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	315305	A. BUILDING _____ B. WING _____	04/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMBOY CARE CENTER	**1 LINDBERG AVENUE PERTH AMBOY, NJ 08861**

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F 000	INITIAL COMMENTS	F 000		

SURVEY DATE: 4/6/21

CENSUS: 118

SAMPLE: 30

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 CFR §483.80 infection control regulations as it relates to the implementation of the CMS and Centers for Disease Control and Prevention (CDC) recommended practices for COVID-19.

During an Onsite Recertification and COVID-19 Focused Infection Control Survey completed on 04/06/2021, two Immediate Jeopardy were identified in the area of Infection Control F880 at S/S J and F684 Quality of Care at S/S "K"

The facility was not in substantial compliance with 42 CFR §483.80 (Infection Control), Subpart-B-Requirements for Long Term Care Facilities. The facility failed to implement mitigation strategies to prevent the transmission of Covid-19 by not properly isolating residents exposed to Covid-19 as Persons Under Investigation (PUI) for the virus in order to implement the facility's Covid-19 Preparedness Policy (Outbreak Response Plan). The facility's Preparedness Policy included Transmission Based Precautions (TBP) which were not followed.

The facility's Administration was notified of the IJ

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

Electronically Signed | 04/30/2021

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on 3/22/2021 at 3:15 PM. The immediacy was removed on 3/23/2021, based on an acceptable Removal Plan that was implemented by the facility and verified by the survey team on 3/24/21 while the surveyors were still onsite completing the Recertification survey.

F880 Immediate Jeopardy was identified at: CFR 483.80 at a scope and severity of "J." The Immediate Jeopardy situation began on 3/14/2021 and the immediacy was removed on 3/23/2021 at 3:30 PM after onsite verification of the Removal Plan.

COVID-19 (Coronavirus Disease 2019) is a disease caused by the coronavirus SARS-CoV-2. COVID-19 is thought to spread mainly from person to person, mainly through respiratory droplets produced when an infected person coughs or sneezes.

A second Immediate Jeopardy (F684) was identified at: CFR 483.25 - F680 Quality of Care at a scope and severity of "K". The Immediate Jeopardy situation was determined to have started on 11/19/20 at 2:30 PM when Resident #101 experienced [redacted] and [redacted] upon return from an offsite physician visit. The team identified this IJ on 3/24/21 and the facility was notified at 3/24/21 at 4:30 PM.

The facility failed to recognize Resident #101 was at risk for serious harm or death from a [redacted]. The resident experienced repeated episodes of [redacted], [redacted], and [redacted] after

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F 000	Continued From page 2 returning from offsite physician visits and the 3 times per week visits to an outpatient [redacted] clinic. The facility submitted an acceptable Removal Plan via email on 3/26/21. A revisit was made on 3/29/21 to verify implementation of the Removal Plan. The plan was determined to not be implemented and the immediacy remained. A second revisit was made on 4/6/21 and based on this onsite visit and review of policies and procedures not available at the 3/26/21 revisit the immediacy was removed on 3/26/21 at 10:51 AM. The facility was advised of the removal at that time.	F 000		
F 684 SS=K	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: Based on observations, staff interviews, physician interview, medical record review and review of other pertinent documents, it was determined that the facility failed to a.) recognize and assess the risk factors that placed a resident at risk for serious harm from [redacted]. b.) evaluate a resident's repeated symptoms of [redacted] that often occurred after the	F 684	F Tag- 684 1. Resident #101 no longer resides at the facility. Any residents receiving [redacted] will no longer be allowed to pick up [redacted] at the clinic. All [redacted] will be picked up by facility Nursing staff. All residents receiving	5/11/21

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F 684	Continued From page 3 resident's return from treatment at a [redacted] clinic from [redacted] to [redacted]. c.) Evaluate the resident's non-compliance and how it may impact other residents. This deficient practice was identified for Resident #101, 1 of 24 residents reviewed for the quality of care provided to the facility residents and was evidenced by the following: Resident #101 experienced repeated significant changes in mental and physical condition that included [redacted] following visits to outside physicians and the [redacted] clinic . The facility could not provide any evidence that they attempted to determine the reason for repeated sudden drastic declines in the resident's mental and physical condition. Nor was there any evidence the facility communicated with the methadone clinic the resident's [redacted] condition upon return to the facility from the methadone clinic or possible misuse of the [redacted] given to the resident for the days he/she did not go to the clinic. This failure to determine and address the cause of these episodes and other episodes of noncompliance posed a serious threat to the safety and well being of Resident #101 and other resident's at the facility. This resulted in an Immediate Jeopardy situation that began on 11/19/2020 at 2:30 PM when Resident #101 experienced a sudden change in condition involving [redacted] and difficulty to rouse upon return to the facility from a [redacted] visit.	F 684	Methadone who experience a change in mental and/or physical status, will be evaluated immediately. Information in regards to a resident's change in mental and/or physical condition will be discussed with the [redacted] Clinic. A Policy and Procedure for [redacted] receipt, storage and administration of [redacted] was reviewed and updated by the Administrator, Director of Nurses and Medical Director. 2. All residents receiving [redacted] have the potential to be affected by this deficient practice when an evaluation of the resident is not done immediately when there is a change in physical and/or mental conditions. All residents receiving [redacted] have the potential to be affected by this deficient practice when there is lack of communication between the facility and the [redacted] clinic. 3. On 4/7/2021, an in-service was done by the Director of Nurses with all nurses in regards to the Policy and Procedure for residents receiving [redacted]. An in-service was done by the Director of Nurses on 4/7/2021 with all nurses in review of the policy and procedure to evaluate a resident with any changes in mental and/or physical changes and to report any changes to the primary care physician. Observations were done with the Director of Nurses with all nurses with for review of return of competencies. 4. The Director of Nurses, Assistant Director of Nurses, Unit Manager and	

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F 684	Continued From page 4 The Licensed Nursing Home Administrator (LNHA) was notified of the IJ on 03/24/2021 at 4:30 PM. The lack of monitoring of Resident #101 who left the facility three times a week ([redacted]) for treatment at a [redacted] clinic and the repeated nature of Resident # 101's sudden change in condition upon return from the [redacted] clinic and other follow up medical appointments constituted Immediate Jeopardy due to the potential for injury or death to the resident. The Team Coordinator provided the Administrator and the Director of Nursing (DON) the IJ Template and informed the LNHA that an acceptable Removal Plan must be submitted to the Department of Health on 03/25/2021 by 10:00 AM. On 03/26/2020 the facility submitted a Removal Plan by e-mail. The Removal Plan was reviewed and accepted by the New Jersey Department of Health (NJDOH) on 3/26/21. The survey team conducted an onsite visit on 03/29/2020 for the verification of the removal plan. The survey team could not verify the facility's removal plan for the following reasons: The facility was unable to provide the following information that had been included in their Removal Plan: 1. Policy and procedure for methadone receipt from a clinic that prohibits the facility to acquire the drug and receipt, storage, and administration of methadone. 2. A copy of the Root Cause Analysis (RCA) that was completed 3. Policy regarding resident's escort to and from the [redacted] clinic	F 684	Nursing Supervisor will monitor all residents receiving [redacted] for any change in mental and/or physical changes for 24 hours after returning from the [redacted] Clinic. All findings will be reviewed at the Quality Assurance Meeting x 2 quarters.	

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F 684	Continued From page 5 4. Documented evidence that the administrator spoke with the methadone clinic on 3/26/21 and scheduled a weekly conference with the case management of the clinic to discuss the compliance of the resident 5. A contract from the administrator and the transport service regarding transport and monitoring to the clinic. On 3/29/21 at 10:37 AM the the surveyors interviewed a staff member who identified herself as being part of the Quality Assurance (QA) team. She told the surveyors that she was not involved in the development of the Root Cause Analysis. This was done by the Department Heads and Regional Corporate person and she would get a copy when it was completed, she continued that otherwise she was not involved. At 10:46 AM the surveyor interviewed the Receptionist who stated she did not receive any inservice during the survey relating to Resident #101's transportation to and from the [redacted] clinic. She did receive some training relating to transport about a month and a half ago. Surveyors interviewed 5 Certified Nursing Assistants (CNAs) and only one CNA had received an in-service education regarding the [redacted] monitoring of Resident #101. The facility administrator was unavailable, either in person or by phone. On 4/6/21 the surveyors made a second onsite visit to determine if the removal plan for F684 had been implemented. Based on interview with	F 684		

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administrative staff and review of records, On 4/6/21 AT 10:51 AM the survey team determined the Removal Plan had been implemented by the facility. The IJ was removed.

The facility currently has no residents on Methadone treatment.

The deficient practice is evidenced by the following:

The surveyor reviewed the clinical record of Resident #101 on 03/19/2021 at 01:57 PM. The admission Face Sheet revealed that Resident #101 was admitted to the facility on [redacted] There was a readmission on [redacted] with diagnoses that included [redacted].

Physician's orders dated [redacted] (a Readmission) contained an order for [redacted] mg[redacted] ml by mouth daily for a diagnosis of [redacted] is a [redacted] and has strict regulations for the ordering, dispensing, and accountability of the [redacted]. It is the facility's responsibility to appropriately receive, store, dispense and account for this medication.

The facility was unable to provide a Policy and Procedure for the receipt, transportation from the [redacted] clinic, storage, dispensing and accountability of the [redacted] It was not noted on the Medication Administration Records reviewed until [redacted]

The Annual Minimum Data Set (MDS)

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assessment tool dated [redacted] and the Quarterly MDS dated [redacted] revealed that Resident #101 was [redacted]. Resident #101 scored [redacted] on the Brief Interview for Mental Status (BIMS), indicating [redacted]

Further review of the clinical record on 03/19/2021 revealed a form titled: "New Jersey Universal Transfer Form" (NJUTF). This form is used to document pertinent medical information about a resident for the receiving health care facility when a resident is sent out for an acute care treatment or when returning from treatment.

The surveyor noted the following NJUTFs for Resident #101:

Feb. 12, 2020 PM (no specific time) the NJUTF from the acute care hospital (MC #1 to the facility noted the reason for transfer as [redacted]. Allergies listed were [redacted].

NJUTF dated [redacted] and timed 12:50 PM from the facility to MC #1. This form noted Resident #101 was sent to MC #1 for "[redacted]. The form listed the resident was allergic only to [redacted]

NJUTF dated [redacted] timed 2:45 PM from the facility to MC #1 noted that Resident #101 was found on the floor and was difficult to rouse. The form failed to include the information that the resident had returned earlier that day from the methadone clinic. The Interdisciplinary Progress Notes concerning this incident documented that

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the resident returned from the [redacted] clinic at 10:45 AM. At 12:45 PM the resident had been found [redacted] in the bathroom with water running and flooding his/her room. At 2:00 PM the resident was found collapsed on the floor by his/her wheelchair and was described as difficult to rouse with several attempts and had been incontinent. The facility called 911 and when the ambulance arrived at 2:15 PM the resident refused to go to the hospital.

That same day at 10:00 PM after returning from the outside smoking area the resident requested to go to the hospital for a [redacted] MD was called and ordered transport to MC #1 which the resident refused, insisting on going to MC #2. The resident packed belongings and went to his/her friend's room and then to outside smoking area. The transport company arrived, refused to take him/her to MC #2. Resident insisted Emergency 911 be called because they would take him/her to their choice of MC #2. Resident left the facility at 12:30 AM on [redacted] via the 911 Emergency ambulance service.

There is no NJUTF from MC #2 to Amboy Care. According to the IDCP notes, the resident returned on [redacted] at 5:30 PM and told the staff he/she had [redacted]. The transport service employee said she did not have [redacted] paperwork from sending hospital did not note [redacted], and a rapid test at the facility was negative for [redacted]. The resident then proceeded to the outdoor smoking area.

On 03/22/2021 at 9:30 AM, the surveyor requested the investigative reports and any hospital records for the above dates but the

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facility did not provide any of this information. The surveyor also requested the police reports from the two dates the police were called for Resident #10. The facility could not provide these reports.

On 03/22/2021 the surveyor requested a copy of the Interdisciplinary Progress Notes concerning the above incidents from the DON and the Regional Licensed Practical Nurse (R-LPN).

The IDCP note dated [redacted] at 10:30 AM, indicated that Resident #101 was picked up by the ambulance for a post-operative appointment. The note reflected that Resident #101 returned to the facility and was wheeled to the nursing unit by his/her roommate at 2:30 PM and that the resident appeared [redacted] speech. A nurse followed the resident into their room, the resident verbalized that he/she was tired and wanted to go to sleep and did not want to eat. The nurse documented that they would continue to monitor the resident every [redacted] and that they notified the physician who ordered a [redacted] and [redacted]. It was documented the [redacted] specimen was collected on [redacted]

On 03/23/2021 at 11:55 AM, the LNHA provided the surveyor a copy of the [redacted] lab result. The lab result showed that Resident #101 tested positive for [redacted]. The [redacted] were part of a prescribed medication, the [redacted] was not.

Review of an IDCP note dated [redacted] revealed that the physician was made aware of the laboratory result on [redacted] and that no

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new order was received. The note also indicated that the physician asked the nurse to inform the DON of the [redacted] positive lab result.

An attached note dated 1[redacted] (the date of collection of the specimen) and signed by the LNHA, acknowledged that LNHA was aware of the [redacted] specimen positivity for [redacted]

On 03/23/2021 at 3:35 PM, the DON provided the surveyor with the investigation of the [redacted] incident. The investigation revealed that the facility team met with Resident #101 to discuss the positive [redacted] lab result. The investigation indicated that the police were called to the facility to speak with Resident #101. The facility further documented on the investigation that Resident #101 would be escorted to the [redacted] clinic by staff to monitor the resident. The plan was written up and presented to the resident to sign but Resident #101 refused.

The IDCP note dated [redacted] and timed 4:00 PM, indicated that Resident #101's room had a strong odor of [redacted], and that the LNHA and Director of Nursing were notified. The IDCP note indicated that the facility installed a [redacted] in the resident's room that same day at 4:30 PM. The facility was unable to provide the surveyors with an investigation into why the resident's room smelled of [redacted] Smoking is prohibited in the facility. The resident is familiar with the facility smoking area as evidenced by numerous IDCP notes reflecting the resident is out in smoking area.

The IDCP note dated [redacted] and timed 6:00 PM, reflected that Resident #101 was observed in

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their room seated in the wheelchair, slumped over onto the bed, and was difficult to rouse. There was no further information provided by the facility regarding this [redacted], and no evidence of an assessment into the reason for the [redacted]. The resident stated [redacted]

The IDCP note dated [redacted] and timed 12:30 PM documented that staff looked through the window and observed Resident #101 in the courtyard slumped over in the wheelchair. The IDCP noted that the night shift reported the resident had left for the clinic. The return time was not noted. Resident #101 had returned from the [redacted] clinic but did not report to the nursing unit until 11:30 AM. An IDCP note timed 12:15 PM indicated that the resident still appeared [redacted] over when staff observed the resident in the doorway to his/her room after returning to the nursing unit. The staff notified the MD and DON. The MD ordered the administration of [redacted] 1 dose and to send Resident #101 to the Emergency Department for evaluation. The Resident refused to go to the hospital and refused to take [redacted]. The facility could not produce an investigation of the incident in order to determine the cause of the [redacted]. There was no communication with the [redacted] clinic concerning dosage given at the clinic and the [redacted] sent back to the facility with the resident.

That same day at 8:45 PM nursing staff documented that a resident reported Resident #101 asked for his/here [redacted]

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combination medication. The resident refused to give Resident #101 any [redacted]

A [redacted] note at 11:00 PM reported resident was off the floor outside most of the shift and [redacted] ."

An IDCP note dated [redacted] indicated that Resident #101 left for the [redacted] clinic at 9:45 AM with one transport escort. The staff were unable to determine the resident's return time. A 12:00 PM IDCP note documented that at 11:45 AM, they saw the resident outside with other residents.

A 12/4/20 IDCP note timed 12:15 PM noted the resident was in his/her room slumped in wheelchair, [redacted] speech/ The physician was in the facility, was notified and ordered a [redacted] and it was noted the resident was compliant with the order. At 1:30 PM the resident was observed by staff to be still asleep in the wheelchair. At 2:30 PM the resident was found in a [redacted] condition kneeling on the floor with a reddened [redacted] Resident denied pain except for the post surgical [redacted]. The DON and Supervisor were notified and ordered transport to MC #1 for evaluation. At 4:00 PM the transport service arrived and the resident refused hospitalization. The facility called the police who did arrive and interview the resident . The police told the facility that they cannot force her to go to hospital. There was no documentation of [redacted] being ordered, there was no documentation of the [redacted] clinic being contacted about the resident's condition. There was no information provided regarding who accompanied the resident to and from the [redacted] clinic, what time the resident

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returned, how the [redacted] for the next days' doses was transported to the facility and how that [redacted] is held once in the facility.

A Licensed Practical Nurse (LPN # 5) documented in an IDCP Note dated [redacted] 4:45 PM, that " [redacted] obtained and lab collected."

A report from the laboratory dated [redacted] provided to the surveyors on [redacted] at 2:45 PM, revealed that the request for [redacted] [redacted] test was not performed because no specimen was received and that the test should be rescheduled. There was no evidence that the test was completed as ordered. There was no documentation that the MD was made aware.

An IDCP note dated [redacted] timed 9:00 AM, indicated that the resident returned from the [redacted] clinic. The [redacted] bottle was checked by staff who noted the seal had been opened and there was a '[redacted] When staff questioned the resident about the open [redacted] bottle seal the resident stated, "That is what I received."

