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	j6tdgc	A. BUILDING: _____ B. WING _____	10/13/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARE ESTATE, THE	201 CROSSWICKS STREET BORDENTOWN, NJ 08505

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A 000	Initial Comments Initial Comments: TYPE OF SURVEY: Standard CENSUS: 29 SAMPLE SIZE: 11 The facility is not in substantial compliance with all of the standards in the New Jersey Administrative Code 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs. The facility must submit a plan of correction, including a completion date for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations.	A 000		
A 311	8:36-3.4(a)(2) Administration (a) The administrator or designee shall be responsible for, but not limited to, the following: 2. Planning for, and administration of, the managerial, operational, fiscal, and reporting components of the facility This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility failed to ensure that the operational, management, and administrative responsibilities of the facility Administrator/Executive Director (ED) were consistently performed and implemented for the	A 311		

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

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A 311	Continued From page 1	A 311		

provision of care, services, and safe environment to its residents.

The facility did not have an appointed Administrator/ED nor a designated alternate to perform the Administrator/ED responsibilities since 9/18/21. It was determined the provider's non-compliance with one or more requirements of participation had caused, or was likely to cause, serious injury, harm, impairment, or death to residents.

This was evidenced by the following:

On 10/5/21 at 9:55 a.m., during an interview, the scheduler who was also a certified home health aide (CHHA), told the surveyor that the facility Administrator/Executive Director resigned "sometime in September (2021), I think it was before the 20th." She stated that a Human Resources (HR) person/HR Manager, a representative of the corporation, was at the facility and may be able to answer the specifics regarding the Administrator/ED departure from the facility.

At 10:50 a.m., the surveyor interviewed the HR Manager who informed the surveyor that the Administrator/ED resigned on 9/18/21 and that the corporation/owner had not hired a replacement for the Administrator/ED. She told the surveyor that the corporation/owner was still reviewing applicants' credentials. The surveyor asked the HR Manager who the designated Alternate Administrator was and she stated that "temporarily, the Licensed Practical Nurse (LPN) was in charge." When asked to explain, the HR Manager stated there was no one at the facility designated as an alternate administrator. She stated that the LPN would be able to answer some of the surveyors' questions. However,

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A 311	Continued From page 2 when the surveyor asked the LPN if she was in charge of the facility at that time (10:50 a.m.), the LPN stated, "No." The surveyors observed the LPN administering medications to residents on the first floor. The facility had no Administrator and no designee since 9/18/21 leaving no one to fulfill the job responsibilities of an Administrator/ED jeopardizing the safety and well being of the residents of the facility as evidenced by the following: 1. The facility had no Administrator/ED/designee to ensure that a Registered Nurse (RN) delegated safely delegated medication administration and provided oversight to Certified Medication Aides (CMAs) in accordance with the New Jersey Board of Nursing, N.J.A.C. 13:37-6.2, Delegation of Selected Nursing Task, and with the requirements of N.J.A.C. 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes, and Assisted Living Programs. Reference: New Jersey Board of Nursing, N.J.A.C. 13:37-6.2, Delegation of Selected Nursing Task states, " ... c) The registered professional nurse shall be responsible for the proper supervision of licensed practical nurses and ancillary nursing personnel to whom such delegation is made. The degree of supervision exercised over licensed practical nurses and ancillary nursing personnel shall be determined by the registered professional nurse based on an evaluation of all factors including: 1) The condition of the patient; 2) The education, skill and training of the licensed practical nurse and ancillary nursing personnel to whom delegation is being made; 3) The nature of the tasks and the activities being delegated; 4)	A 311		

