| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____ | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315180 | | 11/03/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| ALAMEDA CENTER FOR REHABILITATION AND HEALTHCARE | 303 ELM STREET<br>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 |
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| F 000 | INITIAL COMMENTS | F 000 | | |
| | SURVEY: 11/3/2021<br><br>CENSUS: 209<br><br>SAMPLE: 35+3<br><br>A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.<br><br>In addition, a COVID-19 Focused Infection Control Survey was conducted. | | | |
| F 658<br>SS=D | Services Provided Meet Professional Standards<br>CFR(s): 483.21(b)(3)(i)<br><br>§483.21(b)(3) Comprehensive Care Plans<br>The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-<br>(i) Meet professional standards of quality.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and review of medical records, it was determined that the facility failed to properly assess the need for, obtain a physician order and develop a care plan for a [redacted] consistent with professional standards of clinical practice for 1 of 35 residents reviewed, Resident #70.<br><br>This deficient practice was evidenced by the following:<br><br>Reference: New Jersey Statutes, Title 45,Chapter 11,Nursing Board, The Nurse Practice Act for the state of New Jersey states; "The practice of | F 658 | Resident # 70 was immediately re-evaluated. New, [redacted] Risk Assessment was completed and indicated low [redacted] risk. Resident was interviewed about leaving the facility. Resident was educated on 'Out-on-Pass' procedure. [redacted] device was removed.<br>All residents wearing [redacted] have the potential to be affected.<br><br>1. Comprehensive audit was performed for all residents wearing the device. Facility did not identify other individuals | 11/10/21 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 11/25/2021

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

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| F 658 | Continued From page 1<br>nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such counseling, and provision of care supportive to or restorative of life and well being, and executing medical regimes as prescribed by a licensed or otherwise legally authorized physician or dentist:" Reference New Jersey Statutes, Title 45, Chapter 11, Nursing Board, The Nurse Practice Act for the state of New Jersey states; "The practice of nursing as a licensed practical nurse is defined as performing task and responsibilities within the framework of case finding; reinforcing the patient family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the duration of a registered nurse or licensed or otherwise legally authorized physician or dentist."<br><br>According the the facility Admission Record, Resident #70 was admitted to the facility in [redacted] with diagnoses which included but were not limited to; [redacted] to the [redacted]<br><br>A review of the Admission Minimum Data Set (MDS), an assessment tool, dated [redacted], revealed Resident #70 scored a [redacted] on the Brief Interview for Mental Status (BIMS) which indicated the resident had [redacted]. Further review revealed [redacted] was not in use.<br><br>A review of the Physician Orders revealed no order for a [redacted]. | F 658 | with inappropriate use of wander guard.<br>2. Weekly audit which considers below aspects:<br>- BIMS- Dx of [redacted] □s<br>- [redacted] Risk Assessment Score<br>- [redacted] behaviors<br>- Previous [redacted] attempts<br>- [redacted]<br>- Determination of appropriateness<br>- Physician□s order for [redacted]<br>- Care plan<br>- Picture of resident at the front desk<br>3. Re-evaluation of elopement risk on admission/re-admission, every three (3) months and as needed (example: if new [redacted] seeking behaviors occur).<br>4. Re-education of nurses on [redacted] Risk Assessment and appropriate use of [redacted] which includes admissions, readmission and change in behavior.<br>1.DON-continue comprehensive audit on weekly basis x 90 days. All residents with previous and new [redacted] device will be reviewed during the audit to ensure appropriate use, but also physician order and care plan is in place.<br>2. Findings will be presented in QAPI meetings on monthly basis.<br>3. The QAPI Committee will make recommendations based on the results of the audits.<br>4. The QAPI Committee will determine tapering or resolving monitoring tool once consistent compliance at 100% have been achieved. | |

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| F 658 | Continued From page 2<br><br>A review of the resident's care plans revealed no care plan for the use of a [redacted]<br><br>A review of the [redacted] risk dated [redacted] revealed a score of [redacted] that indicated the resident was low risk for [redacted]<br><br>A review of the [redacted] Check" for [redacted] and [redacted] revealed the [redacted] was located on the resident and checked daily.<br><br>On 10/13/21 at 08:58 AM, during tour of the unit, the surveyor observed Resident #70 walking in the hallway with a [redacted] was on his/her [redacted].<br><br>During an interview with the surveyor on 10/15/21 at 02:20 PM, Resident #70 stated the staff placed the [redacted] on him/her when he/she came into the facility in [redacted] Resident #70 stated he/she would not try to leave because he/she was in the process of getting an apartment in the community.<br><br>During an interview with the surveyor, on 10/15/21 at 02:30 PM, the Licensed Practical Nurse (LPN) stated that when residents have wander guards there was usually an order and it would "pop up" on the Electronic Medication Administration Record (EMAR). In the presence of the surveyor, the LPN was unable to find an order or see in on the EMAR. She stated she did not know why the resident did not have an order for the [redacted]<br><br>During an interview with the surveyor, on 10/15/21 at 02:50 PM, the Assistant Director of | F 658 | | |

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| F 658 | Continued From page 3<br>Nursing (ADON) stated there should be a physician order, a care plan and documentation for the [redacted].<br><br>During an interview with the surveyor on 10/15/21 at 03:00 PM, the Certified Nursing Assistant (CNA) stated she monitored and logged the residents with [redacted] daily.<br><br>During an interview with the surveyor on 10/18/21 at 08:30 AM, The Director of Nurses (DON) stated the resident did not have an order or a care plan for the [redacted] and did not know why.<br><br>During an interview with the surveyor on 10/20/21 at 11:15 AM, the [redacted] floor Registered Nurse (RN) stated when completing an admission, the nurse must assess the residents' need for a [redacted]. She stated would assess if the resident was alert and oriented, check the [redacted] risk. If a resident required a [redacted], she would call the doctor to get an order and complete a care plan for the [redacted]. She stated [redacted] were checked every shift, by a nurse, for placement and documented on the Treatment Administration Sheet (TAR).<br><br>During a meeting with the survey team on 10/20/21 at 02:00 PM, administration was informed of the findings. The DON stated there was an elopement assessment for Resident #70, whose score was [redacted]). The DON stated the resident was admitted to the facility with [redacted] status and a [redacted] was placed on the resident. She stated there should have been a physician order, a care plan, and the resident should be assessed quarterly. | F 658 | | |