There was no evidence the facility contacted the [redacted] clinic to confirm the dosage give to the resident and the condition of the bottle and seal.

At 9:45 the staff documented in an IDCP note that Resident #101 was observed in his/her room, was [redacted] and had dropped [redacted] cell phone to the floor. When staff approached the resident he/she told them to leave him/her alone. At 10:45 AM the resident went outside, and at 11:10 AM was asleep in front of the nurses station.

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F 684	Continued From page 14 IDCP note from [redacted] timed 8:38 AM documented '[redacted] given" "resident has the key to the box." At this same time staff documented there was some drainage from the [redacted] site, resident advised to [redacted] but refused. On 12/6/21 at 6:00 PM staff documented that the resident was [redacted] seated in wheelchair with head slumped over onto bed sleeping. Was rousable. An IDCP note date [redacted] time 7 AM to 3 PM noted "resident looks sleepy, took all meds, but was sleeping when taking meds, only woke when name called, [redacted] mouth while sleeping in wheelchair and leaning over bed" On 12/8/20 the IDCP note documented the resident went out to the [redacted] clinic at 9:00 AM and returned at 10:45 AM stating [redacted] At 12:45 AM the resident was found seated in wheelchair by bathroom sink with the water running and flooding the entire room. Resident stated [redacted] At 2:00 PM staff documented resident found on floor by wheelchair, difficult to rouse and incontinent. No injuries noted, Emergency 911 called, DON and Supervisor notified. When Emergency ambulance arrived the resident once again refused to go to hospital. Review of an investigation dated 12/08/20, revealed that a Certified Nursing Assistant (CNA) found Resident #101 on the bedroom floor. LPN #2 documented that she assessed Resident #101 and noted the resident's [redacted] with redness. Resident #101 reported feeling tired and was	F 684		

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transferred from the floor to the wheelchair and assessed further by nursing staff, who found no other apparent injury. Staff called 911 to transfer the resident to the emergency room for further assessed since the fall was unwitnessed, but the resident refused to go.

On this same day at 10:00 PM after smoking outside with close friend, the resident came to the nurse and stated he/she wanted to go to hospital, after calling the MD the transport service arrived. While awaiting transport service resident returned with friend to smoking area. The resident refused transport service and demanded Emergency 911 be called because they would take him/her where he/she wanted to go, MC #2. Resident returned to facility on [redacted] at 5:30 PM.

IDCP note dated [redacted] timed 2:00 PM notes resident seen putting pills in pocket, resident did comply with showing meds to nurse. Nurse was shown 1[redacted] tablet,[redacted] mg. The medication taken from the resident. The LNHA, physician and DON were notified. The Physician ordered all meds to be crushed going forward.

[redacted] is used to treat [redacted], it is included in the class of drugs known as [redacted] Among other disorders is used to treat [redacted]. It can cause [redacted] when taken with [redacted] medicines. [redacted] can cause [redacted] or [redacted] and can [redacted] and [redacted]

On 03/22/2020 at 11:28 AM, the surveyor interviewed Resident #101 regarding holding onto

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the [redacted] pills. Resident #101 informed the surveyor that sometimes he/she would save the physician prescribed [redacted] and used the [redacted] dose with half of his/her [redacted] n) dose and would take them together at night to get a good night sleep. The surveyor informed the Registered Nurse (RN #1) of the above statement. RN#1 did not indicate that she was aware that Resident #101 was accumulating or saving the medication instead of taking it.

An IDCP Note dated [redacted] at 2:00 PM, indicated that RN #1 observed Resident #101 putting a [redacted] dose in the coat pocket. RN #1 asked Resident #101 to search the coat. Resident #101 removed the [redacted] tablet and gave it to RN #1.

On 03/23/2020, the surveyor interviewed RN #1 who wrote the [redacted] IDCP note. RN#1 confirmed the [redacted] event. RN #1 stated that she informed the MD who is also the Medical Director and that MD suggested that the [redacted] be crushed to promote resident's compliance.

Review of medical record showed that the facility did not follow through with the MD's order of crushing the [redacted] Review of the Medication Administration Record (MAR) showed that the Klonopin dose had not been crushed to promote compliance. RN #1 documented that the LNHA and the DON were made aware that Resident #101 saved his/her medication without taking it as prescribed. The facility was unable to provide any investigation into this behavior.

When interviewed on 3/23/21 at 4:00 PM, the LNHA stated that he could not recall if he was

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F 684	Continued From page 17 made aware of the above incident. An interview with RN #1 on 03/23/2021 at 11:40 AM, revealed that Resident #101 would bring the [redacted] box and it's key to the facility and would give the key to the nurse. After the incident the nurse kept the [redacted] box on the medication cart, and the resident had the key. There was no Policy and Procedure or consistent process regarding the management and storage of [redacted] being brought by the resident from the [redacted] clinic. During interview with the facility administration on 3/23/21 at 4:00 PM, the LNHA denied that Resident #101 currently brought [redacted] to the facility and stated that was in the past. The LNHA did not provide a policy and did not seem to be aware that Resident #101 brought [redacted] to the facility. At the first revisit on 3/29/21 at 10:46 AM the surveyor interviewed the Receptionist about Resident #101 and the [redacted] Clinic. The Receptionist told the survey that she accompanied the resident to the [redacted] Clinic in [redacted] She would wait in the transport van unless she had permission from the resident to enter the building. She never entered the building, the resident entered alone. After being seen the resident walked directly from the clinic to the van. She stated in the past this had been a problem and that is why she was assigned to accompany the resident. The resident would return to the van with the box. The receptionist did no know if the box was locked. At the facility	F 684		

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the resident would give the box to the Lead Receptionist. The Receptionist told the surveyor that sometimes Resident #101 was drowsy and sometimes normal.

Review of the plan of care dated [redacted] included focus areas for drug abuse and potential for complications such as recurrence of [redacted] disturbance. Interventions included to discuss issues which may lead to [redacted]. Explore alternative methods of coping. Notify MD when observed to be [redacted]. Send Resident to hospital. Obtain consent of resident for personal items to be reviewed. Obtain [redacted] specimen to test for [redacted] Educate on risk of [redacted] and to inform the resident that continued [redacted] may result in 30 days discharge notice.

The resident had episodes of sudden change in condition on [redacted] and [redacted]. The surveyor noted that these days corresponded to the days the resident went to [redacted] clinic for treatment. There was no evidence that the facility contacted the [redacted] clinic to inform them of the resident's condition upon return from the clinic, implemented the plan of care or put a system in place to address the risk factors in order to protect Resident #101 and other residents.

An observation of Resident #101 was made during the initial tour of the facility on 03/15/21 11:25 AM, as the resident was seated in the wheelchair in their room. The surveyor interviewed Resident #101 and noted that the

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resident was [redacted], answered all questions appropriately. Resident #101 expressed concerns over his/her [redacted] and stated that the [redacted] was not being addressed by the facility.

On 03/16/21 12:27 PM, the surveyor went to see the resident, but staff informed the surveyor that the resident was not in the facility because he/she went to the [redacted] clinic.

On 03/17/21 at 10:03 AM, the surveyor was informed that the resident was admitted to the hospital.

On 03/19/21 at 10:56 AM, the surveyor observed the resident in the room eating breakfast, awake and alert and reported no [redacted].

On 03/22/2020 at 11:28 AM, the surveyor interviewed Resident #101 regarding the change in condition that occurred on [redacted] Resident #101 stated that he/she could not recall the event.

On 03/23/2021, the surveyor interviewed LPN #8 who completed the NJUTF dated [redacted]. LPN #8 informed the survey team that the DON assessed Resident #101 on [redacted] and notified the MD and that it was the MD who dictated the [redacted] information that the DON entered on the NJUTF.

On 03/23/2021 at 11:20 AM, the surveyor interviewed LPN #2 who wrote the IDCP Notes dated [redacted] and [redacted]. LPN #2 stated that she noted that Resident #101 was [redacted] and that she obtained

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the resident's vital signs which included: Blood Pressure [redacted] Heart Rate [redacted] Oxygen saturation [redacted] LPN #2 further stated that she notified the Physician and the DON and that when the ambulance arrived, the resident's B/P was [redacted] Heart rate [redacted], oxygen saturation was [redacted]. LPN #2 commented that Resident #101 had a history of [redacted].

03/24/2021 at 2:02 PM, the surveyor interviewed the DON who confirmed that Resident #101 had a change in condition on [redacted]. The DON informed the surveyor that she assessed Resident #101 and that Resident #101 was [redacted], with [redacted] and [redacted]. The DON stated that Resident #101 had a history of [redacted] and that the MD had ordered [redacted] which Resident #101 refused. The DON did not provide further information as to how they ensured that the resident did not experience repeated episodes of negative health symptoms on the days he/she went to the [redacted] clinic.

On 03/24/2021 at 10:30 AM, the surveyor conducted an interview with the Attending Physician for Resident #101 who was also the Medical Director (MD.) The MD indicated that he was familiar with Resident #101 and was aware of the change in condition that occurred on [redacted] and other subsequent episodes. The MD stated that Resident #101 [redacted] at the facility from overdose and that [redacted] was administered. He added that investigations were completed, and that the police was called. When asked about the evidence of investigation, the MD told the team that he does not have time to document and that Resident #101 was non-compliant. The MD did not provide any

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information regarding how the facility addressed the problem to prevent it from continuing to happen.

The surveyor asked for the police reports but the facility was unable to produce them.

On 03/24/2021, the surveyor reviewed the Physician's Progress Notes which did not reflect the incident of [redacted] nor the other incidents.

On 03/24/2021 at 11:30 AM, the surveyor asked the DON for the investigations and the Hospital record for Resident #101 for the episodes of change in condition on [redacted] and [redacted]. The surveyor noted that investigations were completed for the following dates: [redacted] and [redacted] There was no evidence that the facility implemented interventions to address the root causes of these incidents.

On 3/24/21 at 4:41 PM two surveyor interviewed the LNHA and the DON. The DON stated that at some point the facility asked the [redacted] Clinic if a staff member could go to the clinic and pick up the resident's prescribed dose. The DON told the surveyors the clinic said only the resident could pick up the [redacted]. The DON also stated that the resident would bring the [redacted] back to the facility and the nurses would put it in the narcotic box. The DON also said that at times the dosage appeared to be off and the facility was not sure if the resident took any of it before handing the [redacted] over to the nurse. The DON stated there was documentation in her office that a staff member had called the clinic to check on the resident.

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F 684	Continued From page 22 The surveyors asked for this but it was not provided. The Management Team Note dated [redacted] included the following: On [redacted], the resident was seen by the management staff and presented with a copy of [redacted] screen that was positive for [redacted] The resident denied any use of [redacted]. The Management Team asked the resident for permission to check his/her belongings for [redacted]. The police were notified and came to the facility to speak with the management team as well as the resident. The resident was informed that an [redacted] from the transport company would follow him/her to the [redacted] clinic and would stay with the resident until the resident was brought back to the facility. The Team Note also reflected that the resident was educated on the interactions of [redacted] and medications, and informed that items brought to the facility from others will be reviewed by management and that continued [redacted] may result in a 30-day notice of discharge but the resident refused to sign this plan. The facility did not provide any information as to what they did after Resident #101 refused to follow the above plan, and continued to experience episodes of [redacted] after returning from [redacted] clinic. There was no evidence that the facility had contact with the clinic concerning the resident's frequent medical issues after returning from the clinic or how the [redacted] should be handled.	F 684		

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F 684	Continued From page 23 After the [redacted] incident the facility had the nurse store the box in the medication cart and the resident will keep the key. LNHA stated on 3/23/21 at 4:00 PM that he reached out to the transportation provider and arranged for the company escort to stay with Resident #101 at all times. The administrator was asked to provide the accountability log from the transport provider to show that the monitoring arrangement was being followed by the escort but the LNHA did not provide evidence of how the facility accounted for the escort monitoring of Resident #101. An interview with the unit staff revealed that nursing staff could not account for when Resident #101 left and returned to the facility from the [redacted] clinic. There was no follow up done and no laboratory tests completed when Resident #101 exhibited sudden change in conditions on [redacted] The facility did not conduct root cause analysis in regard to Resident #101's pattern of sudden change in condition upon return from the [redacted] clinic and other medical appointments. Review of an undated policy titled: "Suspected and [redacted] Use Policy" indicated the following: "In an effort to provide a continuous safe environment for all residents and staff, if resident is suspected to be under the influence [redacted] or	F 684		

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F 684	Continued From page 24 [redacted] the following is to occur, The resident will be assessed by the assigned nurse or supervisor (vital signs, physical assessment, etc) The assigned physician's will be called to hold all narcotics for 24 hours period. With the consent of the resident, personal items will be reviewed to confiscate additional paraphernalia. Resident will be placed on [redacted] monitoring and if deemed necessary may be placed on a one to one continuous monitoring. With the consent of the resident, a [redacted] will be obtained to test/ verify the use of suspected [redacted] be held with the resident to discuss the incident and the following: 1. Educate the resident on drugs interaction with medications and the use of [redacted]. 2. Educate on the ill effects of [redacted] use. 3. Inform resident that all visitations will take place in monitored location. 4. Items brought into the facility will be reviewed by administration. 5. Continued use of [redacted] may result in a 30-day discharge notification." Another undated policy titled, "[redacted] Policy," was attached to the "[redacted] and [redacted] Policy. This undated policy contained the following information: "[redacted] onset, 911 must be called if [redacted] is used, Notify MD. [redacted] can be administered."	F 684		

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F 684	Continued From page 25 The LNHA provided an email note to the team dated [redacted], where he indicated that he had made arrangement with a transportation company to transport, monitor and wait on site for Resident #101. The LNHA did not provide any contract that he made with the transport company and no system to track that the transportation escort provided the service of watching the resident. On 03/24/2021 at 1:40 PM, the surveyor interviewed Resident #101 regarding transport company arrangement. Resident #101 informed the surveyor that the [redacted] clinic was located [redacted] minutes away from the facility and that each visit lasted between 10 to 15 minutes. The resident stated that the transport [redacted] stayed outside the clinic because the visit did not last long. Resident #101 also stated that for other medical appointments, the transport escort provider did not stay, and that the transport would come back to pick him/her up when he/she finished. The surveyor reviewed an attached document to the facility policy which reflected [redacted] monitoring interval sheets with the dates of [redacted]. On [redacted] at 3:00 PM and [redacted] the facility implemented hourly monitoring. There was no monitoring sheets completed for [redacted], [redacted]. The facility could not provide an explanation for why the every [redacted] monitoring was not completed for the above dates. NJAC:39-27.1	F 684		
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AMBOY CARE CENTER	1 LINDBERG AVENUE PERTH AMBOY, NJ 08861

(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 689	Continued From page 26 CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of medical record and other pertinent documents, it was determined that the facility did not have a Policy and Procedure to ensure a safe temperature for serving hot beverages to residents. A resident spilled [redacted] on his/her [redacted] sustaining a [redacted] to both [redacted]. The facility failed to thoroughly investigate and institute in a timely manner staff training and procedures for serving hot beverages in order to mitigate further instances of harm to residents. This deficient practice was identified for Resident #85, 1 of 2 residents reviewed for accidents and hazards and was evidenced by the following. During the initial tour on 03/15/21 at 12:15 PM, the surveyor observed Resident # 85 in bed as the Certified Nursing Assistant (CNA) assisted the resident with lunch. The CNA told the surveyor that Resident #85 had some [redacted] and behavior issues. The surveyor observed the resident ate some ice cream and stated that he/she was not feeling well. On 03/17/21, the surveyor reviewed the medical record which showed that Resident #85 was admitted to the facility with diagnoses that	F 689	F-tag 689 1. Resident #85 [redacted] are healed as of 5/4/21. Resident #85 with a BIMS score of 11 will continue to be reminded during social events to handle hot beverages with caution. The Administrator and Director of Nurses were given individual counseling by the Regional Consultant in regards to the Policy and Procedure for Investigating and Reporting. A RCA (Root Cause Analysis) was started by the Management team to identify the cause of the event and to make corrective actions. The Activity Director as well as the Activity staff were provided individual in-servicing by the Regional Consultant in regards to the acceptable temperature of the coffee in the coffee urn. The [redacted] urn was calibrated to a temperature of 160 degrees. Individual counseling was given to the Dietary staff by the Regional Consultant as to the proper temperatures of hot beverages. 2. All residents have the potential to be affected by this deficient practice when	

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F 689	Continued From page 27 included [redacted]). The most recent Minimum Data Set (MDS), an assessment tool dated [redacted], indicated that the resident had Brief Interview for Mental Status (BIMS) score of [redacted] which meant that the resident had [redacted]. The surveyor reviewed an Interdisciplinary Progress Note (IDCP) dated [redacted] at 10:00 AM, which documented that a nurse responded to Resident #85 who was screaming in the hallway and found the resident "[redacted] Resident #85 informed the nurse that he/she spilled [redacted] onto his/herself. The IDCP note documented that the spill was from [redacted] that was poured for the resident by a Recreational Aide (RA) during the coffee social activity program. Further review of the nurse's note showed that the resident sustained [redacted] areas. The nurse's note further indicated that staff notified the physician and obtained a treatment order for the [redacted] area. Review of a document titled: "Comprehensive Healthcare Management" dated [redacted] documented that staff heard the resident screaming in hallway around 10:00 AM, after spilling [redacted] onto him/herself. A Licensed Practical Nurse (LPN #5) documented that the resident was [redacted] and staff noted [redacted] on the resident's [redacted]. Upon further review of the "Comprehensive Healthcare Management", the surveyor noted that there were two statements: one from the resident's nurse (LPN #5) and another one from a Certified Nursing Assistant (CNA #10). CNA #10 stated that she responded to a call to change	F 689	residents receive hot beverages. 3. An in-service was done by the Administrator and Director of Nurses with all staff members in regards to the policy and procedure of Investigating and Reporting of Incidents and Accidents. A RCA (Root Cause Analysis) was developed by the management team that identified the cause of the event and made corrective actions. The Management team identified that the hot beverage in the [redacted] urn was to be checked prior to coming from the kitchen. All staff involved in the delivery of hot beverages need to be able to identify if the beverage is within the appropriate guidelines as to not cause injury to a resident. 4. The Administrator and Director of Nurses as well as the Food Service Director and the Activity Director will monitor daily x 30 days the temperature logs of the coffee urn prior to serving the coffee to the residents. The Food Service Director will monitor daily the calibration of the [redacted] urn to be at no greater than 160 degrees x 30 days. All findings will be reviewed at the Quality Assurance meeting x 3 quarters.	

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Resident #85's [redacted]. LPN #5 stated that she responded to the resident's "screaming for help."

There was no evidence to show that the facility investigated the root cause of this incident. There were no statements from the recreational aides who were responsible for pouring [redacted] for residents during [redacted] socials. There was no statement from RA #2 who served the [redacted] to Resident #85, no statement from the Food Service Director (FSD) or any kitchen staff who were responsible for brewing the [redacted] and pouring it into the Urn, and who might have provided information about the temperature of the coffee on the day of the incident.

There was also no evidence that the facility put a system in place to monitor/check [redacted] temperature at the kitchen before it was sent to the recreational staff to serve for [redacted] social or on the units when staff were about to serve the coffee.

On 03/17/21 at 01:40 PM, the surveyor interviewed the Activity Director (AD). The AD stated that the recreation department provided [redacted] socials as part of routine activity program every morning at about 09:30 AM. The AD stated that recreational Aides or herself usually obtained the [redacted] Urn from the kitchen, would take it to residents' rooms, and offered it to residents. When questioned about how they checked the [redacted] temperature (temp) prior to offering it to residents, the AD stated that recreational department did not usually check [redacted] temperatures because she believed the kitchen department checked the temperatures before giving it to recreational staff. The AD added that

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since the "[redacted]" incident a few weeks ago, she had suggested to the Food Service Director-(FSD) to prepare the [redacted] an hour prior to pick up to ensure the coffee had time to cool down. The AD added that she had not provided written in-service to recreation department staff but that she verbally informed staff to make sure the [redacted] temperature was taken by kitchen staff before they picked the Urn from the kitchen. When asked about the recommended [redacted] hot liquid temperatures, she stated that did not know the recommended hot liquid [redacted] temperature for nursing home residents.

On 03/17/21 at 2:00 PM, the surveyor interviewed the Recreation Aide (RA #1). The AD told the surveyor that RA #1 was in-charge of the [redacted] social program. RA#1 told the surveyor that she had worked at the facility for [redacted] months. She stated that she usually picked up the coffee Urn from the kitchen and would go from room to room giving out [redacted] to any resident that wanted it on all the three units. When asked about coffee temperature checks, she stated that she believed that the kitchen staff checked the temperature before sending it for [redacted] social. RA#1 stated that she would feel the back of [redacted] cups with her hands before giving it to residents. When questioned about the [redacted] incident with Resident #85, she stated that she was not asked to make a statement and that she was not the person that served [redacted] on the day of the accident. RA#1 also stated that she received in-service about hot coffee one day ago.

At 2:06 PM, the surveyor interviewed the FSD who stated that kitchen staff usually made a pot of [redacted] in the morning for use at the [redacted]

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social. The FSD added that he had started checking [redacted] temp before it was poured into the Urn for [redacted] social since the hot [redacted] accident, and that they did not check [redacted] temperature prior to the incident. The FSD added that the [redacted] temperature in the kitchen was 200 degrees Fahrenheit and that they let the coffee stand for a while before sending it to recreational staff. When asked for [redacted] temperature log since the [redacted] incident, FSD stated that he did not have a log. The surveyor had checked the temperature of the [redacted] earlier that day and found the temperature to be 190 degrees Farenheit.

When asked if he provided in-service to kitchen staff regarding checking the temperature of the coffee to be used at the coffee social, he stated that he had not provided a written in-service to staff but that he informed the cook and kitchen staff verbally to check [redacted] social temperatures. The FSD also stated that they now send the coffee to recreational staff at a temperature of 160 degrees Fahrenheit. He stated that the Licensed Nursing Home Administrator (LNHA) informed him some days after the [redacted] incident, and told him to ensure that [redacted] temp was checked.

On 03/17/21 at 2:45 PM, the surveyor interviewed the Director of Nursing (DON) and the LNHA in the presence of the survey team. The DON stated that she was notified by nursing staff shortly after the [redacted] incident. The DON stated that nursing staff assessed the resident, notified the physician, and obtained an order for treatment [redacted] treatment for the [redacted]. The DON stated that nursing staff investigated the incident and

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that she verbally informed staff to always check the [redacted] temperature before giving to residents. The DON further stated that she verbally informed the FSD, the kitchen and the recreational staff about checking the temperature of coffee being served to the residents. The DON stated that she was not sure that a formal in-service was conducted and that she would check with the Infection Preventionist (IP) to see if she conducted a formal in-service with staff.

The surveyor conducted a follow up interview with the DON on 3/18/21 at 10:00 AM. The DON told the surveyor they did not need to look back 24 hours during the investigation because they knew exactly the time and cause of the resident's burns as verbalized to them by the resident. The DON did not explain why they did not obtain statements from staff members that were directly involved in the incident to determine the root cause of the incident. The DON did not provide any documented evidence of post accident interventions to ensure such accident did not happen again.

On 3/18/21 at 3:45 PM, the Infection Preventionist provided the surveyor with an attendance sheet with the topic: "ensuring proper procedure.. ..when providing hot liquid to residents." The IP stated that she educated staff on 2/24/21. Review of the attendance sheet reflected signatures of some staff members. The surveyor noted that the cook, Dietary Aide #1, whom the FSD identified as part of [redacted] crew, and RA #2, the recreational aide that served the coffee to Resident #82, were not on the list of attendees to the in-service. The IP did not provide an explanation for why the above staff members were not in-serviced after the incident.

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On 3/18/21 at 10:50 PM, the surveyor interviewed the Registered Nurse (RN #1)caring for the resident. RN #1 stated Resident #85 did not have tremors and was usually able to feed him/herself and took own fluid independently.

On 3/18/21 at 01:00 PM, the surveyor interviewed Recreational Aide #2, who served the [redacted] to Resident #85 on 2/24/21. She stated that she did not remember if she served the resident with [redacted] with milk. RA #2 stated that [redacted] was hotter and that most residents took their [redacted] with milk. She also stated that she was not aware of Resident #85's accident until much later when the AD informed her. RA #2 added that she could not remember the date she received an in-service regarding hot coffee/beverage temperature. She also stated that she was not in-serviced on the recommended [redacted] hot beverage for nursing home residents. She told the surveyor she usually felt the [redacted] cup with her hands and checked for steam before serving [redacted] to residents.

On 3/19/21 at 09:45 AM, the surveyor interviewed the Cook who stated that he attended an in-service on [redacted] concerning temperatures of hot liquids and that he became aware of the [redacted] incident on [redacted] when he returned to work. He stated that he had been sending out [redacted] social at the temp of between 180 - 190 degrees Fahrenheit. The Cook stated that he believed the recommended hot liquid temp was 165 degrees Fahrenheit to serve residents in the nursing home.

On 3/19/21 at 09:50 AM, the surveyor interviewed Dietary Aide #1 who stated that she was one of

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the kitchen staff in charge of [redacted]. Dietary Aide #1 also stated that she received in-service on [redacted] but she was not informed of the recommended hot beverage [redacted] temperature for nursing home residents.

On 3/19/21 at 10:05 AM, the surveyor interviewed Certified Nursing Assistant (CNA #4) who stated that she was not involved in [redacted] social and that she was provided in-service about [redacted] temp on [redacted]

On 3/22/21 at 11:45 AM, the LNHA provided the surveyor with two written statements, which were signed by FSD, RA #1 and RA #2. The LNHA stated that the facility obtained the statements after surveyor inquiry and added that they should have conducted a thorough investigation by obtaining statements from all involved staff members.

Review of policy titled: Safety of Hot Liquids dated 2/2/21, indicated that food service will monitor and maintain food temperature that comply with food safety requirements. The policy also stated that they will maintain hot liquid temperature that was no more than 180 degrees Fahrenheit., they would implement interventions to minimize risks of burns., which included maintaining hot liquids serving temperature of not more than 180 degrees Fahrenheit.

During a meeting with the facility administrative team on 3/19/21 at 2:25 PM, the Regional Licensed Practical Nurse (R-LPN) stated that the facility should have obtained statements from dietary, recreational as well as nursing staff in order to find out the root cause of the incident.

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Review of policy on investigation of incidents dated 4/12/2020: indicated that staff would initiate investigations promptly and would gather information regarding the circumstances of the incident, obtain witness statements to the incident and their account of what happened, There was no evidence that the facility obtained statements from all the involved staff members until after surveyor inquiry.

On 03/19/21 at 12:50 PM, the surveyor went to Resident #85's room and noted the resident seated in wheelchair. The resident appeared confused and talked about calling the police and asking for his/her mother and father. The surveyor tried to interview Resident #85, but the resident declined to answer questions.

On 03/19/21 at 12:55 PM, the surveyor interviewed CNA #7 who stated that she used to care for the resident in the past. CNA #7 stated that the resident was not confused prior to his/her [redacted] diagnosis last year. CNA #7 also stated that she was not involved in the [redacted] social.

The surveyor monitored coffee temperature from the Urn and during [redacted] social throughout the survey and the temperature was between 135-160 degrees Fahrenheit.

Facility did not provide any evidence that they checked coffee temperatures in the kitchen prior to sending and no temperature logs were started until the surveyor requested to review the logs.

Review of Resident #85's current care plan did not reflect any interventions to ensure hot liquids

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F 689	Continued From page 35 was served safely to resident. Review of policy titled: "safety and supervision of residents/Amboy Care Center" and dated 2/2/21, reflected that "when accidents are identified, the safety committee shall evaluate and analyze the causes of the hazards and develop strategies to mitigate..." NJAC 8:39-27.1	F 689		
F 880 SS=K	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,	F 880		6/15/21

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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.
The facility will conduct an annual review of its IPCP and update their program, as necessary.

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F 880	Continued From page 37 This REQUIREMENT is not met as evidenced by: Based on observation, interview, medical record review, and review of other facility documentation during a Recertification survey ending on 4/6/21, it was determined that the facility failed to: a.) follow isolation precaution protocols for residents on Transmission-Based Precautions (TBP) on the unit for Persons under observation (PUI) and b.) properly isolate PUI residents from well, non [redacted] exposed residents as a preventative measure to prevent the transmission of [redacted] Residents and Health Care Personnel who have been exposed to Covid-19 have the potential to be Covid-19 positive and show no symptoms, thereby spreading this deadly virus. The facility's failure to isolate Resident #4, #45, #104, and #321 from the well, non-exposed residents posed a serious and immediate threat to the safety and wellbeing of the well, non-exposed residents. This resulted in an Immediate Jeopardy (IJ) situation that began on 3/14/2021, when it was determined that the the facility failed to follow Transmission Based Precautions of 14 -day quarantine for Residents #4, #45, #104 and #321. The facility's Administration was notified of the IJ on 3/22/2021 at 3:15 PM after the surveyors consultation with the New Jersey Department of Health. On 3/23/2021 while the Recertification survey was still in progress the surveyors received an acceptable Removal Plan. On 3/24/21 the immediacy was removed after verification that the Removal Plan was	F 880	F tag-880 1. Resident #4, #45, #104 and #321 were moved to the [redacted] floor and a PUI unit was set up to prevent these resident from exposing other well residents to the [redacted] virus. Individual counseling was given to the Administrator, Director of Nurses and Infection Preventionist by the Regional Consultant as to the Policy and Procedure for PUI (Persons Under Investigation) and TBP (Transmission Based Precautions) and its implementation in regards to residents newly exposed or potentially exposed to [redacted] virus. A RCA (Root Cause Analysis) was started by the management team to identify the cause of the event and to make corrective actions to prevent a reoccurrence of this deficient practice. Policies for Infection Control were reviewed and revised by the Medical Director, Administrator and Director of Nurses. The Administrator, Director of Nurses, and the Regional Director reviewed and revised new policies and procedure in regards to "Resident Leaving Without Physician Approval" and Resident Non-Compliant with regulatory isolation guidelines during COVID-19 pandemic." 2. All residents as well as staff members have the potential to be affected by this deficient practice when the Policy and Procedure for isolating residents with possible or actual exposure to the [redacted] virus is not followed.	

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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 38 implemented. This deficient practice was identified for 4 of 4 residents reviewed for infection control precautions; (Residents #4, #45, #104, and #321) and was evidenced by the following: 1. During the initial tour of the third-floor nursing unit on 3/15/21 at 12:08 PM, the surveyor observed that the third floor was divided into two wings, with a nurse's station in between the two wings. The surveyor noted that the negative, well residents resided on one wing while the opposite wing housed residents under a 14-day observation for potential exposure to [redacted] / Persons Under Investigation (PUI) side. The surveyor observed Resident #4 as he/she walked down the hallway, dressed in a coat and carrying a plastic bag. The resident was not wearing a mask as he/she entered the of room of Resident #104. At 12:30 PM, the surveyor observed Resident #4 exit Resident #104's room, walk down the hall and into his/her own room. The surveyor was not aware of either resident's isolation status at the time of this observation. The surveyor observed a sign on Resident #4's door warning "Stop - please see nurse before entering room." There was also a 3- drawer plastic cart filled with Personal Protective Equipment (PPE) which was outside the room. The surveyor noted that there was no signage on the door of Resident #104's room and no isolation cart with PPE outside the room. On 3/15/21 at 12:32 PM, the surveyor interviewed Resident #4's assigned Certified Nursing Assistant (CNA #1). CNA #1 informed the	F 880	3. The Director of Nurses, Administrator and all management team members were provided with training on CDC/Train conducted by an Infection Preventionist which included Module #1 (to the Management Staff) and Module #6-B to all staff received training in regulatory videos which included CDC [redacted] Prevention messages for front line long term care staff: Keep [redacted] OUT. The Infection Preventionist and Director of Nursing will conduct will conduct rounds throughout the facility daily to ensure infection control procedures are being followed. Staff competency will be observed daily by the Director of Nurses and Infection Preventionist to validate compliance. The management team conducted a RCA (Root Cause Analysis) which discovered a lack of education to the management and frontline staff in regards to Infection Control resulting in this event and deficiency. The Administrator, and Regional Director hired a Consulting Firm APIC Consulting Services (APIC) to fulfill the CIC role. An Infection Plan and LTC self assessment were developed. The nurses were in-serviced on the policy and procedure for residents who are non-compliant with isolation guidelines during [redacted] pandemic and resident leaving without physician approval. 4. The Administrator, Director of Nurses, Assistant Director of Nurses will monitor 3 employees weekly to ensure the proper policy and procedures are being followed	

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F 880	Continued From page 39 surveyor that Resident #4 was supposed to be in isolation but "refuses." CNA #1 stated that Resident #4 wanders everywhere and did not follow rules. CNA #1 stated that Resident #104 was not on isolation. On 3/15/21 at 12:38 PM, the surveyor interviewed the Licensed Practical Nurse (LPN #1) who was caring for Resident #4. LPN #1 told the surveyor Resident #4 was in the hospital on [redacted] and that he/she was on PUI precautions. LPN #1 stated that Resident #4 was supposed to be on quarantine, but that Resident #4 refused to stay in the PUI designated section of the [redacted] floor and was given a private room to quarantine in place. LPN #1 further stated that Resident #4 often left their room and refused to remain in the room. LPN #1 stated that Resident #104 was not on isolation or any precautions. The surveyor observed that Resident #4's private room was located at the end of the well residents' wing of the [redacted] floor. On 3/15/21 at 12:40 PM, the surveyor spoke with Resident #22 who resided on the Well side of the third floor unit. Resident #22 told the surveyor that Resident #4 was supposed to be on quarantine, but usually left their room and walked everywhere in the facility. Resident #22 remarked that Resident #4 walked around the facility "like he/she owns the place." Resident #22 further stated that he/she was concerned for his/her own health because Resident #4 was supposed to be on isolation. Resident #22 stated that he/she had reported these concerns and observations to the Licensed Nursing Home Administrator (LNHA) more than once. Resident #22 did not explain how he/she learned of Resident #4's isolation status.	F 880	for infection prevention x 30 days, this will include return competencies via observation for validation of training, ongoing. All information will be reviewed at the Quality Assurance meeting x 3 quarters.	

