STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315204		C 12/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CANTERBURY AT CEDAR GROVE	398 POMPTON AVENUE CEDAR GROVE, NJ 07009

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F 000	INITIAL COMMENTS	F 000		
	Complaint #: NJ146204, NJ145427 Census: 107 Sample Size: 4 The facility is not 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 to not 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: 12/13/2021 - 12/14/2021			
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Complaint Intake #: NJ145427	F 684	Element # 1 Resident #2 was assessed by the Director	1/31/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/18/2022

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 684	Continued From page 1 Based on observation, interviews, and facility policy, it was determined the facility failed to ensure medications administered were confirmed to be taken by the resident and not left at bedside for 1 (Resident #2) of 3 residents reviewed for not receiving medications. Findings included: 1. The facility admitted Resident #2 on [redacted] with diagnoses of [redacted] ([redacted]). The quarterly Minimum Data Set (MDS), dated [redacted] revealed the Brief Interview for Mental Status (BIMS) score to be an [redacted] out of [redacted] which indicated the resident was [redacted]. A record review of Resident #2's December physician's orders and medication administration record (MAR) indicated that the resident's 9:00 AM medications on 12/13/2021 included [redacted] for [redacted], [redacted]. In an observation and interview on 12/13/2021 at 11:16 AM, Resident #2 was sitting up on the edge of the bed. Certified Nursing Assistant (CNA) #1 was in the resident's room with the resident and stated that they were getting the resident up for	F 684	of Nursing (DON) on 12/13/2021, and no adverse effects occurred as a result of the deficient practice. Resident #2 received [redacted] medication as ordered on 12/13/2021. Physician for Resident #2 was notified of the medication incident on 12/13/2021. LPN #1 was re-educated on Medication Administration policy by the DON on 12/13/2021. A Medication Administration Observation and competency was provided by the DON for LPN#1 on 12/14/2021. A disciplinary action was given to LPN #1 by the DON on 12/14/2021 for failing to follow the facility policy on Medication Administration. Element # 2 All residents has the potential to be affected by the deficient practice. Element # 3 All nurses are re-educated by the DON/Designee on December 17, 2021 on the Medication Administration Policy and ongoing. DON/Designee will perform medication administration audits on 4 nursing staff to identify any deficient practice on Medication Administration weekly X 2 monthly X2 and quarterly X2. Element # 4 Results of the audit will be presented to the QAA Committee meeting during monthly QAPI meetings.	

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F 684	Continued From page 2 the day. Resident #2 had approximately [redacted] pills visible in their left hand. CNA #1 stated that the resident liked to sleep in, and the medications in the resident's hands were their [redacted] medications. Resident #2 also stated that the medication was left at the bedside, and it was their [redacted] medication. In an interview on 12/13/2021 at 11:37 AM, Licensed Practical Nurse (LPN) #1 stated that they provided the resident's [redacted] medications at 10:00 AM that morning, but they were due to be given at 9:00 AM. LPN #1 stated that they were allowed two hours to provide the resident's medication. LPN #1 stated that they had left the medications at the bedside because the resident "takes an hour and is very slow" with taking their medications. The LPN would go back to the resident's room to ensure the medications had been taken but had not yet gone back to the resident's room. LPN #1 confirmed that they should not have left the medications at the resident's bedside. In an interview on 12/14/2021 at 9:41 AM, the Director of Nursing (DON) stated that staff should stay in the resident's room and watch the resident swallow the pills before exiting the room. The DON stated they were aware of the concern that happened on 12/13/2021, and LPN #1 was in-serviced on the incident. The DON stated that was the second in-service that had been completed specifically for LPN #1. On 06/10/2021 LPN#1 had been in-serviced for the proper administration of medications [redacted] The DON stated the LPN should have notified the doctor and documented it in the progress notes.	F 684	Identified negative findings will be immediately addressed and trends will be reported on the QAPI meeting.	

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F 684	Continued From page 3 In an interview on 12/14/2021 at 11:48 AM, Resident #2 stated that the nurse did sometimes leave medications at the bedside, but the resident was not able to recall dates, times, or names of staff. In an interview on 12/14/2021 at 5:04 PM, the Administrator stated that they did not believe medications should be left at the bedside. A record review of the policy, "Medication Administration," with a revision date of 11/2017, indicated that staff administering medication should "observe resident consumption of medication." New Jersey Administrative Code § 8:39-29.2(d)	F 684		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals	F 880		2/17/22

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F 880	Continued From page 4 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. §483.80(e) Linens.	F 880		

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F 880	Continued From page 5 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, interviews, record review, and facility policy review, it was determined the facility failed to take necessary precautions when providing an aerosol generating procedure for a resident that was [redacted] for 1 of 1 resident (Resident #4) that was on isolation precautions. The deficient practice occurred during the [redacted]. Findings included: 1. The facility admitted Resident #4 on [redacted] with a diagnosis of [redacted] The admission Minimum Data Set (MDS) had not been completed at the time of record review and therefore was unable to indicate the resident's [redacted] status. In a review of the resident's December physician's orders, Resident #4 had an order for droplet and contact isolation for fourteen days, with a start date of [redacted]. Resident #4 also had a physician's order for [redacted], and to [redacted] (mL) every [redacted] hours at 12:00 AM, 6:00 AM, 12:00 PM, and 6:00 PM. In an observation and interview on 12/14/2021 at 1:50 PM, Resident #4 was located at the very end of the [redacted] Hall. The facility did not have a	F 880	Element # 1 Resident #4 was assessed by the Director of Nursing on December 14, 2021, no adverse effects occurred as a result of the deficient practice. A Signage stating to "Keep Door Closed" when patient is receiving [redacted]) is placed on December 15, 2021 for Resident #4. RN #3 was re-educated by the Director of Nursing on December 14, 2021 on the protocol and precautions that need to be in place when a [redacted] resident is receiving an [redacted]). RN #3 Element #2 All [redacted] residents requiring the administration of [redacted] have the potential to be affected by the deficient practice. Element #3 Root Cause Analysis was conducted by	

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F 880	Continued From page 6 dedicated [redacted] The resident's bedroom door was open, and the resident was receiving an [redacted]). RN #3 stated that the resident's bedroom door was always open because the resident was at the end of the hall and not near any other residents. RN #3 did not know what the policy was regarding what precautions to put into place when a [redacted] resident was receiving an [redacted]. In an interview on 12/14/2021 at 1:57 PM, the Infection Preventionist was on the [redacted] floor and stated Resident #4's door should be shut during an [redacted]. In an interview on 12/14/2021 at 5:11 PM, the DON stated that a resident that was [redacted] was allowed to keep their door open. The DON stated that during an [redacted] the door could still be open, per best nursing practice. In an interview on 12/14/2021 at 5:35 PM, the Administrator stated that it was not required for the bedroom door of a resident that was [redacted] for [redacted] to be closed; however, it was recommended, but not required, to have it closed during an [redacted]. A review of "Infection Prevention and Control Program Policy," with a revision date of 01/2021, indicated, "A resident with an infection or communicable disease shall be placed on transmission-based precautions as recommended by the CDC guidelines." New Jersey Administrative Code §	F 880	the QAA Committee and it was determined that the alleged deficient practice occurred because there was no process in place for auditing of compliance with Infection Control and Prevention and protocols for [redacted]. An Audit Checklist was developed, and all staff were educated on the tool to ensure compliance. A Performance Improvement Project is in place to ensure consistent and systematic changes. Directed In-Service Training provided on the following topics: Nursing Home Infection Preventionist Training Course Module 1 Infection Prevention & Control Program provided to Topline Staff and infection preventionist CDC [redacted] Prevention Messages for Front Line Long-Term Care Staff: Keep [redacted] Out! provided to Frontline Staff CDC [redacted] Prevention Messages for Front Line Long-Term Care Staff: Closely Monitor Residents! provided to Frontline Staff CDC [redacted] Prevention Messages for Front Line Long-Term Care Staff: Use PPE Correctly for [redacted] provided to Frontline Staff Nursing Home Infection Preventionist Training Course Module 4 Infection Surveillance provided to Topline Staff and infection preventionist Nursing Home Infection Preventionist	

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F 880	Continued From page 7 8:39-19.4(a)1-6	F 880	Training Course Module 5 Outbreaks provided to Topline Staff and infection preventionist Nursing Home Infection Preventionist Training Course Module 6A - Principles of Standard Precautions provide to all staff including Topline Staff and infection preventionist Nursing Home Infection Preventionist Training Course Module 6B - Principles of Transmission-Based Precautions provide to all staff including Topline Staff and infection preventionist All staff were re-educated by the RN-Infection Preventionist relating to infection prevention and control protocols required when aerosol-generating procedures are done for patients with suspected or confirmed [redacted] diagnosis on December 17, 2021 and ongoing. The RN-Infectionist will audit compliance with infection prevention practices relating to Aerosol-generating procedures daily x 2 weeks, weekly x 2 months, then monthly x 4 months. A Signage stating "Keep Door Closed" will be placed on rooms of [redacted] or [redacted] residents when receiving an [redacted]). All staff are re-educated on the protocol on December 16, 2021 and ongoing. Audit tools to be reviewed by	

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F 880	Continued From page 8	F 880	DON/designee daily x weeks, weekly x 2 months, then monthly x 4 months. DON/Infection Preventionist/designee will identify compliance, trends and make recommendations based on audit results and report to QAA Committee. Element #4 Results of the audit will be presented to the QAA Committee meeting during monthly QAPI meetings. Identified negative findings will be immediately addressed and trends will be reported on the QAPI meeting.	