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| F 658 | Continued From page 4<br><br>A review of the policy labeled '[redacted] Resident" with a revised date of 04/2021, revealed residents who are admitted to the facility will be evaluated for potential risk for [redacted]. The residents who meet the at-risk characteristic will also have an order for [redacted] device and the use of the [redacted] will be documented and care planned. The care plan will include appropriate interventions for potential and actual occurrences of [redacted]. | F 658 | | |
| F 689<br>SS=D | NJAC 8:39-27.1(a)<br>Free of Accident Hazards/Supervision/Devices<br>CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, it was determined that the facility failed to a.) ensure that a resident's environment was as free from hazards as possible by failing to ensure that medical equipment was plugged directly into an electrical receptacle without the use of a power strip or adapter for 1 of 35 residents reviewed, Resident #39 and b.) ensure residents remained free of accident hazards by failing to provide residents with proper hand sanitizing | F 689 | Medical equipment with inclusion of [redacted] and [redacted] device of resident # 39 were reconnected to electrical receptacles/outlets. Resident□s personal devices (example: phone charger, tablet, etc.) were plugged into power strips. Resident did not experience disruption in delivery of [redacted] treatment. All residents using [redacted] and/or [redacted] might be at potential risk for | 11/17/21 |

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| F 689 | Continued From page 5<br>wipes on 1 out of 5 floors, [redacted] floor day room.<br><br>This deficient practice was evidenced by the following:<br><br>1. According to the Admission Record, Resident #39 was admitted to the facility in [redacted] with diagnoses that included but were not limited to: [redacted] .<br><br>Review of Resident #39 Quarterly Minimum Data Set (MDS), an assessment tool dated [redacted], revealed the resident had a Brief Interview for Mental Status (BIMS) of [redacted] which indicated that the resident's [redacted].<br><br>On 10/15/2021 at 09:03 AM, the surveyor observed Resident #39 in bed with a [redacted] (a machine that sends [redacted]) in use.<br><br>On 10/19/2021 at 12:20 PM, the resident was out of his/her room. The surveyor observed the [redacted] and the [redacted] running and plugged into an extension cord that was plugged into overbed light and draped over the headboard.<br><br>During an interview on 10/19/2021 at 12:30 PM, the Licensed Practical Nurse Unit Manager (LPN/UM) stated she moved the plugs "all the time" into the wall. She stated the resident kept using the extension cord that the resident purchased. She began to unplug the [redacted] machine and the [redacted] from the extension cord. | F 689 | deficient practice.<br>1.Surge protector identified in resident #39 was removed immediately, and resident notified of not using medical equipment in a surge protector.<br>- Comprehensive audit was performed to identify potential deficient practice with all residents who use [redacted] and [redacted] devices. No further deficient practice was identified.<br>2. Nursing, Certified Nursing Assitant, and maintenance (MT) staff was re-educated on use power strips along with importance of plugging medical equipment directly to electrical outlets situated in the wall.<br>3. The audit tool will be completed for 5 residents with [redacted] and/or [redacted] therapy on weekly basis to ensure compliance and prevent from potentially hazardous situation.<br>4. Primary nurses and Unit Manager were instructed to perform check on medical equipment plugged to outlets during rounds.<br>5. Anticipate medical equipment needs before admission/re-admission.<br>6. Change of room/floor (to [redacted] floor) if number of medical equipment exceeds number of electrical outlets available.<br>1. Daily findings will be corrected and reported immediately to DON and MT.<br>2. Weekly audit will be performed by Maintenance Director x 90 days.<br>3. Findings will be presented in QAPI meetings on monthly basis x 3 months.<br>4. The QAPI Committee will make | |

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| F 689 | Continued From page 6<br><br>During an interview with the surveyor on 10/19/21 at 12:35 PM, Resident #39 stated there are not enough plugs in his/her room and he/she purchased an extension cord. Resident #39 stated they cannot plug the [redacted] or the [redacted] into the extension cord, and that the staff does it for him/her.<br><br>During an interview with the surveyor on 10/19/21 at 12:40 AM the maintenance director stated the medical equipment could not be plugged into extension cords and all medical equipment must be plugged directly into an outlet. He stated that the [redacted] could be plugged into the wall outlet and the [redacted] into the overbed light outlet.<br><br>During a meeting with the survey team on 10/21/2021 at 10:01 AM, the Administrator was made aware of the concerns. He stated the maintenance director made rounds every week.<br><br>A review of the facility's policy and procedure labeled "Power Strip Use" revealed that the use of extension cords is prohibited in the facility. Power strips that are in residents' rooms are not used for patient care-related electrical equipment. The purpose of the policy was to reduce fire hazards and health risks.<br><br>2. On 10/14/21 at 12:33 PM, Surveyor #1 observed lunch service on the [redacted] floor in the [redacted] floor Day Room. Multiple residents and staff were present in the Day Room. During that time, after residents were finished eating, Surveyor #1 observed a Corporate Administrator (CA) handing four residents wipes out of a plastic orange and | F 689 | recommendations based on the results of the audits.<br>5. The QAPI Committee will determine tapering or resolving monitoring tool once consistent compliance at 100% have been achieved.<br>Skin assessment was performed on residents #124, #112, #168 and #101 which was unremarkable.<br>All residents denied [redacted], [redacted].<br>All residents utilizing dining room during mealtime might be at potential risk for deficient practice.<br>1. Disinfectant wipes were immediately removed from the dining room tables.<br>2. All residents were made aware of the improper wipes that were used.<br>3. All residents [redacted] were assessed for skin irritation, skin breakdown, redness, pain, and discomfort.<br>4. Handwashing with soap and water was performed for all residents.<br>5. All the alert residents were educated on the proper hand wipes.<br>6. All nursing staff, Unit Managers, Activities Department and Central Supply personnel were given immediate education on the proper hand wipes - good for the residents to clean their hands before/after meals.<br>7. One to one education with Cooperate Administrator, who was handing the wipes to residents about proper hand wipes use.<br>8. Inspection of other dining rooms for wrong disinfectant wipes (floors in compliance with proper hand wipes).<br>9. Ongoing monitoring of hand wipes | |

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| F 689 | Continued From page 7<br>white cylinder container.<br><br>Surveyor #1 observed the following:<br><br>Resident #124 blew their nose and wiped their hands with the wipe, Resident #112, #168, and #101 wiped their hands with the wipe.<br><br>At 12:38 PM, Surveyor #1 observed the plastic orange and white cylinder container sitting on a table next to the CA. Upon review of the orange and white cylinder container, the surveyor identified the wipes as disinfecting wipes. Continued review of the disinfecting wipes revealed the instructions, "do not use as diaper wipe or for personal cleansing". During an interview with Surveyor #1 at that time, the CA stated the wipes in the container were the wipes he had given to the residents.<br><br>At 12:47 PM, Surveyor #1 observed resident #168 using the wipe to wipe the table and bilateral arms.<br><br>At 12:50 PM, Surveyor #1 observed the CA and Activity Aide asking Resident #112 to use hand sanitizer.<br><br>During an interview with Surveyor #2 on 10/14/21 at 12:50 PM, the Assistant Director of Nursing/Infection Preventionist (ADON/IP) stated that residents should perform hand hygiene before and after they eat. The ADON/IP reviewed the wipes in the plastic orange and white cylinder container in the presence of the two surveyors. She stated that the wipes did not contain bleach so they were safe for the residents to use.<br><br>At 1:36 PM, Surveyor #1 observed LPN #2 | F 689 | used in dining rooms in the form of ICP/DON/ADON rounds in the dining rooms 3 days per week at minimum and collection of findings in weekly audit.<br>1. Weekly audit will be performed by ICP x 90 days.<br>2. Findings will be presented in QAPI meetings on monthly basis x 3 months.<br>3. The QAPI Committee will make recommendations based on the results of the audits.<br>4. The QAPI Committee will determine tapering or resolving monitoring tool once consistent compliance at 100% have been achieved. | |

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| F 689 | Continued From page 8<br>instructing resident #101 to wash their hands with soap and water. During an interview with the surveyor at that time, Resident #101 stated, "they gave me a towel that has some type of soap in it". Resident #101 denied irritation from the use of the wipes.<br><br>During an interview with Surveyor #1 on 10/14/21 at 01:39 PM, Resident #168 denied irritation from the use of the wipes.<br><br>During an interview with Surveyor #1 on 10/14/21 at 01:47 PM, Resident #124 denied irritation to skin from the use of the wipes.<br><br>During an interview with Surveyor #1 on 10/19/21 at 12:22 PM, the ADON/IP stated residents were offered hand hygiene before and after they eat to prevent infection. Residents were typically given hand wipes designated for disinfecting hands. The ADON/IP stated the wipes used on 10/14/21 were accidently given to the residents and that the resident's skin could get irritated from using the wrong wipes.<br><br>During an interview with Surveyor #1 on 10/19/21 at 12:31 PM, the CA stated that he didn't notice he gave the residents the incorrect wipes. He stated it was important to give the residents the correct hand wipes to prevent skin irritation or an allergic reaction. | F 689 | | |
| F 804<br>SS=D | NJAC 8:39-31.2(e)<br>Nutritive Value/Appear, Palatable/Prefer Temp<br>CFR(s): 483.60(d)(1)(2)<br><br>§483.60(d) Food and drink<br>Each resident receives and the facility provides- | F 804 | | 12/15/21 |

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| F 804 | Continued From page 9<br><br>§483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance;<br><br>§483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and review of pertinent facility documentation it was determined that the facility failed to serve hot foods at an acceptable temperature for the residents. This deficient practice was identified for 1 of 7 residents who attended a Resident Council group meeting, and on 1 of 5 nursing units ([redacted] floor) during the lunch meal service and was evidenced by the following:<br><br>1. On 10/15/21 at 10:33 AM, a surveyor conducted a group meeting with seven residents who regularly attended the facility resident council meetings. One out of seven residents indicated the food was cold.<br><br>2. On 10/18/21, the surveyor conducted a regular diet and a pureed diet test tray with the Director of Dining Services (DDS) and the Regional Director of Dining Services which resulted in the following:<br><br>At 11:47 AM the DDS stated the [redacted] floor was a patient under investigation (PUI) unit, a potentially contagious patient unit, so all the dishware for that unit was disposable.<br><br>At 11:50 AM the surveyor observed the cook checking food temps with a thermometer prior to serving on the food line. | F 804 | A. CORRECTIVE ACTIONS<br><br>The DDS was immediately in-serviced on the on the proper temperature policy that food shall be maintained and served.<br><br>B. IDENTIFY AT RISK RESIDENTS<br>All Residents have the potential to be affected.<br><br>C. SYSTEMIC CHANGES/ MEASURES<br>All dietary staff were in-serviced on the facility policy regarding the proper food temperature that food shall be cooked and maintained to serve, in addition to its importance, and the action steps to take.<br><br>D. MONITORING CORRECTIVE ACTION<br>The DDS or designee will take temperatures of food prior to leaving the kitchen and complete 3 test trays weekly x 4 weeks. All results to be logged prior to service.<br><br>The Dietary Director will review results of test tray results and develop/ present at monthly QAPI meetings.<br>Dietary Director will perform weekly audits | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____ | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315180 | | 11/03/2021 |

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|---|---|---|---|---|
| F 804 | Continued From page 10<br>At 12:17 PM the dietary aide exited the kitchen with the meal cart, which included the test trays, accompanied by the surveyor and the DDS.<br><br>At 12:19 PM the dietary aide delivered the meal cart, which included the test trays, to the dining room on the [redacted] floor nursing unit.<br><br>At 12:20 PM the resident meal pass began.<br><br>At 12:33 PM the last resident meal tray was served.<br><br>During an interview with the surveyor at that time, the DDS confirmed the thermometer she brought to take the food temps was calibrated.<br><br>At 12:34 PM, in the presence of the surveyor, the DDS took the following food temperatures:<br>Lasagna: 135.1 degrees Fahrenheit (F)<br>Broccoli: 122.8 degrees F<br>Pureed potatoes: 123.9 degrees F<br>Pureed pasta: 115.5 degrees F<br>Pureed bread 117.3 degrees F<br><br>At that time, the surveyor interviewed the DDS regarding what the appropriate food temperature should be when the food was served. The DDS stated the hot foods should be 120 degrees or above when served.<br><br>At 12:39 PM the surveyor again interviewed the DDS regarding appropriate food temperatures when the food was served. The DDS stated the serving temperature should be 135 degrees or above on the nursing units and acknowledged that not all of the temps were 135 degrees. She further stated it was important to maintain proper temps so the food would remain hot when it was | F 804 | to ensure compliance with labeling and dating as well as removing any products close to expiration. | |

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|---|---|---|---|---|
| F 804 | Continued From page 11<br>served.<br><br>Review of the facility's policy, "Hot Food," dated 6/3/2013, revealed Procedure: 7. d. Hot foods should be at 135 degrees F or above at the time food is served to the residents. | F 804 | | |
| F 812<br>SS=E | NJAC 8:39-17.4 (a)<br>Food Procurement,Store/Prepare/Serve-Sanitary<br>CFR(s): 483.60(i)(1)(2)<br><br>§483.60(i) Food safety requirements.<br>The facility must -<br><br>§483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.<br>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.<br>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.<br>(iii) This provision does not preclude residents from consuming foods not procured by the facility.<br><br>§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and review of facility documentation it was determined that the facility failed to a.) properly handle and store potentially hazardous foods in a manner that is intended to prevent the spread of foodborne illnesses, b.) maintain equipment and kitchen | F 812 | All residents had potential to be affected. All residents were monitored for any Gastro Intestinal symptoms.<br><br>A. IMMEDIATE CORRECTIVE ACTIONS | 12/15/21 |

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|---|---|---|---|
| | 315180 | | 11/03/2021 |

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|---|---|---|---|---|
| F 812 | Continued From page 12<br>areas in a manner to prevent microbial growth and cross-contamination and c.) maintain sanitation in a safe and consistent manner to prevent foodborne illness.<br><br>This deficient practice was observed and evidenced by the following:<br><br>On 10/12/21 from 09:48 AM until 11:12 AM, the surveyor toured the kitchen in the presence of the Director of Dietary Services (DDS) and observed the following:<br><br>1. Handwashing sink #2 had no trash can nearby to discard paper towels. The DDS acknowledged there was no trash can and stated there should be one next to the sink.<br><br>2. In refrigerator #1, there was one opened plastic bag of cheddar cheese wrapped in clear plastic wrap with a received date sticker of 9/30/21 with no opened or use by date. There was one opened package of white turkey breast wrapped in clear plastic wrap with an opened date of 10/7 and no use by or received on date.<br><br>During an interview at that time, the DDS acknowledged the missing dates and stated the cheese should have had an open date and the turkey should have had a received on date. She further stated that the opened turkey was only good for three days and that the turkey and the cheese would be discarded.<br><br>3. In refrigerator #2, there was a one quarter sized deep metal pan containing eggs that the DDS identified as hard-boiled, with a received sticker dated 10/12/21 with no label and no use-by date. There was a one quarter sized deep | F 812 | 1.Trash can immediately placed by the handwashing sink to properly discard paper towels. Employees were educated on the protocol for proper handwashing and had competency observation of handwashing.<br>2, 3, 4, 6,8 . All opened items that weren□t properly labeled and dated with a use by or opened date were immediately discarded. The dietary staff was educated on the labeling and dating policy.<br>5. The robot coupe cover was immediately removed from the metal rack and cleaned. Staff were educated on cross contamination.<br>7. The coffee filters were immediately discarded. The dietary staff was educated on cross contamination.<br>9,13. The dented can was immediately placed in the designated dented can area. The dietary staff was educated on storing dented cans as they are not to be used.<br>10. The spices were properly dated with an open date. Parsley flakes and any other spice without a received by date were discarded.<br>11. The pan with greasy liquid was immediately removed and discarded.<br>12, 14. Stove and slicer immediately cleaned. Cooks in-serviced to notify the DDS of spillage that needs to cleaned.<br>B. RISK POTENTIAL OF RESIDENTS<br>1-14. All residents have the potential to be affected<br>C. NEW INTERVENTIONS/ MEASURES<br>1. A step-on trash can was purchased for handwashing sink. DDS or designee will in-service all dietary staff on the protocol for proper handwashing. | |

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|---|---|---|---|
| | 315180 | | 11/03/2021 |

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|---|---|---|---|---|
| F 812 | Continued From page 13<br>metal pan containing a yellow substance that the DDS identified as scrambled eggs, with a received sticker dated 10/12/21 with no label and no use by date. There was one quarter sized deep metal pan containing a brown substance that the DDS identified as pureed sausage, with a received sticker dated 10/12/21 with no label and no use by date. There was a one half sized deep metal pan containing brown strips of meat that the DDS identified as cooked bacon, with a received sticker dated 10/12/21 with no label and no use by date. There was one 10 pound unsealed package of genoa salami, wrapped in clear plastic wrap, dated received on 10/3 and opened on 10/3 with no use by date. There was one large opened cardboard box containing 30 raw eggs with a received sticker dated 9/1/21 with no use by date.<br><br>During an interview at that time, the DDS stated the salami and the eggs were good for three days once they were opened and that they would be disregarded or thrown away. She stated it was important to date food items so it was known when they were received and when they should be used by to prevent food poisoning.<br><br>4. In the freezer there was one 20 pound box of frozen chicken with no received on or use by date. There was one clear sealed bag of brown round balls, with a large amount of white ice crystals in the bag, with no label and no dates. The DDS identified the food as meatballs and stated they should have had a received on date and a label and that they would be discarded.<br><br>5. On a metal rack in the clean and dry pot area, there was a metal cover, that the DDS identified as the top cover to the robot coup, with pieces of | F 812 | Handwashing competency will be performed and added to the new hire orientation<br>2, 3,4, 6, 8,10. All dietary staff were educated on the label and dating policy.<br>5,7. All dietary staff were educated on cross contamination and the actions to take to avoid.<br>9, 13. All dietary staff were educated on where to store dented cans to ensure they are not pulled for production.<br>11. Stove to be repaired. Quote completed.<br>12, 14. The cleaning schedule to include stove and meat slicer cleaning and monitoring of additional cleaning tasks as needed.<br>2. MONITORING INTERVENTIONS/ MEASURES<br>1. The DDS or designee will monitor the handwashing procedure of 3 employees per week x 4 weeks to ensure the proper protocol is followed. Results will be reviewed at the next QAPI meeting.<br><br>2,3,4, 6,8,10. The DDS to complete daily routine inspections x 8 weeks to ensure the proper label and dating protocol is performed. All unlabeled and undated items will be discarded. Results to be reviewed at the next QAPI meeting.<br><br>5,7. The DDS to complete daily routine inspections x 8 weeks to identify cross contamination hazards and educate as necessary. Results to be reviewed at the next QAPI meeting.<br><br>9, 13. The DDS to complete weekly | |

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|---|---|---|---|
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|---|---|---|---|---|
| F 812 | Continued From page 14<br>dried white debris and dried white liquid debris. The DDS acknowledged the cover was dirty and moved it to the dishwashing area.<br><br>6. In the free standing deep freezer, there was one frozen bundle of small brown long oval shaped pieces of meat wrapped in clear plastic wrap that were dated 10/9/21 with no label and no use by date. The DDS acknowledged there was no label, identified them as hot dogs and stated that the marked date was the open date. There were two frozen red circular patties wrapped in clear plastic wrap with no label and no dates. There were three frozen red circular patties wrapped in clear plastic wrap with a received date 9/19/21 with no label and no use by date. The DDS identified the patties as hamburgers, acknowledged there was no use by date and stated she was unsure when they should be used by. There was one frozen bundle of large brown oval shaped pieces of meat partially wrapped in clear plastic wrap with the meat visible and exposed to air with a received sticker dated 9/24/21 with no label or use by date. The DDS identified the meat as kielbasa and stated they were no good and to disregard them. The DDS threw all of the meat into the garbage.<br><br>7.On top of a plastic storage bin, there was a metal basket containing sealed bags of coffee that were resting directly on seven large coffee filters that were uncovered and exposed to air. The DDS stated they should not be stored there and that they were usually stored in the dry storage area.<br><br>8. In the dry storage area, there was one 10 pound opened box of unbagged egg noodles, with the noodles visible and exposed to air, with a | F 812 | inspection x 8 weeks to ensure dented cans are placed in designated area. Results to be reviewed at the next QAPI meeting.<br><br>11. The DDS to notify facility of all equipment in need of repair on an as needed basis. Log to be maintained.<br><br>12,14. The DDS to monitor the cleaning schedule for satisfactory cleanliness. Results to be reviewed at the next QAPI meeting.<br>All staff were in serviced on the appropriate use of hairnets and beard guards while handling food.<br>13.The Dietary Director/Designee will monitor all staff daily to wear hairnets/beard guards while handling food and will report compliance in the Qapi meeting for 90 days<br>14.Regional management/DDS/Designee will conduct weekly kitchen sanitation audits X 90 days. | |

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|---|---|---|---|
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|---|---|---|---|---|
| F 812 | Continued From page 15<br>received sticker dated 9/30/21 with no open or use by date. The DDS stated she would discard the noodles.<br><br>9. On the canned goods metal rack #1, there was one dented 6 pound 10 ounce can of mandarin oranges. The DDS acknowledged the can was dented and removed the can to the dented can rack.<br><br>10. On the spice rack there were:<br>One opened 28 ounce jar of seasoning salt with a received date 10/6/21 with no open date.<br>One opened 1 pound jar of pure ground pepper with a received date 10/12/21 with no open date.<br>One opened 12.5 ounce jar of ground ginger with a received date 7/20/21 no open date.<br>One opened 10 ounce jar of parsley flakes with no received date and no open date.<br><br>During an interview at that time the DDS stated the spices should have had an open date.<br><br>11. On the floor, under the flat top grill where chicken was being cooked, there was a large full sized metal pan that contained a large amount of yellow greasy liquid. The DDS stated they were drippings from the flat top grill.<br>12.In the oven, below the flat top grill, there were large amounts of dried white debris covering the bottom of the oven and the door of the oven.<br><br>During an interview at that time the cook acknowledged the flat top grill was not draining correctly. He stated the grill should not drain into the oven nor into the pan on the floor.<br><br>13. On the canned goods metal rack #2, there was one dented 5 pound 12 ounce can of | F 812 | | |

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|---|---|---|---|
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|---|---|---|---|---|
| F 812 | Continued From page 16<br>mashed potatoes. The DDS acknowledged the can was dented and removed the can to the dented can rack.<br><br>14. The meat slicer was covered with a clear plastic bag. The DDS removed the bag and there was white and pink dried debris on the slicer blade and on the slicer handle. The DDS acknowledged the debris should not be there and that once the slicer was used it was cleaned and bagged.<br><br>On 10/12/21 at 11:05 AM the surveyor observed the cook cooking chicken on the flat top grill wearing a surgical mask with facial hair visible around the surgical mask. The cook acknowledged he was not wearing a beard cover and stated staff were to wear hairnets in the kitchen at all times. The cook further stated that he did not get a policy on facial hair but that it was important to wear a hairnet so no hair would get into the food.<br><br>On 10/14/21 from 08:58 AM until 09:22 AM, the surveyor toured the kitchen in the presence of the Director of Dietary Services (DDS) and observed the following:<br><br>1. In refrigerator #1, there was one opened 5 pound container of cottage cheese with a received sticker dated 9/15/21 and manufacturer's expiration date of 10/7/21 with no opened or use by date. There was one opened 5 pound container of cottage cheese with a received sticker dated 9/13 and manufacturer's expiration date of 10/7/21 with no opened or use by date. The DDS stated the containers are expired and discarded them into the trash.<br>2. On the floor, under the unused flat top grill, | F 812 | | |

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|---|---|---|---|---|
| F 812 | Continued From page 17<br>there was a large full sized metal pan that contained a large amount of dark yellow greasy liquid.<br><br>A review of personal hygiene inservice, dated 2/23/21, revealed the cook was inserviced on hairnet usage.<br><br>A review of the facility's policy, "Personal Hygiene," with a revision date of 6/3/2013, revealed Procedure: 3. Cover all hair and facial hair with restraint (hairnet, beard net, cap or hat).<br><br>A review of the facility's policy, "Receivable and Storage," with a revision date of 6/3/2013, revealed Procedure: 11. Ensure that all food are securely covered, dated, and labeled.<br><br>A review of the facility's policy, "Kitchen Equipment General Cleaning," with a revision date of 4/2019, revealed Policy: The director of dining services or designee will ensure that all equipment is maintained, kept clean, and in a sanitary condition before and after each use. Procedure: 1. Conventional/convection ovens a. clean, inside and out, using soap and water. 4. Griddle/flat top c. be sure to clean grease tray.<br><br>A review of the facility's policy, "Dishwashing," with a revision date of 2/20/2017, revealed Procedure: 10. Remove dishes and inspect for cleanliness and dryness.<br><br>A review of the facility's policy, "Pot Washing," with a revision date of 2/14/2017, revealed Policy: Kitchen will wash, rinse, and sanitize all pots, pans and cook ware and small wares following each meal. Procedure: 7. Wash all dirty pots and wares ...8. Rinse all clean pots and wares ...9. | F 812 | | |

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|---|---|---|---|---|
| F 812 | Continued From page 18<br>Sanitize all clean pots and wares ...10. Air dry all clean and sanitized pots and wares ...<br><br>NJAC 8:39-17.2(g) | F 812 | | |
| F 880<br>SS=D | Infection Prevention & Control<br>CFR(s): 483.80(a)(1)(2)(4)(e)(f)<br><br>§483.80 Infection Control<br>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.<br><br>§483.80(a) Infection prevention and control program.<br>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:<br><br>§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;<br><br>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:<br>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;<br>(ii) When and to whom possible incidents of | F 880 | | 1/1/22 |

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| F 880 | Continued From page 19<br>communicable disease or infections should be reported;<br>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;<br>(iv)When and how isolation should be used for a resident; including but not limited to:<br>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and<br>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.<br>(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<br>(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.<br><br>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.<br><br>§483.80(e) Linens.<br>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.<br><br>§483.80(f) Annual review.<br>The facility will conduct an annual review of its IPCP and update their program, as necessary.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interviews, and review of facility documentation, it was determined that the facility failed to a.) follow appropriate infection control practices and perform hand hygiene as indicated during dining observation for 1 of 5 units | F 880 | Residents in rooms [redacted] and [redacted] were monitored for signs and symptoms of possible infection. Residents were unaffected.<br>All residents on [redacted] floor have the | |

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|---|---|---|---|
| | 315180 | | 11/03/2021 |

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|---|---|---|---|---|
| F 880 | Continued From page 20<br>[redacted] floor dining room) observed and b.) ensure respiratory equipment was kept in a clean and sanitary condition, and stored properly to reduce the risk of infection for 1 of 6 residents reviewed for respiratory equipment, Resident #18.<br><br>The deficient practice was evidenced as follows:<br><br>1. On 10/14/21 the surveyor observed the following:<br><br>At 12:24 PM, an Activity Aide (AA) delivered a lunch tray to room [redacted]. The AA placed the tray on the bedside table (BST). The AA adjusted the height of the BST and used the resident's bed remote control to raise the head of the bed. The AA did not perform hand hygiene before or after delivering the meal to the resident. The AA went back to dining room and picked up another lunch tray, filled a mug with a brown liquid from a white carafe and put it on the tray. She then placed a milk and a juice container on the tray. The AA did not perform hand hygiene before picking up the new lunch tray.<br><br>At 12:27 PM, the AA knocked on the door for room [redacted]. The AA entered the room, placed the lunch tray on the BST and used her hands to push the curtains out of the way. The AA unwrapped the resident's salad, opened the milk and pushed the BST over to resident. The AA donned (put on) gloves and helped the resident with their shoes. The AA doffed (removed) the gloves. She then opened the salad dressing and put it on the salad. The AA exited room. The AA did not perform hand hygiene before or after delivering the meal to the resident, or before or after she donned and doffed the gloves. | F 880 | potential to be affected by deficient practice.<br>[redacted] machine in room of resident # 18 was changed to a new device.<br>[redacted], and storage bag were exchanged to new ones and dated appropriately. Resident was monitored for signs and symptoms of possible infection. Resident was unaffected.<br><br>1. Activity Aide was re-educated on proper hand hygiene (HH) as well as donning and doffing gloves.<br>2.Activity Aide and Employee□s competency on HH and donning and doffing gloves was evaluated with correct return demonstration. ICP will preform 2 competency return demonstrations per shift per week X90 days to ensure compliance.ICP will continue to conduct monthly audits to ensure full compliance with all infection control protocols and will report findings of Hand Hygiene audits which will be reviewed by monthly QAPI committee.<br>3.RCA revealed the following reasons for deficient practices:<br>-Uncertainty how and when the procedure shall be performed<br>-Lack of direct observation of employees while performing the procedure to ensure that it is done correctly<br>-Disruption of daily routine and activities of Nursing Administration and ICP personnel<br>-ICP and Nursing Administration preoccupied with other tasks i.e., working on the floors, focusing on COVID-19 requirements, managing other operations of the building | |

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| F 880 | Continued From page 21<br>At 12:30 PM, the AA returned to the dining room without performing hand hygiene. She picked up another lunch tray. She took the tray to room [redacted] and placed it on the BST. She moved BST over to the resident, she adjusted height of the table for the resident. The AA the opened the clear wrap on the silver ware and opened resident's straw. The AA did not perform hand hygiene before or after delivering the meal to the resident.<br><br>At 12:31 PM, the AA returned to the dining room without performing hand hygiene. She then poured a brown liquid from a white carafe into a mug and placed a lid on it. The AA held the lid down on the mug with her hand and delivered it to the resident in room [redacted]. The AA did not perform hand hygiene before or after delivering the mug to the resident. The AA exited the room and walked behind the nurse's station. While speaking to other staff members, the AA placed both her hands on the counter at the nurse's station.<br><br>At 12:34 PM, the AA returned to the dining room without performing hand hygiene. The AA picked up another lunch tray. She took the tray to room [redacted]. She knocked on the door, opened door, and placed the tray on BST. She closed the door after exiting the room. The AA did not perform hand hygiene before or after delivering the meal to the resident.<br><br>At 12:36 PM, the AA returned to the dining room without performing hand hygiene. She rested her hand on the white carafe. She took another tray and gathered condiments and placed them on the tray.<br><br>At 12:39 PM, the AA knocked on the door for | F 880 | 3. Completion of DPOC including Root Cause Analysis and staff specific training on Infection Control and Prevention focusing, but not limited to hand hygiene, COVID-19 training, contact/transition and standard based precautions. Modules that staff was educated on:<br>- Module 1: Infection Prevention and Control Program viewed by Topline Staff and Infection Control and Preventionist<br>- Module 4: Infection Surveillance viewed by Topline Staff and Infection Control and Preventionist<br>- Module 6A: Principles of Standard Precautions viewed by all staff including Frontline, Topline Staff and Infection Control and Preventionist<br>- Module 6B: Principles of Transmission Based Precautions viewed by all staff including Frontline and Topline Staff and Infection Control and Preventionist<br>- Module 7: Hand Hygiene viewed by all staff including Frontline,Topline Staff and Infection Control Preventionist<br>- Module 11A: Reprocessing Reusable Resident Care Equipment viewed by Topline Staff and Infection Control and Preventionist<br>- Module 11B: Environmental Cleaning and Disinfection viewed by all staff including Frontline,Topline Staff and Infection Control and Preventionist<br>- CDC COVID-19 Prevention Messages for Front Line Long Term Care Staff: Clean Hands viewed by Frontline Staff<br>- CDC COVID-19 Prevention Messages for Front Line Long Term Care Staff: Closely Monitor Residents viewed by Frontline Staff | |

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|---|---|---|---|---|
| F 880 | Continued From page 22<br>room [redacted] and entered the room. The resident refused the tray. The AA did not place tray down, exited the room and closed door. She returned to the dining room without performing hand hygiene. The AA fixed her hair with her left hand and then picked up a wrapped sandwich with the same hand without performing hand hygiene. She walked to the elevator to a resident that was sitting in a wheelchair and touched the resident's shoulder and gave the resident the sandwich. The resident handed the sandwich back to the AA and she unwrapped it and handed it back to him/her.<br><br>At 12:44 PM, the AA returned to the dining room without performing hand hygiene. She fixed the jacket that was tied around her waist. She opened a juice and gave it to a resident sitting in the dining room. The AA did not perform hand hygiene before or after delivering the juice.<br><br>During an interview with the surveyor on 10/14/21 at 12:45 PM, the AA stated that hand hygiene should be performed when you come in to work in the morning and when you eat. The AA stated that she had not received in-services on hand hygiene. She stated that she did not receive orientation on how to serve meals to residents. The AA said she was just told to put the meal trays down. The AA stated that she should have washed her hands after doffing gloves when she assisted the resident with the shoes.<br><br>During an interview with the surveyor on 10/14/21 at 12:48 PM, the Licensed Practical Nurse (LPN) stated that hand hygiene should be performed before you start serving food and in between residents. She stated the purpose of hand hygiene is to get rid of germs. | F 880 | - CDC COVID-19 Prevention Messages for Front Line Long Term Care Staff: Keep COVID-19 Out! viewed by Frontline Staff.<br><br>1. All utilized [redacted] machines were checked for cleanliness. Further dirty devices were not identified.<br>2. [redacted] and plastic bags associated with [redacted] devices were changed to a new one and dated appropriately.<br>3. Nursing staff was re-educated on current [redacted] Treatment Policy and Procedure which outlines steps of [redacted] equipment disinfection and storage.<br>4. Audit monitoring cleanliness disinfection and storage of [redacted] equipment was developed to monitor and ensure compliance with [redacted] Treatment Policy and Procedure and therefore, reducing risk of possible infection transmission to residents receiving nebulizer treatments<br>1. ICP will continue the audit on weekly basis x 90 days. ICP will choose 5 residents who were prescribed [redacted] treatment and check the devices for cleanliness. ICP will check the same sample group to ensure that equipment is disinfected and appropriately stored. Findings will be immediately corrected if needed.<br>2. Findings will be presented in QAPI meetings on monthly basis.<br>3. The QAPI Committee will make recommendations based on the results of the audits. | |

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|---|---|---|---|---|
| F 880 | Continued From page 23<br><br>During an interview with the surveyor on 10/14/21 at 12:50 PM, the Assistant Director of Nursing/Infection Preventionist (ADON/IP) stated that staff should wash their hands before delivering the meal tray. She stated that hand hygiene should be performed between each resident to prevent spread of any germs. The ADON/IP stated that hand hygiene should be performed before and after donning and doffing gloves.<br><br>Review of the facility's, "Certificate of Completion" form dated June 16, 2021, revealed that the AA had completed and earned 0.5 contact hours for the program on "Hand Hygiene".<br><br>Review of the facility's In-Service sign in sheet, "Creating a homelike dining experience and Dining room Process and Hand Hygiene Procedure during mealtime" dated 7/23/21, revealed that the AA had attended the in-service. Review of the "In-Service on the Aspects to consider for Dining Room", revealed Infection Control: Staff need to wash their hands before meals are served. If staff come in direct contact with a residents skin (such as while feeding) they must re-wash their hands before coming in contact with another resident.<br><br>Review of the facility's "Hand Hygiene" policy, reviewed 10/2021, revealed Purpose: Hand hygiene is a simple and effective method for preventing the spread of pathogens, such as bacteria and viruses, which cause infections. Pathogens can contaminate the hands of a staff member during direct contact with residents or contact with contaminated equipment and environmental surfaces within close proximity of | F 880 | 4. The QAPI Committee will determine tapering or resolving monitoring tool once consistent compliance at 98% have been achieved | |

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|---|---|---|---|---|
| F 880 | Continued From page 24<br>the resident. Failure to clean contaminated hands can result in the spread of these pathogens to residents, staff (including the person whose hands were contaminated), and environmental surfaces. Hand washing with a non-antimicrobial soap and water or with anti-microbial soap and water is indicated for the following: before having direct contact with patients; after contact with inanimate objects in the immediate vicinity of the patient; after removing gloves; before and after preparing food; before delivering meal tray and prior to leaving the resident's room.<br><br>Review of the facility's "Nutritional Services" policy and procedure, revised 1/2021, revealed ESSENTIAL POINTS: Staff must wash hands before and after serving trays.<br><br>2. According to the facility's Admission Record, Resident #18 was admitted to the facility in [redacted] with diagnoses which included but were not limited to; [redacted]<br><br>Review of the resident's Order Summary Report revealed an order dated [redacted] for [redacted] milligrams per [redacted] milliliters [redacted] orally every [redacted] hours for [redacted].<br><br>Review of Resident #18's October Medication Administration Record (MAR) reflected the above physician's order and was documented as administered.<br><br>On 10/13/21 at 09:15 AM during the initial tour of the [redacted] floor, the surveyor observed a [redacted] | F 880 | | |

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|---|---|---|---|---|
| F 880 | Continued From page 25<br>machine in Resident #18's room. The [redacted] machine was on the resident's dresser on top of an opened plastic bag. There were [redacted] substances on the [redacted] machine. The [redacted] was exposed, connected to the medication cup, and the [redacted] was connected to the [redacted] machine. Condensation was observed inside the [redacted] medication cup.<br><br>On 10/14/21 at 10:17 AM, the surveyor brought the assigned Licensed Practical Nurse (LPN) to Resident #18 's room. The [redacted] mask, medication cup, and [redacted] were in an unlabeled bag and were connected to the [redacted] machine. The LPN stated that [redacted] equipment should be detached, cleaned after use, and stored in a bag to prevent infection.<br><br>During an interview with the surveyor on 10/18/21 at 10:09 AM, the Infection Preventionist stated that the [redacted] should be detached and washed after each use, air-dried, and then stored in a plastic bag. The IP further stated that the [redacted] machine should be cleaned if it was soiled. The IP stated the Resident #18's [redacted] equipment should have been clean and properly stored.<br><br>Review of a facility policy titled, [redacted] Treatment, revised 8/2021, included that when the treatment was complete, remove the mask, disconnect the [redacted], and medication cup. Rinse and disinfect the [redacted] equipment according to the manufacturer's recommendations or wash the pieces with warm water after each use. When the equipment is completely dry, store it in a plastic bag marked with the resident's name and the date. Clean | F 880 | | |

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|---|---|---|---|---|
| F 880 | Continued From page 26<br>equipment if visibly soiled and change tubing, mask/mouthpiece, and other parts of the equipment regularly (every Tuesday night) and if needed. | F 880 | | |
| F 886<br>SS=F | NJAC 8:39-19.4 (m)(n), NJAC 8:39 27.1(a)<br>COVID-19 Testing-Residents & Staff<br>CFR(s): 483.80 (h)(1)-(6)<br><br>§483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must:<br><br>§483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not<br>limited to:<br>(i) Testing frequency;<br>(ii) The identification of any individual specified in this paragraph diagnosed with<br>COVID-19 in the facility;<br>(iii) The identification of any individual specified in this paragraph with symptoms<br>consistent with COVID-19 or with known or suspected exposure to COVID-19;<br>(iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of<br>COVID-19 in a county;<br>(v) The response time for test results; and<br>(vi) Other factors specified by the Secretary that help identify and prevent the<br>transmission of COVID-19. | F 886 | | 12/1/21 |

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|---|---|---|---|---|
| F 886 | Continued From page 27<br>§483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests;<br><br>§483.80 (h)((3) For each instance of testing:<br>(i) Document that testing was completed and the results of each staff test; and<br>(ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test.<br><br>§483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19.<br><br>§483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested.<br><br>§483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview, and review of facility documentation, it was determined that the facility failed to test unvaccinated staff for COVID-19 at a frequency based on the county COVID-19 level of community transmission. This deficient practice was identified for 5 of 5 unvaccinated staff members in the facility reviewed for COVID-19 | F 886 | 1. ICP and DON became familiar with updated testing guidelines for unvaccinated staff members which came into effect on 09/10/2021 and included, In nursing homes located in counties with substantial to high community transmission, unvaccinated HCP should | |

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|---|---|---|---|---|
| F 886 | Continued From page 28<br>testing and was evidenced by the following:<br><br>According to the U.S. Centers for Disease Control and Prevention (CDC) guidelines, Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 [COVID-19] Spread in Nursing Homes updated 9/10/21 included, "In nursing homes located in counties with substantial to high community transmission, unvaccinated HCP should have a viral test twice a week."<br><br>According to the Interim Final Rule (IFC), CMS-3401-IFC, Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency related to Long-Term Care (LTC) Facility Testing Requirements revised 9/10/21 included, "Routine testing of unvaccinated staff should be based on the extent of the virus in the community ...Facilities should use their community transmission level as the trigger for staff testing frequency ...Routine Testing Intervals by County COVID-19 Level of Community Transmission: Low (blue) testing frequency: not recommended; Moderate (yellow) testing frequency: once a week; Substantial (orange) testing frequency: twice a week; and high (red) testing frequency: twice a week."<br><br>On 10/12/21 at 10:22 AM during the Entrance Conference, the Director of Nursing (DON) and the Infection Preventionist (IP) stated that the facility tested unvaccinated staff once a week on Tuesdays. The surveyor requested a list of facility staff and their vaccination status.<br><br>The surveyor reviewed the level of community transmission via the CDC COVID-19 Integrated County View site which indicated the facility's | F 886 | have a viral test twice a week.<br>2. DON will continue to monitor County Covid-19 Activity Level Index/Community Transmission Level and log the findings weekly.<br>3. ICP will adjust frequency of testing of unvaccinated staff based on above mentioned levels.<br>4. Testing logs will be audited on weekly basis to ensure that 1. ICP and DON became familiar with updated testing guidelines for unvaccinated staff members which came into effect on 09/10/2021 and included, In nursing homes located in counties with substantial to high community transmission, unvaccinated HCP should have a viral test twice a week.<br>2. DON will continue to monitor County Covid-19 Activity Level Index/Community Transmission Level and log the findings weekly.<br>3. ICP will adjust frequency of testing of unvaccinated staff based on above mentioned levels.<br>4. Testing logs will be audited on weekly basis to ensure that unvaccinated employees receive correct number of tests per week.<br>5unvaccinated employees receive correct number of tests per week.<br>5. COVID-19 Testing Policy was revised and updated to reflect the new guideline on testing frequency.<br>6. Staff was educated on importance of adhering to updated COVID-19 testing policy.<br>7. Unvaccinated staff was consulted/re-educated about COVID | |

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| F 886 | Continued From page 29<br>level of community transmission was high and in the red.<br><br>The surveyor selected five unvaccinated facility staff for COVID-19 testing. The surveyor identified that 5 of the 5 facility staff did not have evidence of twice a week COVID-19 testing in accordance with the aforementioned testing requirements. The following was revealed:<br><br>A review of the IP's work schedule revealed the IP worked on the following dates: [redacted], and [redacted]. The IP was tested for COVID-19 via rapid antigen on [redacted] and [redacted]<br><br>A review of Certified Nurses Aide #1 (CNA #1) work schedule revealed the CNA worked on [redacted] and [redacted] CNA #1 was tested for COVID-19 via rapid antigen on [redacted]<br><br>A review of CNA #'2's work schedule revealed CNA #2 worked on [redacted]. CNA #2 was tested for COVID-19 via rapid antigen on [redacted].<br><br>A review of an Occupational Therapist's (OT) work schedule revealed the OT worked on [redacted], and [redacted] The OT was tested for COVID-19 via rapid antigen on [redacted]<br><br>A review of the Staffing Coordinator's (SC) work schedule revealed the SC worked on [redacted], [redacted] and [redacted] The SC was tested for COVID-19 via rapid antigen on [redacted]. | F 886 | vaccination.<br>8. Staff was re-educated about availability of Covid vaccines at the facility.<br>1. ICP will audit testing logs on weekly basis x 90 days.<br>2. Findings will be presented in QAPI meetings on monthly basis.<br>3. The QAPI Committee will make recommendations based on the results of the audits.<br>4. The QAPI Committee will determine tapering or resolving audit tool once consistent compliance at 100% have been achieved | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____ | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 315180 | | 11/03/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ALAMEDA CENTER FOR REHABILITATION AND HEALTHCARE | 303 ELM STREET<br>PERTH AMBOY, NJ 08861 |

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|---|---|---|---|---|
| F 886 | Continued From page 30<br><br>During an interview with the surveyor on 10/15/21 at 11:29 AM, the DON and IP stated that the unvaccinated staff were tested weekly for COVID-19. The DON and IP stated they were unaware of the change in testing requirements.<br><br>A review of a facility policy titled, "COVID-19 Testing" revised 9/2021, included that the facility will test all residents and staff according to CDC and NJDOH guidelines. Routine testing of unvaccinated staff should be based on the extent of the virus in the community.<br><br>NJAC 8:39-5.1(a) | F 886 | | |