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A 311	Continued From page 3 Supervision may require the direct continuing presence or the intermittent observation, direction and occasional physical presence of a registered professional nurse. In all cases, the registered professional nurse shall be available for on-site supervision ...." a. The surveyor reviewed a facility form titled, "CMA Quarterly Observation" that identified the delegating Registered Nurse (RN) had not consistently conducted quarterly medication pass observations and therefore failed to evaluate the competencies of 4 of 4 CMAs delegated to administer medications to residents. The RN's last medication administration evaluation and observation of the CMAs were as follows (all in 2020): 1) CMA#1 on 5/27/20 and 9/1/20 2) CMA#2 on 10/19/20 3) CMA#3 on 10/26/20 and 4) CMA#4 on 11/1/20. On 10/6/21 at 11:15 a.m., the surveyor interviewed CMA #1 who stated, "It had been a while since I was last observed by the RN, it was over a year ago." b. The facility failed to provide RN delegation to ensure that the CMAs administered medications from a unit of use/unit dose distribution system (each medication individually and separately labeled and packaged). The surveyor reviewed the medication administration records (MARs) on 10/5/21 and 10/6/21 and observed two medications for each of two residents, Resident [redacted] and [redacted], had not been dispensed in a unit of use distribution system but rather in multidose bottles. These medications though dispensed in multidose bottles were signed as administered by CMAs on the MAR. These medications in multidose bottles included	A 311		

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A 311	Continued From page 4 two medications, [redacted] and [redacted] to treat [redacted] for Resident [redacted] and two medications, [redacted],an [redacted] medication and [redacted], a [redacted] pill, for Resident [redacted]. c. The facility did not ensure that an RN conducted an initial assessment upon admissions of two residents, Resident [redacted] and Resident [redacted] to determine and assess the immediate needs and level of care of the residents. d. There was no plan of care developed by an RN for Resident [redacted], upon the resident's admission to determine the level of assistance to be provided to the resident. There was no Health Service Plan (HSP) to indicate interventions initiated to address and evaluate the effectiveness of the care and services provided, including the physical therapy and speech therapy which had been ordered by the physician for the resident. e. On 9/22/21, the surveyor reviewed Resident [redacted] medical record which identified that there was no documented evidence that an RN and the resident's physician had been notified when the resident's [redacted] resulted in the need for the resident to be sent to the hospital. There was no RN to ensure assessment of the resident's change in condition for timely and appropriate provision of nursing and medical care. There was no documented evidence of a physician's instruction or intervention for the resident. 2. The facility had no Administrator/ED or designee to manage and ensure that the dietary services were provided in accordance with the requirements of N.J.A.C. 8:36, Standards for Licensure of Assisted Living Residences,	A 311		

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A 311	Continued From page 5 Comprehensive Personal Care Homes and Assisted Living Programs and with N.J.A.C. 8:24, Retail Food Establishments and Food and Beverage Vending Machines, Chapter XII of the New Jersey Sanitary Code for the health and safety of its residents, a highly susceptible population, from food-borne illnesses. Reference: N.J.A.C. 8:24, Retail Food Establishments and Food and Beverage Vending Machines, Chapter XII of the New Jersey Sanitary Code requires and states, "... 8:24-2.1(c) v. Through routine monitoring of solution temperature and exposure time for hot water sanitizing, ...that employees are properly sanitizing cleaned multi-use equipment and utensils before they are used ... 8:24-2.1(c) The person in charge shall ensure the following: 3 ...iii. Through daily oversight of the employees' routine monitoring of the cooking temperatures using appropriate temperature measuring devices properly scaled and calibrated, that employees are properly cooking potentially hazardous food, being particularly careful in cooking those foods known to cause severe foodborne illness and death, such as eggs and comminuted meats ... 8:24-2.4(c) 1. food employees shall wear hair restraints such as hats, hair coverings, or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food ... 8:24-3.2(f) Requirements for receiving temperatures are as follows: 1. Refrigerated, potentially hazardous food shall be at a temperature of 41 degrees Fahrenheit or below when received ... 8:24-3.2(f) 3. Potentially hazardous food that is cooked to safe cooking temperatures and received hot shall be at a temperature of 135 degrees Fahrenheit or above ...	A 311		

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A 311	Continued From page 6 8:24-4.9(k) In a mechanical operation, the temperature of the fresh hot water sanitizing rinse as it enters the manifold may not be more than 194 degrees Fahrenheit, or less than: 1. For a stationary rack, single temperature machine, 165 degrees Fahrenheit; or 2. For all other machines, 180 degrees Fahrenheit ...." a. The facility failed to ensure hot meals were served at the proper safe temperatures of 135 degrees F, to remain palatable and prevent the risk of foodborne illnesses, for all its residents. The facility dietary staff including a newly contracted Food Service Coordinator (FSC), failed to maintain logs of food temperatures to ensure food reached the required safe cooking, holding, and serving temperatures. The surveyor observed the plated food items kept in an uninsulated open cart where heat and proper temperatures could not be maintained. Hot food items were served below the required holding temperature of 135 degrees Fahrenheit (F), some food items were below 100 degrees F when the surveyor requested to test the food temperatures. b. The facility failed to ensure that the dishwashing machine "Wash" cycle reached the minimum required temperature of 160 degrees F, in accordance with N.J.A.C. 8:24 and the manufacturer's instruction affixed to the side of the machine. The facility dishwashing machine, when tested on 10/5/21 and 10/7/21, reached 126 degrees F which was below the required hot water temperature for a "Wash" cycle. c. The facility's failed to ensure the dietary staff and the interim Food Service Coordinator (FSC) monitored food temperatures and maintain a log of these temperatures to ensure potentially hazardous cold and hot food reached	A 311		

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the required cooking and holding temperatures to prevent food borne illness. On 10/7/21, the interim FSC failed to provide documented evidence that food temperatures had been logged and recorded.

d. The facility failed to ensure dietary staff and the interim Food Service Coordinator (FSC) maintained temperature logs of the refrigerator and freezer temperatures to ensure cold food were safely stored and kept at required temperatures to maintain the integrity of the food items and prevent the development of food borne illness.

e. On 10/5/21 and 10/7/21, the interim FSC, the cook, and the dishwasher staff were observed with no hair restraints while in the kitchen in the food preparation and cooking area. Upon surveyor request for a hair restraint before entering the kitchen, the surveyor was told that the facility did not have any hair restraints.

3. The facility had no Administrator/ED or designee to ensure that the facility contracted and/or retained a qualified person to be the facility's Infection Control Preventionist (ICP) in accordance New Jersey State Laws and the Department of Health (DOH) Directives, including the Executive Directive 020-026, to provide on-site management of the Infection Prevention and Control (IPC) program and at least perform infection surveillance, competency-based training of staff and audits of adherence to the recommended infection prevention and control practices.

Reference:
Executive Directive No. 020-026, " ...The provisions in this Directive apply to all residential healthcare facilities Long-Term Care Facilities,

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A 311	Continued From page 8 Assisted Living Residences, Comprehensive Personal Care Homes, Residential Health Care Facilities, and Dementia Care Homes (collectively "LTCFs" or "facilities"); as defined in N.J.S.A. 26:2 H-12.872 ; and N.J.A.C. 8:43, N.J.A.C. 8:39, N.J.A.C. 8:36 and N.J.A.C. 8:37 ... II. Required Core Practices for Infection Prevention and Control. 1. Regardless of a facility's current reopening phase, core infection prevention and control practices must be in place at all times. Maintaining core infection prevention and control practices is key to preventing and containing outbreaks and is crucial in ensuring the delivery of quality, safe care ... i. Facilities must educate residents, staff, and visitors about COVID-19, current precautions being taken in the facility, and protective actions. Facilities must encourage social distancing with physical separation. ii. All facilities, except for facilities with ventilator-dependent residents, are required to have one or more individuals with training in infection prevention and control employed or contracted on a full-time basis or part-time basis to provide on-site management of the Infection Prevention and Control (IPC) program. The requirements of this Directive may be fulfilled by: a. An individual certified by the Certification Board of Infection Control and Epidemiology or meets the requirements under N.J.A.C. 8:39-20.2; b. A physician who has completed an infectious disease fellowship; c. A healthcare professional licensed and in good standing by the State of New Jersey, with five (5) or more years of infection control experience... iii. The facility's designated individual(s) with training in infection prevention and control shall assess the facility's IPC program by conducting internal quality improvement audits ...." On [redacted] the facility failed	A 311		

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to consistently provide a person to instruct, monitor and screen staff and visitors upon entering the facility in accordance with ED 020-026. The surveyors observed that the facility reception desk contained blank screening forms to be filled out by staff and visitors upon entering the facility for infection control monitoring. The surveyor observed a digital thermometer scanner secured to a wall across the reception desk and on the side wall by the facility's main door entrance for temperature check.

