STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060736	A. BUILDING: _____ B. WING _____	09/23/2021

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ALLIANCE CARE REHABILITATION AND NURSING CE	155 40TH STREET IRVINGTON, NJ 07111

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S 000	Initial Comments THE FACILITY WAS NOT IN COMPLIANCE WITH THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE, CHAPTER 8:39, STANDARDS FOR LICENSURE OF LONG TERM CARE FACILITIES. THE FACILITY MUST SUBMIT A PLAN OF CORRECTION, INCLUDING A COMPLETION DATE, FOR EACH DEFICIENCY AND ENSURE THAT THE PLAN IS IMPLEMENTED. FAILURE TO CORRECT DEFICIENCIES MAY RESULT IN ENFORCEMENT ACTION IN ACCORDANCE WITH THE PROVISIONS OF THE NEW JERSEY ADMINISTRATIVE CODE, TITLE 8, CHAPTER 43E, ENFORCEMENT OF LICENSURE REGULATIONS.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interviews and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios for the day shift as mandated by the state of New Jersey. This was evidenced for 4 of 14 day shifts reviewed. Findings include: Reference: New Jersey Department of Health (DOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey	S 560	1. What corrective action will be accomplished for those residents affected by the deficient practice? The DON will review the daily staffing schedule for the next day daily with the staffing coordinator for compliance with daily staffing requirements. Staffing will meet the daily staffing ratio requirements. In order to comply with the daily required staffing ratios of 1:8 for day shift, 1:10 for evening shift, and 1:14 for night shift, all vacation requests will be reviewed and granted based upon facility needs for adequate staffing coverage to maintain at	10/11/21

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S 560	Continued From page 1 Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. A review of the "Nursing Staffing Report" completed by the facility for the weeks 8/22/2021 through 8/28/2021 and 8/29/2021 through 9/04/2021, revealed the staffing to residents' ratios did not meet the minimum requirement of 1 CNA to 8 residents for the day shift as documented below: - 8/22/21 had 12 CNAs for 102 residents on the day shift. - 8/28/21 had 11 CNAs for 107 residents on the day shift. - 8/29/21 had 10 CNAs for 107 residents on the day shift. - 9/4/21 had 13 CNAs for 106 residents on the day shift. On 9/10/21 at 1:16 PM, the Vice President of Operations stated "we are trying hard to comply	S 560	least the daily required staffing ratios. Multiple staff will not be granted vacation or time off at the same time. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by the same deficient practice 3. What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur? Staffing schedule will be reviewed daily by the DON to ensure adequate, required ratios for staffing is provided per residents in facility. The facility will continue hiring Certified nursing assistant to ensure the minimum staffing requirement for nursing home facility is met. The facility has placed ads for certified nursing aids employment. The facility has coordinated with a certified nursing aid training program starting on 12/6/2021. The Facility hires temporary aids as needed. The facility has in place a recruitment bonus offered to staff that recruits Certified Nursing Aids. The Facility has in place a sign-on bonus offered to newly hired full time Certified Nursing Aids. 4.How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur? Assisting Director of Nursing and or	

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S 560	Continued From page 2 with the minimum staffing requirements." On 9/13/21 at 10:29 AM, the Director of Nursing stated that the facility did not have a staffing policy and the facility was following the Executive Director from the Governor regarding the new staffing requirements. On that same date and time, the staffing coordinator stated that she was aware of the new staffing requirements and that she makes sure she prepares the nursing schedule for the Certified Nursing Aides (CNAs) and Nurses at least two months ahead due to "a lot of nursing staff in the facility are Per Diem." She further stated that "the staff are offered over time when needed" and she acknowledged and stated the facility was not in compliance with the new staffing requirements on 8/28/21 and 8/29/21 due to four CNAs were out at the same time due to vacation, one call out and one out on FMLA [Family and Medical Leave Act], and one scheduled off. "We tried to get replacement but there was no one available." She stated that overtime was offered and staff refused and "we can't force them to work because CNAs are under union and it was in their contract." She also stated that the facility was not able to get agency staff because of a stipulated union contract.	S 560	designee will audit staffing schedule daily x 1month and weekly x month and random audit x 1 month. Any variances will be reported to Director of Nursing and Administrator. The Director of nursing will report results of audits to the quarterly quality control committee for the next two quarters.	

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F 000	INITIAL COMMENTS Standard Survey: 9/24/21 Census: 103 Sample Size: 24 The facility is not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for long term care facilities.	F 000		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to maintain the necessary [redacted] care and services for a resident who was receiving a [redacted] treatment according to standards of practice. This deficient practice was identified for 1 of 2 residents (Resident #45) reviewed. This deficient practice was evidenced by the following: On 9/9/21 at 11:01 AM, the surveyor observed Resident #45 laying on a [redacted] inside their	F 695	1. What corrective actions will be accomplished for those residents found to have been affected by the deficient practice. Care plans were immediately updated for Resident # 45 The [redacted] setting was immediately corrected and the [redacted]	10/8/21

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F 695	Continued From page 1 room with [redacted] in use. On 9/13/21 at 12:00 PM, the surveyor observed a Certified Nursing Aide (CNA) feeding the resident in their room. The resident had [redacted] attached to the [redacted] at [redacted]. On 9/14/21 at 9:40 AM, the CNA informed the surveyor that Resident #45 was [redacted], required total assistance with activities of daily living (adls) and a feeder. The CNA further stated that it was the nurse's responsibility to take care of the [redacted] The surveyor reviewed the medical record for Resident # 45. A review of the resident's Face Sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses that included [redacted] disease, dependence on [redacted] (when the number of healthy [redacted]), [redacted] (elevated [redacted] A review of the [redacted] Comprehensive Minimum Data Set (CMDS), an assessment tool used to facilitate care management, revealed a Brief Interview for Mental Status (BIMS) score was [redacted] which indicated that the resident's cognition was [redacted] A review of the Order Audit Report revealed an original order date of [redacted] for [redacted] at [redacted] every shift and to check every shift.	F 695	immediately changed for Resident #45. Resident #45 was stable and there was no negative effect 2. 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 the same deficient practice. All residents have the potential to be affected by the same deficient practice. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. All nursing staff was immediately in-serviced by Assistant Director of Nursing on writing and updating care plans with timeliness to include any changes with patient's health status. A system was initiated that when 11-7 supervisor does 24 hour	

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F 695	Continued From page 2 Further review of the medical record showed that the [redacted] and [redacted] electronic Medication Administration Record (eMAR) and electronic Treatment Administration Record (eTAR) reflected the above orders and were signed by nurses as administered and checked every shift. A review of the personalized care plan revealed that there was no care plan for [redacted] care and the use of [redacted] of Resident #45. On 9/13/21 at 12:03 PM, the Registered Nurse/Unit Manager (RN/UM) informed the surveyor that it is the responsibility of the admitting nurse to initiate a care plan upon admission. The RN/UM stated that it is the UM, Director of Nursing (DON), and Assistant Director of Nursing (ADON) responsibility to update and revise the care plan when there is a change to a resident which include the new order for [redacted] RN/UM indicated that care plan should be initiated within 24 hours to reflect the current condition of the resident. She further stated that the care plan should be reviewed quarterly and as needed when there is a change. The RN/UM stated "it was an oversight on our part," why the care plan for [redacted] use and [redacted] care was not done. On 9/14/21 at 12:02 PM, the surveyor observed that the resident was not in their room. The [redacted]-floor Quality Assurance/Certified Nursing Aide (QA/CNA) informed the surveyor that Resident#45 was transferred to [redacted] floor "yesterday." On 9/14/21 at 12:05 PM, the surveyor and the Registered Nurse (RN) went inside the resident's	F 695	chart check, she will verify if care plan revisions and updates for any new orders, and changes in patient's condition are completed. All new orders will be reviewed at the morning meeting by the unit managers and care plans will be updated/implemented immediately at the morning meeting. The RN caring for resident #45 was immediately in-serviced by the Director of Nursing to ensure doctor's orders for [redacted] administration is followed and to check all residents in [redacted] administration for functioning [redacted] or [redacted] administration. 4. How the corrective actions will be monitored to ensure the deficient practice will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the system change	

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F 695	Continued From page 3 room and observed the resident laying on a bed with head of the bed elevated at 45 degrees, with [redacted] in use [redacted] at [redacted] attached to the [redacted]) [redacted]. The resident was not in distress. On that same date and time, the surveyor asked the RN how much [redacted] the resident should be receiving. The RN pointed with her finger toward the [redacted] and stated "it's [redacted] The surveyor then asked the RN to show the order for [redacted] At that time, the surveyor left the resident's room and followed the RN to her medication cart (medcart). The RN opened her computer on top of her medcart and stated to the surveyor "the [redacted] should be at [redacted] and I will change it now." Furthermore, the RN attempted to adjust the [redacted] to [redacted] multiple times and the machine will not reach the [redacted]. The RN informed the surveyor that the machine was broken and will have to get the Licensed Practical Nurse/Unit Manager (LPN/UM). On that same date and time, the surveyors observed LPN/UM replaced the broken [redacted] with another [redacted] and assessed the resident with the RN. The LPN/UM indicated that the resident was stable and there was no negative effect. On 9/14/21 at 12:21 PM, the RN informed the surveyors that when she came in today at 7 AM, the resident was seen in their room with [redacted]. The RN further stated that she was not paying	F 695	Assistant Director of Nursing will audit for care plans on residents requiring care plans by doing a random audit of 10 medical records per week for 3 months and report any variance and outcome to Director of Nursing weekly. Director of Nursing will report results of these audits to the administrator weekly. Results of these audits will be reported by the Director of Nursing to the quarterly Quality Control Committee for the next two quarters. The unit managers and supervisors will audit minimum of ten residents on [redacted] administration weekly for orders being followed for 3 months administration of [redacted] and report any variances weekly to the Director of Nursing. Director of Nursing will report results of these audits to the administrator weekly. Results of these audits will be reported by the Director of Nursing to the quarterly Quality Control Committee for the next two quarters.	

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F 695	Continued From page 4	F 695		

attention when she saw the resident "today" that was why she was not sure how much [redacted] the resident was on that time.

On that same date and time, the RN informed the surveyors that it was her responsibility as a nurse to follow the physician's order for [redacted] and to check if it is functioning appropriately. The RN stated that she was not aware that the [redacted] was not working properly not until she attempted to correct the [redacted] order for [redacted]

On 9/14/21 at 1:04 PM, the surveyors met with the LNHA, DON, ADON, and two Regional Directors and were made aware of the above concerns. The DON informed the surveyors that a care plan for [redacted] use and [redacted] care should have been done.

On 9/16/21 at 9:39 AM, the surveyors met with the DON, LNHA. The DON stated that she spoke to the RN and educated the RN to make sure to check the order for [redacted] and [redacted] machine matches the order. The DON further stated that it is the responsibility of the nurse to check the [redacted] for function, to replace the broken [redacted] with a portable [redacted], and not to attempt to fix the [redacted]. The DON indicated that the resident was assessed immediately and there was no negative effect to the resident.

A review of the facility Care Plan Policy/Procedure that was provided by the DON with a revised date of 7/2021 included "Purpose of the Care Plan: An interdisciplinary approach to identification of problems and developing solutions provides individualization and coordination of resident

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F 695	Continued From page 5 care. Policy Interpretation and Implementation: 1. All residents must have a Care Plan that is reviewed, revised, and updated quarterly and more frequently if warranted by a significant change in resident's condition...." A review of the facility [redacted] Administration Per Nasal Cannula that was provided by the DON with a revised date of 12/2020 included "Policy: A physician's order shall be required for administering [redacted] .... Procedure: Verify order in the resident's medical record ....."	F 695		
F 761 SS=D	NJAC 8:39-11.2 (b); 27.1(a) 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 Control Act of 1976 and other drugs subject to	F 761		10/8/21

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F 761	Continued From page 6 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: Based on observation, interview, and record review, it was determined that the facility failed to properly label, store and dispose of medications in 1 of 6 medication carts inspected. This deficient practice was evidenced by the following: On 9/15/21 at 10:15 AM, the surveyor inspected the [redacted] floor [redacted] medication cart in the presence of a Licensed Practical Nurse (LPN). The surveyor observed two opened [redacted] vials that were inside a bag that contained a different resident's name than were on the insulin vial. At that time, the surveyor interviewed LPN who stated that the [redacted] vials should have been placed in the bag with the corresponding names. She stated that she should have double checked to make sure she was placing the vial into the right bag. On 9/15/21 at 1:15 PM, the surveyor met with the Licensed Nursing Home Administrator and the Director of Nursing (DON), and no further information was provided by the facility. A review of the facility's policy for Medication Storage dated 4/14 that was provided by the DON indicated the following: "E). Medications will be stored in the original, labeled containers received from the pharmacy." NJAC: 8:39-29.4 (a) (h) (d)	F 761	1. What corrective action will be accomplished for those residents affected by the deficient practice? The two residents identified medications were placed in the bag corresponding with their names. 2.How will the facility identify other residents having the potential to be affected by the same deficient practice All residents have the potential to be affected by the same deficient practice. 3.What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur? The licensed practical nurse on [redacted] floor high side medication cart who had placed [redacted] vials in the incorrect bags was immediately in-serviced by	

