STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315036	A. BUILDING ______ B. WING ______	C 01/30/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR GLEN CENTER	**25 E LINDSLEY ROAD CEDAR GROVE, NJ 07009**

(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 #: NJ150790 Census: 92 Sample Size: 3 The facility is in compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities based on this complaint survey. A COVID-19 Focused Infection Control Survey was conducted by the New Jersey Department of Health. The facility was found not to be in compliance with 42 CFR §483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Survey date: 01/30/2022 Sample size: 5	F 000		
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	F 880		3/7/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 02/15/2022

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 880	Continued From page 1 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 contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F 880		

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F 880	Continued From page 2 §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 the facility policy, it was determined that the facility failed to maintain appropriate infection control practices during Executive Order Executive Order care treatment provided to Resident #2. The deficient practice had the potential to affect the Executive residents in the facility that required Executive Order care. Findings included: The facility admitted Resident #2 on Executive Order 26, 4.b. with Executive Order 26, 4.b. . A review of the resident's Executive Order 26, 4.b., dated Executive Order 26, 4.b. indicated a Executive Order 26, 4.b. The resident was also identified as Executive Order 26, 4.b. with a Executive Executive Order 26, 4.b. score of Executive Order 26, 4.b. The Executive plan for Resident #2, reviewed Executive Order 26, 4.b., indicated Executive Order 26, 4.b. to Executive Order 26, 4.b. included Executive Order 26, 4.b. Executive Order 26, 4.b. ordered by the physician. On 01/21/2022 at 10:10 AM, an observation was made of Registered Nurse (RN) #1 providing Resident #2's Executive Order 26, 4.b. . Resident #2 was on Executive Order 26, 4.b. for	F 880	F880 HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE •Resident #2 and other residents were not affected by this deficient practice •1:1 education on infection control policy and procedure and competency was completed immediately (1/21/2022) with the nurse who provided the treatment. •All treatment supplies that were brought outside the room were discarded and treatment cart was disinfected immediately. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE •All Residents have the potential to be affected by this practice. WHAT MEASURES WILL BE PUT INTO	

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	315036	A. BUILDING ______ B. WING ______	C **01/30/2022**

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F 880	Continued From page 3 Executive Order 26, 4.b.. RN #1 was observed taking an entire container of bleach wipes, a roll of tape, and a Executive Order 26, 4.b. out of the treatment cart and carrying those items into Resident #2's room. RN #1 was observed placing the items on Resident #2's over-bed table. The nurse then took one of the bleach wipes and cleaned the top of the over-bed table and then took a non-permeable cloth and placed it on the over-bed table. RN #1 then took the Executive Order 26, 4.b. Executive Order 26, 4.b. and placed the bottle on the cloth, along with the Executive Order she was going to use to complete the Executive Order 26, 4.b. The Executive Order 26, 4.b. and the container of Executive Order 26, 4.b. were left to sit on the over-bed table in an area that had not been wiped with the cloths. RN #1 was then observed to remove the dressing and dispose of the dressing in a plastic bag she had attached with tape to the end of the over-bed table. She then removed the gloves, washed her hands, and placed clean gloves on her hands. RN #1 then took the Executive Order 26, 4.b., flipped the top open, and began to squirt Executive Order Executive Order 26, 4 into Resident #2's Executive Order 26, 4.b.. The observation revealed the flip top on the Executive Order Executive Order 26, 4 bottle touched the resident's Executive O above the Executive Order 2 The nurse then Executive Order 26, 4.b. and Executive Order 26, 4.b. Again, RN #1 was observed to use the Executive Order Executive Order 26, 4.b. and Executive Order 26, 4.b. into the Executive Order, and again the flip top of the bottle touched the resident's skin. The nurse completed Resident #2's Executive Order 26, 4.b., removed the gloves and washed her hands. The nurse then took a sharpie out of her pocket, dated the dressing, and placed the sharpie back in her pocket. The Executive Order 26, 4.b., the roll of tape, and the container of bleach wipes were then	F 880	PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR. •Licensed staff were re-educated on the facility infection control policy and procedure related to treatments and discarding unused supplies before leaving room. •Competency on Executive Order 26, 4.b./aseptic: no touch was completed with licensed nurses on 2/3/2022. •Root Cause Analysis has been completed based on the imposed DPOC dated 2/28/2022. All Staff received the following Directed In-service Training on 3/2/2022 to 3/7/2022: •Module 1 Infection Prevention & Control Program https: / /www. train . org/main/course/1081350/ Provide the training to: Topline staff and infection preventionist •Keep COVID-19 out ! https : / / youtu . be/ 7 srwrF9MGdw Provide the training to: Frontline staff •SparklingSurfaces https : / / youtu . be/t70H80Rr51g Provide the training to: Frontline staff •Module 5 -Outbreaks https : / /www . train .	