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F 880	Continued From page 40 A review of the Quarterly MDS (Minimum Data Set) assessment tool dated [redacted], indicated that Resident #22 had BIMS (Brief Interview for Mental Status) of [redacted], which indicated the resident had fully [redacted]. On 3/15/21 at 12:46 PM, the surveyor interviewed LPN #2 who stated that new and readmission residents were supposed to quarantine as PUI for 14 days. LPN #2 stated that Resident #4 was non-compliant, refused to follow PUI protocols and that the supervisor was aware of the resident's behavior. LPN #2 further stated that Resident #4 was educated numerous times about infection control protocols, but the resident refused to follow the rules and that the facility Administration was aware. On 3/15/21 at 3:00 PM, the surveyor observed Resident #4, wearing a surgical mask standing in the lobby of the facility talking to the receptionist who was seated behind the front desk. On 3/16/21 at 10:33 AM, the surveyor observed Resident #104 was not wearing a mask as he/she exited Resident #4's room. The surveyor interviewed Resident #104 who told the surveyor he/she was visiting with Resident #4. Resident #104 further stated that Resident #4 was not on isolation precautions and added: "that sign on the door means nothing." At that time, Resident # 104 walked down the hall and entered his/her own room. On 3/16/21 at 10:35 AM, the surveyor interviewed Resident #4 who stated that he/she did not have to be quarantined because he/she was only at the hospital for a "few hours." Resident #4 stated	F 880		

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that he/she had lung disease and had breathing problems and so, had to go to the hospital on [redacted] Resident #4 stated that there was no reason to have a sign on his/her door for isolation and added: "I came right back."

On 3/16/21 at 12:20 PM, the surveyor interviewed the facility Infection Preventionist (IP), who stated that residents who were newly admitted and readmitted were supposed to be placed on the PUI unit for a 14- day quarantine. The IP stated that Resident #4 refused to stay on the PUI unit. Because of this refusal he/she was given a private room to quarantine in place. The IP stated that Resident #4 was non-compliant and that the resident was "difficult to manage."

At that time, the surveyor requested a copy of the facility's policy on PUI and TBP.
The IP stated that she would provide the policy.
The surveyors never received the facility's policy on PUI/TBP.

On 03/17/21 at 11:30 AM, another member of the survey team observed Resident #4 wearing a surgical mask as he/she walked out of the smoking area located on the [redacted] floor courtyard and onto the elevator. There was no one else in the elevator at the time. The smoking area is for all residents.

On 03/17/21 at 1:33 PM, a second member of the survey team observed Resident #4 wearing a surgical mask and ambulating in the third floor hallway to their room.
The surveyor walked up to Resident #4's room and observed a bin containing PPE outside the resident's room but did not observe any signage indicating isolation precautions. The surveyor

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donned full PPE which included an N-95 mask with surgical mask over it, face shield, isolation gown and gloves and entered Resident #4's room to interview the resident. Resident #4 claimed he/she was not informed that he/she needed to be on isolation. The resident stated, "[redacted]." Resident #4 further stated, "[redacted]

On 03/18/21 at 11:07 AM, the surveyor interviewed RN #2 regarding the facility's protocol for TBP/PUI. RN#2 stated that residents who were readmissions or new admissions to the facility were placed on quarantine on droplet precautions on the PUI Unit for 14 days. RN#2 further stated that Resident #4 went to the emergency room and was supposed to be on quarantine. RN#2 also stated that they frequently encouraged Resident #4 to wear a surgical mask when out of the room.

On 03/18/21 at 12:16 PM, the surveyor interviewed the Director of Social Services (DSS) who stated that the LNHA was very involved with Resident #4 and the resident's daughter. The DSS told the surveyor no other staff or residents had complained to him directly regarding any concerns with Resident #4.

On 3/19/21 at 10:00 AM, the surveyor interviewed LPN #3 about PUI protocol. LPN #3 stated that all admissions and readmissions must be quarantined for 14 days on the PUI unit. LPN #3 stated that Resident #4 was noncompliant with infection control protocols and walked out of his/her room all the time and needed constant encouragement and reminders to wear a mask

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when going to the smoking area. LPN #3 stated that Resident #4 did not follow any rules of the facility.

On 3/19/21 at 10:05 AM, the surveyor interviewed LPN #4 about the facility's TBP protocol. She stated that admissions and readmissions were to be put on the PUI unit and quarantined for 14 days. LPN #4 stated that Resident #4 refused to go on the PUI unit when he/she returned from the hospital, and was given a private room instead. LPN #4 stated that Resident #4 was non-compliant and did not follow any PUI protocols or rules of the facility. LPN #4 further stated that Resident #4 was frequently encouraged by staff to maintain PUI protocol, but the resident refused to follow infection control protocols and would verbally abuse staff when asked to do so.

On 3/19/21 at 10:15 AM, the surveyor interviewed the IP again. The IP stated that residents who were out of the facility for 4 hours or less on appointments did not have to be quarantined. The IP stated that if a resident was out of facility for more than 4 hours, the resident would have to be on the PUI unit and quarantined for 14 days. At this time, the surveyor requested from the IP again, a copy of the facility policy for PUI/TBP but the IP still did not provide the facility's policy.

On 3/22/21 at 9:57 AM, the surveyor interviewed Resident #82 who resides on the [redacted] floor. Resident #82 stated that Resident #4 was supposed to be on quarantine but walked all over the unit and frequently left their room without wearing a mask. Resident #82 also stated that Resident #104 went in and out of Resident #4's room all day and neither Resident #4 nor

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Resident #104 wore masks. Resident #82 also stated that Resident #4 was usually out of the room without a mask while speaking with nurses in the hall. Resident #82 told the surveyor that nursing staff encouraged Resident #4 to wear mask "only when other residents complained about Resident #4."

Resident #82 further stated that on [redacted], he/she observed Resident #4 coughing and touching the food on the meal cart while standing and looking for his/her tray. Resident #82 added that he/she had to order another meal after seeing Resident #4 touch all the meal trays on the cart. Resident #82 stated that he/she was concerned for their own health because Resident #4 was supposed to be quarantined and not walking around without a mask. Resident #82 stated that he/she had reported these concerns to the LNHA more than once. Resident #82 stated that the LNHA usually stated that he would talk to Resident #4. Resident #82 stated that he/she had observed no changes in Resident #4 behavior related to quarantine and that "it is extremely frustrating."

A review of the Quarterly MDS dated [redacted] showed that Resident #82 had BIMS of [redacted], which indicated Resident #82 had [redacted].

On 03/22/21 at 10:03 AM, the surveyor interviewed Resident #35 another resident residing on the [redacted] floor who stated that he/she had observed Resident #4 walking in the hallways and into Resident # 104's room. Resident #35 further stated that Resident #4 was argumentative and added: "I feel he/she is out of control." A review of Resident #35's medical record revealed that Resident #35 was [redacted]

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F 880	Continued From page 45 [redacted] On 3/22/21 at 10:14 AM, the surveyor interviewed Resident #22 who also resided on the [redacted] floor. Resident #22 stated that he/she saw Resident #4 last [redacted] rummaging through the lunch truck and coughing. Resident #22 further stated that he/she ordered another tray because he/she was scared for their health. A review of the Quarterly MDS dated [redacted], indicated that Resident #22 had a BIMS of [redacted] which indicated [redacted] Review of medical record and Quarterly MDS dated [redacted], showed that Resident #4 had BIMS of [redacted], which indicated [redacted]. The MDS also indicated that Resident #4 had diagnosis that included [redacted] Review of Resident #4's care plan indicated that the facility would evaluate and treat, order psychiatric consultation. There was no care plan intervention regarding the resident's non-compliance with infection control/PUI protocol. Further review of the medical record showed that Resident #4 had [redacted] test was on [redacted] and [redacted], [redacted] which were negative for [redacted]. On 3/22/21 at 11:51 AM, during an interview with the administrative team, the LNHA and the Regional MDS Coordinator (MDS) both stated that Resident #4 and his/her [redacted] were given verbal notification regarding Resident #4's pending discharge to another facility due to Resident #4's continued non-compliance with the facility's policies.	F 880		

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The LNHA and MDS also indicated that both Resident #4 and his/her [redacted] would be issued the discharge notification in writing today being [redacted] and that Resident #4 had agreed to be discharged to another facility.

There was no intervention in place to protect other residents in the facility given Resident #4's noncompliance with infection control protocols.

2. On 3/23/21 at 9:34 AM., the surveyor observed a resident (Resident #321), in the elevator with another resident. Resident #321 informed the surveyor that he/she was newly admitted to the facility on [redacted] from the hospital. The surveyor noted that both residents wore surgical masks. The surveyor observed the other resident got off on the [redacted] floor. Resident #321 rode in the elevator with the surveyor and got off the elevator on the [redacted] floor. The surveyor observed Resident #321 walk past the nurses' station and onto the PUI area, then went into his/her room on the PUI wing of the unit.

Review of Resident #321's medical records revealed that Resident #321 was newly admitted to the facility on [redacted]. There was no MDS completed at this time.

On 3/23/21 at 9:40 AM, during interview, LPN #3 stated that residents on PUI could leave the PUI unit to go to the smoking area independently but needed to wear an N95 mask. Staff did not provide information on who or how oversight was provided for residents on PUI unit who went outside to smoke.

3. On 3/23/21 at 9:50 AM, the surveyor observed

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that Resident #104 had a sign on his/her room door warning, "Stop see nurse before entering." There was a cart filled with PPE outside the resident's room but there was no description of the type of precautions to be followed for Resident #104.

Further investigation on 3/23/21 at 9:52 AM, revealed that Resident #104 was on PUI precautions. LPN #3 stated that Resident #104 went to the emergency room on 3/20/21 at 10:30 AM, and returned to the facility the same day [redacted] at 7:30 PM. LPN #3 also stated that Resident #104 refused to stay on the PUI wing of the unit and therefore was given a private room.

On 3/23/21 at 9:55 AM, the surveyor interviewed CNA #1 who stated that Resident #104 was on PUI/TBP precautions.

On 3/23/21 at 10:10 AM, the surveyor interviewed Resident #104 who stated that he/she went to the hospital on [redacted] and returned to the facility on the same day. Resident #104 stated that he/she was on quarantine upon return and was asked to wear an N95 mask when leaving his/her room. When asked about the meaning of Quarantine, Resident #104 stated that Quarantine meant staying 6 feet away from other people. The resident then added: "No one here explained anything to me." Resident #104 stated that when he/she returned to the facility, he/she had a rapid [redacted] test done and that it was negative.

On 3/23/21 at 10:20 AM, the surveyor observed Resident #104 walk out of his/her room without a mask to the nurses' desk and asked for a towel. At that time, the LPN at the nurses' desk escorted

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F 880	Continued From page 48 Resident #104 to his/her room. A review of the Admission Assessment dated [redacted], showed that Resident #104 had a BIMS of [redacted] which indicated [redacted] A review of Resident #104's medical records indicated the resident had diagnoses that included [redacted]. Further review of the medical record showed that Resident #104 had a physician's order dated [redacted] for Transmission Based Precautions (TBP) for 14 days for [redacted] precautions. There was no documented evidence that the facility informed Resident #104's physician regarding the resident's noncompliance with TBP/PUI precautions. On 3/23/21 at 10:46 AM, the surveyor requested from the IP, a copy of the facility's PUI/Quarantine policy, and smoking policy for PUI/Quarantine residents. On 3/23/21 at 10:53 AM, the LNHA provided a one - paragraph untitled statement dated "May 11, 2021," which indicated: "It is the Policy of Amoy Care Center that when a resident is seen outside the facility for a medical appointment or has been seen at the emergency room for less than twenty-four (24) hours, upon return the resident will receive a rapid [redacted] test and a repeat of this test in 72 hours. This written statement from the LNHA was different from the information provided to the survey team by the IP. The LNHA provided another one paragraph statement titled: "Out on Pass Policy during	F 880		

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Covid-19 Pandemic/Amoy Care Center," and dated 9/1/2020 with review date of 1/24/21. The document reflected the following: It is the policy of Amoy Care Center that residents may go out on Pass but upon return each resident will be placed on Transmission based precautions/PUI for a duration of no less than 14 days. The documented also indicated that upon return each resident would be administered a rapid Covid-19 test and that residents were educated on risks of exposure to Covid-19 virus including risk of exposure to other residents and staff members.

There was no evidence that this statement was communicated to the facility staff and that the facility implemented the instructions on the document.

On 3/23/21 at 10:58 AM, during an interview with the LNHA, IP and DON, in the presence of the survey team, the LNHA stated that it was his decision regarding whether a resident was placed on the PUI unit upon returning from the hospital or not, and that the facility was following CDC guidelines.

The LNHA further stated that it was their facility's policy that only residents who were out of the facility for over 24 hours needed to be placed on PUI/TBP upon return. The LNHA did not provide the CDC guidance he followed to make his determination for TBP/PUI quarantine. Also, none of the staff members interviewed was aware of this 24 -hour policy.

The IP stated that the facility encouraged residents to wear an N-95 mask when they left their rooms. The IP further stated that when a resident was on PUI precautions, the residents

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F 880	Continued From page 50 could leave their rooms to go to the designated smoking area and were to wear an N-95 mask. The IP stated that their practice for non-compliant residents was for staff to continue to encourage the residents to cooperate with infection control protocols. The IP did not provide information on how they supervised the noncompliant residents on TBP precautions, to ensure the protection of other residents from potential exposure to [redacted] 4. On 3/23/21 at 01:00 PM, the surveyor reviewed Resident #45's chart. The chart contained an ICP note written by LPN #5 dated [redacted] at 11:00 AM, which reflected that Resident #45 signed a Against Medical Advice (AMA) form to leave the facility and discharged him/herself from the facility. The resident was noted to use a motorized wheelchair. The nurse's note dated [redacted] at 02:35 PM revealed that Resident #45 returned to the facility after being away from the facility for several hours. There was no documentation as to where Resident #45 had gone and no documented evidence that the resident was placed on quarantine after the resident returned to the facility. Review of the Annual Comprehensive MDS dated 10/15/20, Resident #45 was [redacted] and independent for mobility at a wheelchair level. On 03/23/21 at 2:55 PM, the surveyor interviewed LPN #5 who confirmed that Resident #45 had left the facility AMA on [redacted] and returned at 2:35 PM on the same day. LPN #5 stated that Resident #45 returned to his/her room which he/she shared with another resident. Resident #45 was not placed on PUI precautions. LPN #5 did not stated how many hours Resident #45 was	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315305	A. BUILDING _____ B. WING _____	04/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMBOY CARE CENTER	1 LINDBERG AVENUE PERTH AMBOY, NJ 08861

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F 880	Continued From page 51 out of the facility or where the resident went. On 03/24/21 at 10:30 AM, the surveyor interviewed Resident #70, (the roommate of Resident #45), who stated that Resident #45 left the facility on AMA and returned to the facility about two hours later and came back into their room. The surveyor asked Resident #70 if he knew about Resident #45 leaving the building. Resident # 70 told the surveyor that Resident #45 went to visit "[redacted]" and went to [redacted] fast food restaurant. Resident #45 brought Resident back a sandwich. A review of Resident #70's medical record revealed that Resident #70 was [redacted]. The surveyor was unable to interview Resident #45 as the resident had expired. On 03/24/21 at 02:12 PM, the surveyor interviewed the IP who stated that the facility's AMA policy was that if a resident left the facility AMA, the resident should not return to the facility. The facility was unable to provide a policy and procedures for residents that left the facility against medical advice (AMA), and there was no process for readmitting residents that left the facility AMA. A review of the facility's Outbreak Plan revised on 08/2020, defined Isolation as a separation of an individual or group who is reasonably suspected to be infected with a communicable disease from those who are not infected to prevent the spread of the disease. Quarantine was defined as a separation of an individual or group reasonably suspected to have	F 880		

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F 880	Continued From page 52	F 880		

been exposed to a communicable disease but who is not yet ill (displaying signs and symptoms) from those who have not been so exposed to prevent the spread of the disease.

According to the facility's Outbreak Plan, the facility will cohort residents as follows:

A. COHORT A- INFECTED RESIDENTS: This cohort consists of both symptomatic and asymptomatic residents who test positive for the infectious virus, including any new or re-admissions known to be positive, who have not met the discontinuation of Transmission-Based Precautions criteria.

B. COHORT B- NEGATIVE, (EXPOSED): This cohort consists of symptomatic and asymptomatic residents who tested negative for the virus with an identified exposure to someone who was positive.

C. COHORT C- NEGATIVE, (NOT EXPOSED): Facility will dedicate a separate unit/wing with residents who test negative for the virus with no symptoms and are thought to have no known exposure.

D. COHORT D- NEW OR RE-ADMISSIONS: This cohort consists of all persons from the community or other healthcare facilities who are newly or readmitted. This cohort serves as an observation area when persons remain for 14 days to be monitored for symptoms that may be compatible with the infectious virus, including Covid-19.

Review of the U.S. Center for Disease Control and prevention (CDC) guidelines, Clinical

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F 880	Continued From page 53	F 880		

Questions about Covid-19: Questions and Answers, updated 1/7/21, reflected to, "Place potentially exposed patients who are currently admitted to the healthcare facility in appropriate Transmission Based Precautions and monitor them for the onset of Covid-19 until 14 days after their last possible exposure."

Review of the facility's Infection Prevention and Control Program updated on 10/2020, indicated that the facility will implement appropriate isolation precautions when necessary; and follow established general and disease-specific guidelines such as those of the Centers for Disease Control (CDC).

There was no evidence that the facility ensured that new/readmission residents were properly isolated and monitored to prevent potential cross-contamination with infectious agents.

A review of the facility's smoking policy dated 10/19/2020 revealed that during the Covid-19 pandemic, all residents that were positive for Covid-19, PUI, or on Transmission based precautions will be seated away from other smokers on the patio to achieve proper social distancing.

The facility had no process in place to separate TBP/PUI residents away from well residents.

N.J.A.C. 8:39-19.4 (a)(b)(c)(d); 27.1 (a)