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F 761	Continued From page 7	F 761	the Assistant Director of nursing on proper medication storage and labeling All nurses will be re in□serviced on facility policy for medication storage and labeling by the Assistant Director of Nursing Unit manager or designee will check [redacted] medication are stored in proper label bags/containers weekly. for the next month and then monthly for 2 months and then random audits weekly of at least 3 residents for the next 3 months 4. How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur? Assistant Director of Nursing or designee will do weekly audits for medication storage and labeling for the next month and then monthly for the next two months and then random audits of at least 3 resident per unit for the next 3 months. Pharmacy consultant will conduct monthly audits for proper labeling and	

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F 761	Continued From page 8	F 761	storage of medication. Any variances will be reported to Director of nursing. Director of Nursing will report result of these audits to Administrator. Results of these audits will be reported by the Director of Nursing to the quarterly quality control committee for the next two quarters.	
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. §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;	F 880		10/27/21

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(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 9 §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. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315359	A. BUILDING _____ B. WING _____	09/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLIANCE CARE REHABILITATION AND NURSING CENTER	155 40TH STREET IRVINGTON, NJ 07111

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F 880	Continued From page 10 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 record review, it was determined that the facility failed to a.) use the appropriate personal protective equipment (PPE) for 1 of 2 staff, b.) disinfect the table prior to setting up equipment for [redacted] care, c.) properly dispose the [redacted] of the [redacted] and used equipment. This was identified for 1 of 1 resident (Resident #92) reviewed for [redacted] care, and e.) perform appropriate hand hygiene in 1 of 3 nurses observed during medication pass. This deficient practice was evidenced by the following: According to the U.S. Centers for Disease Control and Prevention (CDC) guidelines Summary for Healthcare Facilities: Strategies for Optimizing the Supply of N95 Respirators during Shortages dated 4/9/21 indicated that "Personal Protective Equipment: Respiratory Protection ...Use surgical N95 respirators only for HCP [health care personnel] who need protection from both airborne and fluid hazards (e.g; splashes, sprays). If needed but unavailable, use face shield over standard N95 respirator." According to the U.S. CDC Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, page last updated 2/23/21, included "Personal Protective	F 880	1. What corrective action will be accomplished for those residents affected by the deficient practice? Resident #92 disinfecting of equipment set-up was immediately performed on 9/13/21 How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by the same deficient practice What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur? The Respiratory therapist for the 1st floor who was performing care by rolling over bed table to bedside and without disinfecting was rein-serviced immediately by regional respiratory therapist on proper infection control practices with disinfecting surface being used prior to rendering care. The respiratory therapist will have a competency done as it relates to infection control by Assistant Director of Nursing on proper disinfecting technique while providing care. All [redacted] therapist will be	

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	315359	A. BUILDING _____ B. WING _____	09/23/2021