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F 880	Continued From page 4 collected by RN #1, taken out of Resident #2's room, and placed back into the treatment cart. Immediately after RN #1 was observed placing the items into the cart, an interview was held with the nurse. She stated she had not been trained to leave items in a resident's room once the items had been taken into a resident's room. She stated both residents were on isolation so that was not an issue. On 01/21/2022 at 10:40 AM, Unit Manager (UM) #1 was interviewed. UM #1 stated standard infection control guidelines indicated items taken into residents' rooms could not be brought out of the rooms and returned to the treatment cart or used for any other resident. She added that included Executive Order 26, 4.b., tape, and bleach wipes. The UM stated she would have expected RN #1 to take a few wipes out of the container and leave the container of wipes on the treatment cart. The UM stated RN #1 should have only used the amount of tape she needed and not taken the entire roll in Resident #2's room and should have poured a Executive Order 26, 4.b. in a cup and left the remainder of the bottle on the treatment cart. The UM stated that, in her opinion, everything RN #1 did during Executive Order 26, 4.b. for Resident #2 was wrong, and education was needed. The Director of Nursing (DON) was interviewed on 01/21/2022 at 10:45 AM. The DON stated she would have expected RN #1 to prepare for the treatment by gathering the needed supplies before entering Resident #2's room. The DON stated staff had been taught not to bring anything out of a resident's room that had been used in the room, adding the nurse should have Executive Order 2 the	F 880	org/cdctrain/course/10818 03 / Provide the training to: Topline staff and infection preventionist •Module 11B — Environmental Cleaning and Disinfection https : / /www. train . org/main/course/1081815/ Provide the training to: All staff including topline staff and infection preventionist •Module 6Ä — Principles of Standard Precautions https : / /www . train . org/main/course/10818 04/ Provide the training to: All staff including topline staff and infection preventionist •Module 6B- Principles of Transmission Based Precautions https : / /www . train . org/main/course/1081805/ Provide the training to: All staff including topline staff and infection preventionist HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE •Random weekly audits on proper treatment techniques will be conducted by the IP nurse/designee x3 monthly. •Random IP rounds are being conducted every shift by IP nurse/designee and findings are reviewed during morning	

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F 880	Continued From page 5 Executive Order 26, 4.b. in a cup and only taken in a few wipes. She added the nurse should not have placed the used items back on the cart. She stated it would have been reasonable for the nurse to pull the over-bed table to the doorway and set up what was needed for the Executive Order 26 care. The facility's policy, titled, "Treatments," with a revision date of 06/01/2021, indicated under Practice Standards, Bullet #8, "Unused supplies are discarded according to infection control procedure or remain dedicated to the patient and stored appropriately." New Jersey Administrative Code § 8:39-19.4(a)	F 880	meetings; area of concerns if any are addressed immediately. •All findings of audits will be submitted and reviewed during the monthly and quarterly QAPI meetings. •The DON/designee and administrator will follow up as needed. COMPLIANCE DATE: MARCH 7, 2022	

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)
315036	A. Building B. Wing	3/9/2022

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR GLEN CENTER	25 E LINDSLEY ROAD CEDAR GROVE, NJ 07009

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 F0880 Reg. # 483.80(a)(1)(2)(4)(e)(f) LSC	Correction Completed 03/07/2022	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	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	
1/30/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO