

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 90110	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/21/2021
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SUMMIT PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 540 MULLICA HILL ROAD GLASSBORO, NJ 08028
---	---

(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) COMPLETE DATE
A 000	Initial Comments Initial Comments: Census: 29 A Covid-19 Focused Infection Control Survey was conducted by the State Agency on December 21, 2021. The facility was found not to be in compliance with the New Jersey Administrative Code 8:36 infection control regulations standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19.	A 000		
A1073	8:36-15.6(b) Resident Records (b) All assessments and treatments by health care and service providers shall be entered according to the standards of professional practice. Documentation and/or notes from all health care and service providers shall be entered according to the standards of professional practice. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that the facility failed to maintain documentation of services provided during a Norovirus outbreak that occurred at the facility from Executive Order 26, 4.b, according to the standards of professional practice for 12 of 16 residents reviewed, Residents Executive Order 26, 4.b, as evidenced	A1073		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

02/17/22

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 90110	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/21/2021
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SUMMIT PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 540 MULLICA HILL ROAD GLASSBORO, NJ 08028
---	---

(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) COMPLETE DATE
A1073	<p>Continued From page 1</p> <p>by the following:</p> <p>On 12/21/21 at 11:20 a.m., during an entrance conference with the Executive Director (ED), the surveyor inquired about the Executive Order 26, 4.b. at the facility. The ED stated that the Executive Order 26, 4.b. began on Executive Order 26, 4.b.. The ED explained that Executive Order 26, 4.b. residents and 7 staff members were affected and that he was not sure how the Executive Order 26, 4.b. outbreak started.</p> <p>Surveyor review of Resident Executive Order 26, 4.b. Resident Executive Order 26, 4.b. Resident Executive Order 26, 4.b., Resident Executive Order 26, 4.b. Resident Executive Order 26, 4.b., Resident Executive Order 26, 4.b., Resident Executive Order 26, 4.b., Resident Executive Order 26, 4.b. and Resident Executive Order 26, 4.b. medical record from 10:48 a.m., to 1:30 p.m., observed that there were no documented evidence that the residents' physician were notified of the outbreak. In addition, there were inconsistent documentation regarding the outbreak in the residents' medical record.</p> <p>At 2:15 p.m., during interview with the ED, the surveyor informed him of the aforementioned concerns. The ED told the surveyor that the Director of Nursing (DON) notified the physician(s) about the residents Executive Order 26, 4.b. Executive Order 26, 4.b. However, there was no documented evidence in their medical record indicating that the physician(s) was notified according to the facility policy and procedure.</p> <p>The surveyor reviewed the "Infection Control" policy titled, "NOROVIRUS" revised 7/8/19, provided by the ED which revealed under "Upon a suspected outbreak: Notify the ..., physician, ... Document findings in the resident service notes and on the ... Document the date of onset and symptoms, and the date the resident(s) is/are symptom free."</p>	A1073		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 90110	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/21/2021
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SUMMIT PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 540 MULLICA HILL ROAD GLASSBORO, NJ 08028
---	---

(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) COMPLETE DATE
A1185	<p>8:36-17.2(b) Housekeeping-Sanitation-Safety-Maintenance</p> <p>(b) Housekeeping personnel shall be trained in cleaning procedures, including the use and care of equipment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interview, and record review it was determined that the facility failed to ensure a Housekeeping staff followed proper cleaning procedure(s) to prevent potential cross contamination of resident's environment as was evidenced by the following:</p> <p>On 12/21/21 at 1:45 p.m., Surveyor #1 and Surveyor #2 observed a Housekeeper (HKPR) at the back hallway of the facility with a yellow cleaning cart. In addition, the HKPR had a yellow mop bucket and in the bucket was a large string mop head with handle. During interview, the HKPR told the surveyors that she had completed cleaning all the apartments and bathrooms on the back hallway. Further, the surveyor observed that the water in the bucket was discolored and asked the HKPR how often was the cleaning water and the mop head changed. The HKPR informed the surveyor that she only changed the cleaning water and rinsed out the mop head at the end of each hallway.</p> <p>During continued interview, the surveyor then inquired how many rooms were on each hallway and the HKPR stated that there were about 20 rooms on a hallway. Later, the HKPR explained</p>	A1185		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 90110	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/21/2021
--	--	---	---

NAME OF PROVIDER OR SUPPLIER SUMMIT PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 540 MULLICA HILL ROAD GLASSBORO, NJ 08028
---	---

(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) COMPLETE DATE
A1185	<p>Continued From page 3</p> <p>that she would change the water and rinse out the mop head only if a resident was under isolation.</p> <p>At 2:15 p.m., Surveyor #1 informed the Executive Director (ED) about the aforementioned observation and explained to the ED that above practice can increase the spread of infection especially during an outbreak. The ED acknowledged by nodding his head in agreement.</p> <p>The surveyor reviewed the "Infection Control" policy titled, "NOROVIRUS" revised 7/8/19, provided by the ED which revealed under "Upon a suspected outbreak: ... Change cleaning cloths frequently and always change cleaning cloths when moving from one environmental area to the next."</p>	A1185		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 90110	Y1	MULTIPLE CONSTRUCTION A. Building B. Wing	Y2	DATE OF REVISIT 2/24/2022	Y3
NAME OF FACILITY SUMMIT PLACE			STREET ADDRESS, CITY, STATE, ZIP CODE 540 MULLICA HILL ROAD GLASSBORO, NJ 08028		

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


ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A1073	Correction	ID Prefix A1185	Correction	ID Prefix	Correction
Reg. # 8:36-15.6(b)	Completed	Reg. # 8:36-17.2(b)	Completed	Reg. #	Completed
LSC	03/01/2022	LSC	03/01/2022	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 12/21/2021		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 90110	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 12/21/2021
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SUMMIT PLACE	STREET ADDRESS, CITY, STATE, ZIP CODE 540 MULLICA HILL ROAD GLASSBORO, NJ 08028
---	---

(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) COMPLETE DATE
A 000	<p>Initial Comments</p> <p>Initial Comments: Census: 29</p> <p>A Covid-19 Focused Infection Control Survey was conducted by the State Agency on December 21, 2021. The facility was found not to be in compliance with the New Jersey Administrative Code 8:36 infection control regulations standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19.</p>	A 000		
A1073	<p>8:36-15.6(b) Resident Records</p> <p>(b) All assessments and treatments by health care and service providers shall be entered according to the standards of professional practice. Documentation and/or notes from all health care and service providers shall be entered according to the standards of professional practice.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that the facility failed to maintain documentation of services provided during a Executive Order 26, 4.b. that occurred at the facility from Executive Order 26, 4.b. according to the standards of professional practice for of 16 residents reviewed. Residents Executive Order 26, 4.b. as evidenced</p>	A1073	<p>Joseph Horowitz</p> 	2/17/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE **Executive Director**

(X6) DATE

Summit Place
Infection Control Plan of Correction

Submission Due: **2/17/22**

Submission of this response and Plan of Correction is NOT a legal admission that a deficiency exists or, that this Statement of Deficiencies was correctly cited, and is also NOT to be construed as an admission against interest by the residence, or any employees, agents, or other individuals who drafted or may be discussed in the response or Plan of Correction. In addition, preparation and submission of this Plan of Correction does NOT constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency

A1073

Residents **Executive Order 26, 4.b.** did not suffer a negative effect related to this finding.

On 2/16/22, the Care Services Manager (CSM) entered late entry notes into residents **Executive Order 26, 4.b.** **Executive Order 26, 4.b.** health records indicating that the physician was notified of the residents change in condition related to **Executive Order 26, 4.b.** (Exhibit A1)

On 2/16/22, the Regional Director of Care Services, (RDCS) educated the CSM on Enlivant Policy **Executive Order 26, 4.b.** and “*Change of Condition*”. (Exhibit A2)

On 2/16/22, the CSM audited the service notes of residents who experienced symptoms associated with **Executive Order 26, 4.b.** during the **Executive Order 26, 4.b.** outbreak to ensure physician documentation was noted. No omitted entries were identified.

On 2/16/22, the CSM audit the service notes of residents who had experienced a change in condition within the preceding 30 days to ensure physician notification was documented. No omitted entries were identified. The CSM or designee will audit resident service notes for residents experiencing a change in condition weekly x 4 weeks, bi-weekly x 4 weeks, and monthly x one to ensure physician notification was documented.

Results of the audits will be discussed during monthly QI meetings. The QI committee will determine if continued auditing is necessary based upon three consecutive months of compliance.

Completion date: 02/16/2022.

A1185

All residents had the potential to be adversely affected by this finding.

On 2/14/22, the Regional Director of Facilities Management (RDFM) educated the Maintenance and Housekeeping supervisor on proper housekeeping infection control procedures related to mopping.

On 2/8/2022, the RDFM ordered the community a mop kit with attachable microfiber mop pads to better facilitate the changing of mop pads between environmental areas. (Exhibit B2 – invoice)

The ED or designee will round the community 3 x weekly x 4 weeks, bi-weekly x 4 weeks, and monthly x 1 to observe a housekeeper mopping while moving from one environmental area to the next to ensure mop pads are changed between areas.

Completion date: 03/01/2022. Results of the audit will be discussed during monthly QI meetings. The QI committee will determine if continued auditing is necessary based upon three consecutive months of compliance.