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F 880	Continued From page 11 Equipment: HCP who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions and use a NIOSH-approved N95 or equivalent or higher-level respirator, gown, gloves, and eye protection. Hand Hygiene: HCP should perform hand hygiene before and after all patient contact, contact with potentially infectious material, and before putting on and after removing PPE, including gloves. Hand hygiene after removing PPE is particularly important to remove any pathogens that might have been transferred to bare hands during the removal process. HCP should perform hand hygiene by using ABHR with 60-95% alcohol or washing hands with soap and water for at least 20 seconds. If hands are visibly soiled, use soap and water before returning to ABHR. Healthcare facilities should ensure that hand hygiene supplies are readily available to all personnel in every care location. Management of laundry, food service utensils, and medical waste should also be performed in accordance with routine procedures." According to the Occupational Safety and Health Administration (OSHA) for Respiratory Protection Guidance for the Employers of Those Working in Nursing Homes, Assisted Living, and Other Long-Term Care Facilities During the COVID-19 Pandemic indicated "When protection against exposure to splashes and sprays of infectious material from others is also need, an FDA [Food and Drug Administration]-cleared or authorized surgical N95 FFR [filtering facepiece respirators] must be worn by healthcare workers." 1. On 9/9/21 at 12:07 PM, the surveyor observed Resident # 92's door with a stop sign and PPE bin with adequate PPE on the door and	F 880	rein-serviced on proper disinfection technique and policy and procedure for proper infection control by Regional Therapist and or Assistant Director of Nursing within a month. DON/ADON/Regional Respiratory Therapist will observe the respiratory therapists doing bedside [redacted] care weekly on 2-3 residents and randomly for proper use of full PPE and cleaning and disinfecting procedure room surfaces immediately. Detailed Plan of Correction (DPOC) and Root Cause Analysis (RCA) was completed. Staff (RT) stated that table was disinfected prior to entering room and not right before rendering care. The following videos were shown to Topline Staff & Infection Preventionist: Module 1- Infection Prevention & Control Program Module 4- Infection Surveillance Module 11A- Reprocessing Reusable Resident Care Equipment The following videos were shown to Frontline Staff: CDC Covid-19 Prevention Messages for Frontline Long Term Care Staff- Keep Covid 19 Out! The following videos were shown to All Staff including Topline Staff & Infection Preventionist: Module 6A- Principles of Standard Precautions Module 7- Hand Hygiene	

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	315359	A. BUILDING _____ B. WING _____	09/23/2021

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F 880	Continued From page 12 alcohol-based hand rub (ABHR). On 9/10/21 at 10:15 AM, the surveyor observed Resident #92 in bed with eyes closed. The surveyor observed the resident with a [redacted] and on a ventilator machine (a machine that [redacted] into [redacted]). At that same time, the surveyor interviewed the Respiratory Therapist (RT) who stated that the resident is on isolation precautions specifically contact precautions due to [redacted]). On 9/13/21 at 9:30 AM, two surveyors observed the RT perform [redacted] care to Resident # 92. The surveyors observed the RT wearing a blue surgical mask. She donned (put on) a blue disposable gown and gloves and entered the resident's room. She then rolled the overbed table to the bedside and without disinfecting the table she set up the required equipment for the [redacted] care. The surveyors observed the RT dispose of the [redacted] into the regular garbage trash bin and equipment used to render [redacted] care. The surveyors observed the RT doff (remove) the disposable gown and gloves and dispose into a dedicated red bin with an orange color "biohazard" plastic bag inside the resident's room near the door. On that same date at 9:46 AM, the surveyors interviewed the RT who stated "I'm going back in to disinfect the table. I did disinfect the table earlier this morning." The surveyors inquired if she wore a surgical mask for [redacted] care. The RT stated that she doesn't have to use an N-95 mask because the resident was not on transmission-based precautions for COVID-19 but for [redacted]. She further stated that disposing	F 880	How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur? The Regional Therapist or designee will do weekly audits on proper disinfecting of equipment, in specific proper disinfecting of tabletop/surfaces being used for one month and then monthly for the next two months and then random audits of proper disinfecting of tabletops/surfaces for at least two resident for next three months on proper infection control as relates to disinfecting bedside table prior to rendering respiratory care. All Variances will be reported to Assistant Director of Nursing who will report to Director of Nursing and Administrator. Result will be reported by Director of Nursing to the quarterly quality control committee for the next two quarters. 2. What corrective action will be accomplished for those residents affected by the deficient practice? Resident #92 [redacted] was placed in the biohazard container on 9/14/21 How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by the same deficient practice What measures will be put in place or	

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F 880	Continued From page 13 of the [redacted] into the regular garbage bin was her "usual practice as long as there were no blood or body fluids otherwise it would need to go into the red biohazard bag." The RT stated she was trained by the Regional RT and that she followed the facility policy and protocols. On 9/14/21 at 10:40 AM, the surveyor in the presence of the survey team interviewed the Regional RT who confirmed she trained the aforementioned RT. She also acknowledged that placing the [redacted] in the regular garbage trash bin was the facility's practice/protocol. She stated that the use of a surgical mask during [redacted] care "is acceptable for contact precautions." On 9/14/21 at 1:04 PM, the survey team met with the administration staff and discussed the above observation and concerns. The Director of Nursing (DON) stated, "We changed our policy to reflect that we will be using an N95 mask for all patients with [redacted] On 9/14/21 at 1:36 PM, the surveyor in the presence of the survey team interviewed the Infection Control Preventionist who stated, "an N95 mask should be worn when providing [redacted] care and changing of the [redacted]." She stated, "this is according to our protocol, not our policy." She further stated that the RT should have worn an N95 mask during [redacted] and changing the [redacted] because you don't know what is in the splashes." She further stated, "the RT should have disposed of the [redacted] in the biohazard covered bin that was inside the resident's room. This was the facility protocol that all staff on the [redacted] floor should wear an N95 mask when entering the	F 880	systemic changes made to ensure that the deficient practice will not recur? Respiratory therapist who was observed disposing of the [redacted] into the regular garbage trash bin and equipment used to render [redacted] care was in-serviced to revision of policy to dispose of [redacted] in biohazard by Regional Respiratory therapist All respiratory therapist and nurses will be re in-serviced on facility policy revision on disposal of [redacted] in biohazard bags Detailed Plan of Correction (DPOC) and Root Cause Analysis (RCA) was completed. Staff (RT) was unaware that inner cannula should be disposed in a biohazardous bag because it contains body fluid. The following videos were shown to Topline Staff & Infection Preventionist: Module 1- Infection Prevention & Control Program Module 4- Infection Surveillance Module 11A- Reprocessing Reusable Resident Care Equipment The following videos were shown to Frontline Staff: CDC Covid-19 Prevention Messages for Frontline Long Term Care Staff- Keep Covid 19 Out! The following videos were shown to All Staff including Topline Staff & Infection Preventionist: Module 6A- Principles of Standard Precautions	

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F 880	Continued From page 14 resident's room. It doesn't matter what kind of infection." The surveyor reviewed the medical record for Resident # 92. A review of the Significant change in status Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted] reflected that the resident was admitted to the facility on [redacted] with diagnoses which included but were not limited to [redacted], [redacted], and [redacted]. The MDS assessment further revealed that the resident's [redacted] skills for daily [redacted]. The MDS further included that the resident was assessed for [redacted] care, invasive [redacted], and [redacted]. A review of the resident's individual comprehensive Care Plan initiated [redacted] reflected that the resident had an infection of the [redacted] suppressed immune system. The intervention included was to maintain contact precautions when providing resident care and to follow facility policy and procedures for line listing, summarizing, and reporting infections. Further review of the care plan revealed that on [redacted] the care plan for [redacted] related to [redacted] was initiated and it did not specify what PPE to use during tracheostomy care as part of interventions. A review of the Order Listing Report indicated an active physician's order dated [redacted] for "Resident on contact Isolation for [redacted]." 2. On 9/14/21 at 9:25 AM, during a medication	F 880	Module 7- Hand Hygiene How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur? The regional respiratory therapist or designee will do a monthly audit for proper disposal of [redacted] etc for two months and then random audits on 4 residents for the next two months and report any variance to assistant director of nursing who will then report to director of nursing and Administrator. Result will be reported by Director of Nursing to the quarterly quality control committee for the next two quarters. 3. What corrective action will be accomplished for those residents affected by the deficient practice? Resident #92 practice and policy of PPE for providing care was changed to reflect use of N95 mask on 9/14/21 How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by the same deficient practice What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur? Respiratory therapist who was observed wearing a blue surgical mask while doing	

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F 880	Continued From page 15 observation pass, the surveyor observed a Registered Nurse (RN) washed her hands after administering medication to a resident. The surveyor observed the RN put on the faucet, wet her hands then apply soap and immediately rinse her hands under a stream of water without scrubbing her hands for 20 seconds. At that time, the surveyor interviewed the RN who stated that she should have scrubbed her hands away from running water for 20 seconds before rinsing her hands under a stream of water. On 9/14/21 at 1:00 PM, the surveyor met with the DON and Licensed Nursing Home Administrator and no further information was provided by the facility. A review of the facility's policy for Infection Control-Contact Precautions revised 3/24/20 included "it is the policy of the facility to ensure that appropriate infection prevention and control measures are taken to prevent the spread of communicable disease and infections in accordance with State and Federal Regulations, and national guidelines ...Contact precautions are implemented most often for residents who have an infection due to an epidemiologically important organism such as multi-drug resistant organism ...Personal protective equipment is to be worn to protect health care workers (i.e. have a barrier) from contact with body fluids ...The personal protective equipment worn will vary by task being performed and likelihood of exposure to body fluid." A review of the facility's policy undated policy for Airway Management provided by the DON	F 880	[redacted] care and Regional respiratory therapist was in-serviced immediately by Assistant Director of nursing to wear N 95 mask when taken care of any resident that has potential to spread infection rendering treatments that can spread infection via air or droplet must wear n95 mask Detailed Plan of Correction (DPOC) and Root Cause Analysis (RCA) was completed. Staff was unaware that N95 was to be worn while performing trach care. The following videos were shown to Topline Staff & Infection Preventionist: Module 1- Infection Prevention & Control Program Module 4- Infection Surveillance Module 11A- Reprocessing Reusable Resident Care Equipment The following videos were shown to Frontline Staff: CDC Covid-19 Prevention Messages for Frontline Long Term Care Staff- Keep Covid 19 Out! The following videos were shown to All Staff including Topline Staff & Infection Preventionist: Module 6A- Principles of Standard Precautions Module 7- Hand Hygiene How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur? Assistant Director of Nursing will audit 2	

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F 880	Continued From page 16 indicated that the procedure for performing daily tracheostomy care was to "utilize universal precautions (gloves, eye protection, face mask and gown) inclusive of hand washing per facility guidelines before and after the procedure." A review of the facility's policy for Handwashing/Hand Hygiene dated 7/12/20 that was provided by the DON indicated the following: Under Procedure: Rub hands briskly, pay attention to areas between fingers, for at least 20 seconds then rinse hands lowered allowed soiled water to drain directly into the sink. NJAC 8:39-19.4 (a) (1) (n) (2)	F 880	resident receiving treatment care that requires N-95 use of mask every month for the next 3 months. The variance will be reported to Director of Nursing and Administrator. Result will be reported by Director of Nursing to the quarterly quality control committee for the next two quarters. 4. What corrective action will be accomplished for those residents affected by the deficient practice? Proper hand washing was reviewed with the RN who did not perform hand washing correctly during medication pass on 9/14/21 by the assistant director of nursing How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by the same deficient practice What measures will be put in place or systemic changes made to ensure that the deficient practice will not recur? The Registered nurse on 3rd floor who was observed put hands under a stream of water without scrubbing her hands for 20 seconds was immediately in-serviced by the Assistant Director of Nursing on proper hand washing All nursing staff will be re-in-serviced on handwashing policy and handwashing competency will be completed on all staff	

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F 880	Continued From page 17	F 880	within one month Detailed Plan of Correction (DPOC) and Root Cause Analysis (RCA) was completed. Staff (RN) did not wash hands for appropriate time need for proper handwashing and also unaware that friction to hands must be done out of stream of water from sink. The following videos were shown to Topline Staff & Infection Preventionist: Module 1- Infection Prevention & Control Program Module 4- Infection Surveillance Module 11A- Reprocessing Reusable Resident Care Equipment The following videos were shown to Frontline Staff: CDC Covid-19 Prevention Messages for Frontline Long Term Care Staff- Keep Covid 19 Out! The following videos were shown to All Staff including Topline Staff & Infection Preventionist: Module 6A- Principles of Standard Precautions Module 7- Hand Hygiene How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur? Assistant Director will do random audits for the next two month on 5 staff a month. Result will be reported by Director of Nursing to the quarterly quality control committee for the next two quarters.	

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F 880	Continued From page 18	F 880	Result will be reported by Director of Nursing to the quarterly quality control committee for the next two quarters.	

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
060736	A. Building B. Wing	1/30/2023

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLIANCE CARE REHABILITATION AND NURSING CENTER	155 40TH STREET IRVINGTON, NJ 07111

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560 Reg. # 8:39-5.1(a) LSC	Correction Completed 12/23/2022	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
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	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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	
11/23/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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)
315359	A. Building B. Wing	12/2/2021

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLIANCE CARE REHABILITATION AND NURSING CENTER	155 40TH STREET IRVINGTON, NJ 07111

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 F0695 Reg. # 483.25(i) LSC	Correction Completed 10/08/2021	ID Prefix F0761 Reg. # 483.45(g)(h)(1)(2) LSC	Correction Completed 10/08/2021	ID Prefix F0880 Reg. # 483.80(a)(1)(2)(4)(e)(f) LSC	Correction Completed 10/27/2021
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	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
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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	
9/23/2021	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO