signs and symptoms of COVID-19. ¿ No residents were affected or harmed by the deficient practice. II. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE ¿ All residents have the potential to be affected by this deficient practice. III. MEASURES PUT INTO PLACE OR SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: ¿ The kiosk was relocated directly inside the lobby door to cue any person who enters the facility to complete the Screening questionnaire (for signs and symptoms of COVID-19) and perform temperature checks BEFORE entering common areas and patient care areas, if cleared. This will enhance compliance with the Screening Process for all individuals who enter the facility and aid in identifying and controlling infections and communicable diseases. ¿ All staff will be re-educated on the facility□s Policy re: Completing the	

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F 880	Continued From page 10 purpose of the screening process was to see if his temperature was high, because if it was high, he could spread COVID-19 to employees. CNA #3 then screened and proceeded to the resident care area. During an observation on 11/20/2021 at 7:26 AM, an unidentified staff member entered the facility and went straight to the elevator. The unidentified staff member entered the elevator and proceeded into the resident care areas. During an interview on 11/20/201 at 7:50 AM, the Director of Nursing (DON) stated employees and visitors were required to check in at the front desk and screen for signs and symptoms of COVID-19. The DON stated it was not appropriate for employees to clock in and then screen. The DON stated not screening could potentially spread COVID-19 to residents and staff. A comparison was made of the facility's assignment sheet for 11/20/2021 on the 7:00 AM to 3:00 PM shift, and the screening kiosk's check-ins for 11/20/2021 from 5:36 AM to 11:37 AM. The comparison revealed two employees (CNA #4 and CNA #5) were providing direct patient care without having screened for COVID-19. During an interview on 11/21/2021 at 12:16 PM, CNA #4 stated the facility's procedure for screening was to screen prior to clocking in and entering resident care areas. CNA #4 reported clocking in at 6:53 AM and then screened. CNA #4 reviewed the screening kiosk's check-in log for 11/20/2021 and confirmed an entry for CNA #4 was not on the log. CNA #4 stated it was	F 880	Screening questionnaire for signs and symptoms of COVID-19 and completing temperature checks upon entry into the facility prior to entering common areas and patient care areas. IV. MONITORING OF CORRECTIVE ACTIONS: ¿ The Administrator or Designee will conduct 5 Observation Audits a week x 4 weeks; then monthly x 3 months; to ensure that individuals who enter the facility are compliant in completing the Screening questionnaire (for signs and symptoms of COVID-19) and temperature checks BEFORE entering common areas and patient care areas ¿ Audit Findings will be reported to the QAPI Committee on a monthly basis. The QAPI Committee will determine the need for further audits and/or action plan. 1/28/2022 - Listed below is the DPOC and Root Cause Analysis COMPLETE CARE AT KRESSONVIEW PLAN OF CORRECTION F-880: SS=E Infection Prevention & Control CFR(s): 483.80{a)(1)(2)(4)(e)(f) I. CORRECTIVE ACTION S ACCOMPLISHED FOR RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE DEFICIENT PRACTICE: ¿ Involved Staff were immediately counseled and re-educated on the facility□s Policy re: Completing the Screening questionnaire for signs and symptoms of COVID-19 and completing	

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	315207		C 11/21/2021

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F 880	Continued From page 11 important to screen for COVID-19 to avoid potentially spreading it to residents and staff. CNA #4 could not state why the screening was not done. During a concurrent record review and interview on 11/21/2021 at 12:45 PM, the DON reviewed the assignment sheet on 11/20/2021 for the 7:00 AM to 3:30 PM shift, and the screening kiosk's check-ins for 11/20/2021 from 5:36 AM to 11:37 AM. The DON confirmed CNA #4 and CNA #5 did not screen for signs and symptoms of COVID-19 on 11/20/2021 prior to providing resident care. The DON stated every employee was expected to screen, even if they were off duty and entered the facility for a brief period. The DON stated failure to screen could increase the risk of spreading COVID-19. The DON stated the Administrator had access to the screening information and was able to pull the reports on his computer. During an interview on 11/21/2021 at 1:35 PM, the Administrator stated screening kiosk information was accessible, and audits to verify staff were screened prior to working was done daily by the Administrator. The Administrator stated audits would consist of reviewing the screening log. The Administrator stated the screenings were reviewed on 11/20/2021, but the Administrator did not notice the two CNAs (referring to CNA #4 and #5) had not screened. A review of the facility's policy titled, "Completecare Management," with a revision date of 03/06/2020, indicated, "To ensure that staff, and/or new residents are not at risk of spreading the EID (emerging infectious disease) into the care center, screening for exposure risk and signs and symptoms may be done PRIOR to	F 880	temperature checks upon entry into the facility prior to entering common areas and patient care areas. None of the involved staff exhibited any signs and symptoms of COVID-19. ¿ No residents were affected or harmed by the deficient practice. II. IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE ¿ All residents have the potential to be affected by this deficient practice. III. MEASURES PUT INTO PLACE OR SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: ¿ The COVID-19 Screening kiosk was relocated directly by the lobby door to cue any person who enters the facility to complete the Screening questionnaire (for signs and symptoms of COVID-19) and perform temperature checks BEFORE entering common areas and patient care areas, if cleared. This will enhance compliance with the Screening Process for all individuals who enter the facility and aid in identifying and controlling infections and communicable diseases. ¿ All staff were re-educated on the facility□s Policy re: Completing the Screening questionnaire for signs and symptoms of COVID-19 and completing temperature checks upon entry into the facility prior to entering common areas and patient care areas. ¿ DPOC (DIRECTED PLAN OF	

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F 880	Continued From page 12 admission of a new resident and/or allowing new staff persons to report to work. All administrative staff, including the Director of Nursing, Administrator, the infection control preventionist, caregivers, contractors, consultants, volunteers, and visitors shall complete screening questionnaire and complete temperature checks prior to entrance of the facility ...Self-screening-staff will be educated on the care center's plan to control exposure to the residents. This plan will be developed with the guidance of public health authorities and may include i. Reporting any suspected exposure to the EID while off duty to their supervisor and public health. ii. Precautionary removal of employees who report an actual or suspected exposure to the EID. iii. Self-screening for symptoms prior to reporting to work. iv. Prohibiting staff from reporting to work if they are sick until cleared to do so by appropriate medical authorities and in compliance with appropriate labor laws." New Jersey Administrative Code §8:39-19.4(a)1-6	F 880	CORRECTION): Under the guidance of the Infection Prevention and Control Officer, and in collaboration with the IP, Medical Director, Governing Body and the QAPI committee, the following were completed and/or updated: o A Root Cause Analysis was completed by the QAPI Committee, which included the reasons on why the deficiency occurred. o An Infection Prevention and Intervention Plan has been implemented based on the findings of the Root-Cause Analysis. This was incorporated in the QAPI Program with Corrective Actions and a PIP (Performance Improvement Plan) to ensure on-going compliance. This was discussed in the QAPI Meeting on January 25, 2022. ¿ The Directed In-Service Training Programs will be completed as directed by the NJ-Department of Health. Education will be on-going for all new hires. The In-Service Trainings include the following: " Nursing Home Infection Preventionist Training Course Module 1: Infection Prevention & Control Program = Provided to TOPLINE STAFF and INFECTION PREVENTIONIST https://www.train.org/main/course/1081350/ " CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff: Keep COVID-19 Out! = Provided the training to FRONTLINE STAFF	

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F 880	Continued From page 13	F 880	https://youtube/7srwrF9MGdw " Nursing Home Infection Preventionist Training Course Module 5: Outbreaks = Provided the training to TOPLINE STAFF and INFECTION PREVENTIONIST https://www.train.org/cdctrain/course/1081803/ " Nursing Home Infection Preventionist Training Course Module 4: Infection Surveillance = Provide the training to TOPLINE STAFF and INFECTION PREVENTIONIST only https://www.train.org/cdctrain/course/1081802/ " Nursing Home Infection Preventionist Training Course Module 6A: Principles of Standard Precautions = Provide the training to: ALL STAFF including TOPLINE STAFF and INFECTION PREVENTIONIST https://www.train.org/main/course/108l804/ " Nursing Home Infection Preventionist Training Course Module 6B: Principles of Transmission Based Precautions = Provide the training to: ALL STAFF including TOPLINE STAFF and INFECTION PREVENTIONIST https://www.train.org/main/course/108l805/ IV. MONITORING OF CORRECTIVE ACTIONS: ¿ The Infection Preventionist or Designee will conduct 5 Observation	

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F 880	Continued From page 14	F 880	Audits a week x 4 weeks; then monthly x 3 months; to ensure that individuals who enter the facility are compliant in completing the Screening questionnaire (for signs and symptoms of COVID-19) and temperature checks BEFORE entering common areas and patient care areas. Audit Findings will be reported to the QAPI Committee on a monthly basis. The QAPI Committee will determine the need for further audits and/or action plan. ¿ The Infection Preventionist or designees will conduct a comparison of the facility's daily assignment sheet and the COVID-19 Screening Kiosk's check-ins (for the day) on a weekly basis x 4 weeks; then monthly x 3 months - to ensure that every staff member completed the COVID-19 Screening Questionnaire temperature checks upon entry into the facility. Audit Findings will be reported to the QAPI Committee on a monthly basis. The QAPI Committee will determine the need for further audits and/or action plan. V. COMPLETION DATE: FEBRUARY 8, 2022 COMPLETE CARE AT KRESSON VIEW SUMMARY OF IMPLEMENTATION AND COMPLETION OF DPOC and DIRECTED IN-SERVICE TRAININGS DIRECTED PLAN OF CORRECTION (DPOC) ¿ ROOT CAUSE ANALYSIS. The Root Cause Analysis has been completed with	

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F 880	Continued From page 15	F 880	the assistance from the Infection Preventionist, QAPI committee and Governing Body. Completion Date: 1-25-2022 ¿ QAPI-PIP - INFECTION PREVENTION AND INTERVENTION PLAN based on RCA - Discussed and reviewed at QAPI meeting. Completion Date: 1-28-2022 DIRECTED IN-SERVICE TRAINING: COMPLETION DATE = FEBRUARY 8, 2022 The directed in-service training has been completed as directed, as evidenced by Attendance Sheets, Post-Tests or Certificates of Completion Videos: Name the Video Titles and Attendees/Participants 1) Nursing Home Infection Preventionist Training Course Module 1: Infection Prevention & Control Program = Provide the training to TOPLINE STAFF and INFECTION PREVENTIONIST https://www.train.org/main/course/1081350/ 2) CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff: Keep COVID-19 Out! = Provide the training to FRONTLINE STAFF https://youtube/7srwrF9MGdw 3) Nursing Home Infection Preventionist Training Course Module 5: Outbreaks = Provide the training to TOPLINE STAFF and INFECTION PREVENTIONIST https://www.train.org/cdctrain/course/1081	

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F 880	Continued From page 16	F 880	803/ 4) Nursing Home Infection Preventionist Training Course Module 4: Infection Surveillance = Provide the training to TOPLINE STAFF and INFECTION PREVENTIONIST only https://www.train.org/cdctrain/course/1081802/ 5) Nursing Home Infection Preventionist Training Course Module 6A: Principles of Standard Precautions = Provide the training to: ALL STAFF including TOPLINE STAFF and INFECTION PREVENTIONIST https://www.train.org/main/course/108I804/ 6) Nursing Home Infection Preventionist Training Course Module 6B: Principles of Transmission Based Precautions = Provide the training to: ALL STAFF including TOPLINE STAFF and INFECTION PREVENTIONIST https://www.train.org/main/course/108I805/ Completion of in-service training by February 8th, 2022 Completion date: February 8th, 2022	