On 10/6/21 at 10:00 a.m., the scheduler/CHHA told the surveyor that she was designated to be at the reception desk to unlock and allow visitors in, check and instruct visitors to check their temperatures using the thermometer scanner on the wall and to have them fill out the screening form. She also stated that due to inadequate staffing, she was not able to consistently stay in the reception area to ensure proper screening and monitoring of people entering the facility.

On 10/6/21, when asked who was in-charge of the infection control monitoring at the facility, the HR person told the surveyor that it was the former DON/RN. The surveyor asked if the former DON/RN had infection control certification, she stated, "yes." However, she stated that she could not locate and provide a copy of the former DON/RN ICP certification. The surveyor then asked the HR person if the facility had hired another ICP, after the former DON/RN left employment on 9/20/21, and she responded, "no."

4. The facility had no Administrator/ED or designee to ensure residents were provided a safe environment, free from health and fire safety hazards. During the tour of the facility on 10/12/21 and 10/13/21, the surveyor observed the

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A 311	Continued From page 10 following: a. Presence of two portable heaters in the nurses' station. b. Exhaust/ventilation system that was not consistently functioning when tested in resident bathrooms having no windows which required mechanical ventilation. c. Used [redacted] that were not properly and safely disposed of in a one way Sharps container d. No documented evidence that annual electrical inspections that were consistently conducted within the required time frame. The surveyor interviewed the Director of Maintenance on 10/12/21 and 10/13/21, who informed the surveyor that the last inspection had been conducted in 2018. 5. The facility had no Administrator/ED or designee to enter and maintain a current and accurate record of its residents, including residents' admissions and discharges with their discharge destinations. On 10/6/21 and 10/7/2, neither the corporate representative, a Human Resources (HR) person nor the scheduler/CHHA, were able to provide the surveyor with the facility register for review . The HR person and the scheduler/CHHA, both told the surveyor on 10/7/21, that they could not locate the register. On 10/7/21, HR and the scheduler/CHHA both confirmed that they had no information on the number of residents discharged from the facility between October 2020 through October 2021. 6. The facility did not have an Administrator/ED or designee to implement and ensure 12 of 12 employees received the minimum required orientation and in-service training on Assisted Living concept, Alzheimer's/Dementia, infection control, abuse, residents' rights, pain management, and emergency procedures, upon	A 311		

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A 311	Continued From page 11 hire and annually thereafter. Review of the 12 employees' files provided on 10/6/21 and 10/7/21, revealed that there were no in-service records included in the employees' personal files. The HR person and the scheduler/CHHA provided copies of in-services provided to the facility nursing staff, including the "Nursing Manual." However, review of the manual provided, revealed that in-services and training included in the manual were specific to nursing staff only and did not include the seven (7) minimum required in-services. 7. The facility had no Administrator/ED or a designee to ensure 12 of 12 employees' personnel files consistently contained the minimum required employment information on record, including their credentials, certifications, employment history, job descriptions, in-services/training and their health record with history and physicals and tuberculosis (TB) tests and screening results. 8. The facility had no Administrator/ED or a designee to ensure that facility policies and procedures were consistently implemented and enforced including the facility's Health Service Plan, RN Assessment, and facility Register.	A 311		
A 547	8:36-5.7(a)(6) General Requirements (a) A policy and procedure manual(s) for the organization and operation of the facility or program shall be developed, implemented, and reviewed at least annually. Each review of the manual(s) shall be documented, and the manual(s) shall be available in the facility or program to representatives of the Department at all times. The manual(s) shall include at least the following:	A 547		

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A 547	Continued From page 12 6. Policies and procedures for the maintenance of personnel records for each employee, including at least his or her name, previous employment, educational background, credentials, license number with effective date and date of expiration (if applicable), certification (if applicable), verification of credentials, records of physical examinations, job description, records of orientation and inservice education, and evaluation of job performance; This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent documents, it was determined that the facility failed to provide documented evidence that policies and procedures for the maintenance of employee records were developed and implemented to include the minimum required employment information and that the employees' information and documents were available to the representatives of the Department of Health (DOH), as evidenced by the following: On 10/5/21 at 11:40 a.m., the surveyor requested a copy of a list of all facility employees and their job titles/positions from the Human Resources (HR) person/representative. At 2:00 p.m., the HR person provided a list of staff employed at the facility. The surveyor randomly selected 12 employees' files from the list of employees provided for review. The surveyor reviewed the 12 employees files provided by the scheduler/Certified Home Health Aide (CHHA) on 10/6/21 and 10/7/21. Review of the 12 employees' files revealed that the	A 547		

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A 547	Continued From page 13	A 547		

minimum required employees' information and documentation was not consistently included on each employee's personal file which included the following:

1. Job description: 9 of 12 had no information of their job responsibilities including the scheduler/CHHA and the Licensed Practical Nurse (LPN) who the HR person identified as the people in charge of the facility on 10/5/21. Other staff members with no documentation of their job responsibilities included the Certified Medication Aides (CMAs) who were administering medications to the residents and were also caregivers with Certified Nurses' Aides (CNA) certification, housekeeper and the activities staff.

2. Certification: 6 of 6 nursing staff indicated in the staffing schedule with Cardio-Pullmonary Resuscitation (CPR) certification did not have a copy of their CPR certification in their files. On 10/7/21, the HR person told the surveyor that they were not aware where copies of the nursing staff CPR certifications were kept.

3. History and Physicals (H&P): 6 of 12 did not have a physician H&Ps in their files.

4. Two step tuberculosis (TB) test, annual, or a screening TB Questionnaire: 6 of 12 did not have information that they were screened or tested for tuberculosis.

5. Orientation: 3 of 3 newly hired employees from 2019-2020 did not have records of their orientation, including required inservices upon employment.

6. Minimum required annual inservices: 12 of 12 employees files did not include documentation that they received the seven mandatory

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A 547	Continued From page 14 inservices on an annual basis, including Assisted Living Concepts, Resident Rights, Infection Control, Abuse and Neglect, Emergency Training, Alzheimer's/Dementia and Pain Management training. On 10/7/21, the HR person told the surveyor that the documents and files provided were the only information/documents available that she could provide at the time.	A 547		
A 693	8:36-7.1(a) Resident Assessments and Care Plans (a) Upon admission, each resident shall receive an initial assessment by a registered professional nurse to determine the resident's needs. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that the facility failed to ensure that an initial assessment was completed by a Registered Nurse (RN) upon admission to determine the immediate care and assistance needed for 2 of 2 newly admitted residents reviewed, Resident [redacted] This deficient practice was evidenced by the following: 1. On 10/6/21 at 9:55 a.m., during the tour of the facility's [redacted] floor [redacted] Unit area, Resident [redacted] was observed seated in a wheelchair in the resident's room. At that time, the surveyor interviewed the resident who stated that he/she just had breakfast. The resident stated that he/she was just admitted to the facility but that the resident could not remember the month. During the interview, Resident [redacted] told the surveyor that he/she experienced occasional pain	A 693		

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A 693	Continued From page 15 of the shoulder and consequently required assistance with dressing as well as assistance with showers, toileting, and transfers from bed to chair and vice versa. Review of the resident's medical record revealed that the resident was admitted to the facility on [redacted] with diagnoses that included, but not limited to, [redacted]). The resident's medical record failed to provide documented evidence of any initial assessments by the RN of the resident's level of care and conditions upon admission in order to develop and implement the necessary interventions to meet the resident's initial needs. 2. On 10/7/21 at 10:30 a.m., the surveyor reviewed Resident's [redacted]s medical record which revealed that the resident was admitted to the facility in [redacted] with diagnoses which included [redacted]. The "General Service Plan" dated [redacted], completed by an RN, indicated that the resident was [redacted] and [redacted]. Further review of the resident's medical record revealed a documentation in the "Nursing Notes" section (NN) written by a Licensed Practical Nurse (LPN) that the resident was admitted to the facility on [redacted]. At 11:30 a.m., the surveyor interviewed the LPN regarding Resident [redacted]'s admission to the facility and inquired if an initial assessment was performed by an RN. The LPN stated that the former RN was aware of the resident's admission but that she was not sure if an assessment had	A 693		

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A 693	Continued From page 16 been completed.	A 693		
A 769	8:36-7.4(c)(3) Resident Assessments and Care Plans (c) Written policies and procedures shall be developed and implemented to ensure, but not be limited to, the following: 3. Notification of the registered professional nurse if there are significant changes in a resident's condition; This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that the facility failed to notify the Registered Nurse (RN) of a resident's change in condition which resulted in a transfer to the hospital for 1 of 11 residents reviewed, Resident [redacted] This deficient practice was evidenced by the following: On 10/5/21 at 1:10 p.m., the surveyor reviewed Resident [redacted]s medical record and according to the "Resident Face Sheet"section of the medical record, the resident was admitted to the facility in [redacted] with medical diagnoses that included [redacted]). Surveyor review of Resident [redacted]'s "General Service Plan" (GSP) updated on [redacted], indicated that the resident was [redacted] to [redacted] and required assistance with Activity of Daily Living (ADLs). A review of the "Nursing Notes" (NN) dated [redacted] [no time], written by a Licensed Practical	A 769		

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A 769	Continued From page 17 Nurse (LPN), documented, "Resident [redacted] complained of chest pain and was transferred to the hospital and admitted with [redacted] However, surveyor review of the resident's medical record revealed that there was no documented evidence that an RN was notified of the resident's change in condition and the need to be transferred to the hospital. During an interview with the above LPN at 12:45 p.m. regarding Resident [redacted], the LPN confirmed that an RN was not notified and that the facility did not have an RN when the resident was transferred to the hospital, The LPN told the surveyor that there was "No one to call."	A 769		
A 781	8:36-7.5(d) Resident Assessments and Care Plans (d) The resident's physician or the physician's designee, that is, another physician or an advanced practice nurse or physician assistant, shall be notified by the licensed professional nurse of any significant changes in the resident's physical or cognitive/mental condition and any intervention by the physician shall be recorded. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that the facility failed to notify a resident's physician of a change in condition which resulted in a transfer to the hospital for 1 of 11 residents reviewed, Resident [redacted] This deficient practice was evidenced by the following: On 10/5/21 at 1:10 p.m., the surveyor reviewed	A 781		

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A 781	Continued From page 18 Resident [redacted] medical record and according to the "Resident Face Sheet," the resident was admitted to the facility in [redacted]0 with medical diagnoses which included [redacted] Surveyor review of Resident [redacted]s "General Service Plan" (GSP) updated on [redacted] indicated that the resident was [redacted] to [redacted] and required assistance with Activity of Daily Living (ADLs). A review of the "Nursing Notes" (NN) dated [redacted] [no time], written by a Licensed Practical Nurse (LPN) documented that Resident [redacted] complained of chest pain. In addition, the LPN documented that the resident was transferred to the hospital and admitted with a [redacted] However, there was no documented evidence that a physician or a physician's designee was notified of the resident's change in condition and the need for transfer to the hospital. There was no documentation by a Registered Nurse (RN) in the resident's medical record, including in the NN section, to indicate that the physician or designee was notified of the resident's [redacted]. There was also no documentation of interventions and instructions given by the physician for the resident's complaint. During a telephone interview with the LPN on 10/6/21 at 12:45 p.m., the LPN responded that the physician had been notified of the resident's complaint of pain and need for transfer to the hospital. However, there was no documented evidence of that communication with the physician in the resident's medical record.	A 781		

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A 891	Continued From page 19	A 891		
A 891	8:36-10.5(a) Dining Services (a) The facility and personnel shall comply with the provisions of N.J.A.C. 8:24, Retail Food Establishments and Food and Beverage Vending Machines Chapter XII of the New Jersey Sanitary Code. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to ensure dietary services were safely provided to residents in accordance with the N.J.A.C. 8:24, Retail Food Establishments and Food and Beverage Vending Machines, Chapter XII of the New Jersey Sanitary Code and N.J.A.C. 8:36, Standards for Licensure of Assisted Living, Comprehensive Personal Care Homes and Assisted Living Programs. This deficient practice placed all residents, a highly susceptible population, at risk for food-borne illnesses. This deficient practice was evidenced by the following: Reference: N.J.A.C. 8:24, Retail Food Establishments and Food and Beverage Vending Machines, Chapter XII of the New Jersey Sanitary Code, " ... N.J.A.C. 8:24-1.5 Definitions	A 891		

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A 891	Continued From page 20 For the purpose of this chapter, the following words, phrases, names and terms shall have the following meanings, unless the context clearly indicates otherwise... Sanitization means the application of cumulative heat or chemicals on cleaned food contact surfaces that, when evaluated for efficacy, is sufficient to yield a reduction of five logs, which is equal to a 99.999% reduction, of representative disease microorganisms of public health importance ... Risk Type 3 Food establishment means any retail food establishment that has an extensive menu which requires the handling of raw ingredients...and prepares and serves potentially hazardous foods including the extensive handling of raw ingredients; and whose primary service population is a highly susceptible population... 8:24-2.1(c) v. Through routine monitoring of solution temperature and exposure time for hot water sanitizing, ...that employees are properly sanitizing cleaned multi-use equipment and utensils before they are used ... 8:24-2.1(c) The person in charge shall ensure the following: 3 ...iii. Through daily oversight of the employees' routine monitoring of the cooking temperatures using appropriate temperature measuring devices properly scaled and calibrated, that employees are properly cooking potentially hazardous food, being particularly careful in cooking those foods known to cause severe foodborne illness and death, such as eggs and comminuted meats ... 8:24-2.4(c) 1. food employees shall wear hair restraints such as hats, hair coverings, or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food ...	A 891		

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A 891	Continued From page 21 8:24-3.2(f) Requirements for receiving temperatures are as follows: 1. Refrigerated, potentially hazardous food shall be at a temperature of 41 degrees Fahrenheit or below when received ... 8:24-3.2(f) 3. Potentially hazardous food that is cooked to safe cooking temperatures and received hot shall be at a temperature of 135 degrees Fahrenheit or above ... 8:24-4.9 Mechanical warewashing Equipment, states, " (a) A warewashing machine shall be provided with an easily accessible and readable data plate affixed to the machine by the manufacturer that indicates the machine's design and operating specifications, including the following: 1. Temperatures required for washing, rinsing, and sanitizing ... (b) Warewashing machine wash and rinse tanks shall be equipped with baffles, curtains, or other means to minimize internal cross contamination of the solutions in wash and rinse tanks. (c) A warewashing machine shall be equipped with a temperature measuring device that indicates the temperature of the water: 1. In each wash and rinse tank ... (h) A warewashing machine and its auxiliary components shall be operated in accordance with the machine's data plate and other manufacturer's... (i) The temperature of the wash solution in spray type warewashers that use hot water to sanitize shall not be less than: 1. For a stationary rack, single temperature machine, 165°F; 2. For a stationary rack, dual temperature machine, 150°F;	A 891		

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A 891	Continued From page 22 3. For a single tank, conveyor, dual temperature machine, 160°F; or 4. For a multi-tank, conveyor, multitemperature machine, 150°F ... (k) In a mechanical operation, the temperature of the fresh hot water sanitizing rinse as it enters the manifold may not be more than 194°F, or less than: 1. For a stationary rack, single temperature machine, 165°F; or 2. For all other machines, 180°F ...." References: Chapter 24, N.J.A.C. 8:24, "Sanitation in Retail Food Establishments and Food and Beverage Vending Machines" 8:24-4.9(k) "In a mechanical operation, the temperature of the fresh hot water sanitizing rinse as it enters the manifold may not be more than 194 degrees Fahrenheit, or less than: 1. For a stationary rack, single temperature machine, 165 degrees Fahrenheit; or 2. For all other machines, 180 degrees Fahrenheit. 8:24-2.1(c) v. "Through routine monitoring of solution temperature and exposure time for hot water sanitizing, ...that employees are properly sanitizing cleaned multi-use equipment and utensils before they are used;" 8:24-3.2(f) "Requirements for receiving temperatures are as follows: 1. Refrigerated, potentially hazardous food shall be at a temperature of 41 degrees Fahrenheit or below when received .... 3. Potentially hazardous food that is cooked to safe cooking temperatures and received hot shall be at a temperature of 135 degrees Fahrenheit or above." 8:24-2.1(c) "The person in charge shall ensure the following: 3 ...iii. Through daily oversight of the employees' routine monitoring of the cooking temperatures using appropriate temperature measuring devices	A 891		

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properly scaled and calibrated, that employees are properly cooking potentially hazardous food, being particularly careful in cooking those foods known to cause severe foodborne illness and death, such as eggs and comminuted meats;" 8:24-2.4(c) 1. " ...food employees shall wear hair restraints such as hats, hair coverings, or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food ...."

1. On 10/5/21 at 10:00 a.m. during the initial tour of the facility kitchen, the surveyor observed the Executive Chef, the Cook, and the dish washer (DW) were not wearing hair restraints. The surveyor observed the Cook without a hair restraint while stirring a pot of food that was being prepared for lunch. Upon surveyor entrance to the facility kitchen, the surveyor requested a hair net or head covering and the Cook informed the surveyor that the facility did not have any hair nets or head coverings. The Cook told the surveyor that she normally wore her Chef hat.

2. At 10:40 a.m., the surveyor asked the DW to explain the procedure for cleaning and sanitizing the facility dishware. The DW explained that the dishes were run through the dish machine and the pots were soaked and washed in the three-compartment sink. The DW continued to inform to the surveyor that the facility had no sanitizing solution left for the dishwasher machine and for the three-compartment sink. No test strips were available to test the concentration of sanitizer in the 3 compartment sink.

On 10/5/21, the surveyor observed that the dishwashing machine had two external thermometers: one on the actual dishwashing machine and an external thermometer from the sanitizing solution company which recorded both

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the wash and rinse cycle water temperatures. The surveyor asked the dishwasher to run the dishwashing machine on the following dates:

a. On 10/5/21 the surveyor observed that the dishwashing machine temperature for the wash cycle was 126 degrees Fahrenheit (F) on the machine thermometer and 124 degrees F on the external thermometer. The surveyor observed the rinse cycle was 183 degrees F on the machine thermometer and the external thermometer read 181 degrees F on the external thermometer.

The surveyor asked the DW what the acceptable wash cycle temperature range should be. The DW informed the surveyor that the wash cycle temperature should be 160 degrees F. The surveyor asked the DW to provide a copy of the logs for the monitoring of dishwashing machine and the three-compartment sink temperature and PH (a measure of the degree of acidity or alkalinity of a solution). The DW informed the surveyor that the facility did not maintain any temperature or chemical sanitizer monitoring or recording logs.

b) On 10/6/21 at 9:40 a.m., the DW was not at the facility and the Dietary Aide ran the dish washing machine for the surveyor. The surveyor observed the wash cycle temperature on the machine thermometer read 102 degrees F and 105 degrees F on the external thermometer. The surveyor observed the rinse cycle temperature on the dishwashing machine's thermometer read 182 degrees F and 182 degrees F on the external thermometer.

The Dietary Aide also informed the surveyor that he did not know where the dishwashing machine or three compartment sink temperature logs were and that there have been no

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documented readings of dishwasher machine water temperature or the three-sink compartment water and PH temperature and chemical concentration.

c) On 10/7/21 at 11:15 a.m., the DW ran the dishwashing machine for the surveyor. The surveyor observed the wash cycle temperature on the machine thermometer and the external thermometer read 126 degrees F. The surveyor observed the rinse cycle on the machine thermometer and the external thermometer read 184 degrees F.

The surveyor observed the manufacture's label on the side of the dish washing machine which displayed two techniques for sanitizing; "Hot Water Sanitizing and Chemical Sanitizing." The DW and the Dietary Aide reiterated that the facility was out of sanitizing solutions. The surveyor observed that the facility used Hot Water Sanitization which according to the manufacture label, the wash temperature should be 160 degrees F and the final rinse temperature should be a minimum of 180 degrees F and a maximum temperature of 194 degrees F.

On 10/8/21 at 2:20 p.m., the surveyor verified with the facility sanitizing solution and external thermometer representative, that the dish washing machine was a high temperature machine and the facility used hot water sanitization.

3. On 10/5/21 at 11:00 a.m., the surveyor observed that Refrigerator #1, Refrigerator #2, Refrigerator #3, and the facility Freezer had no temperature monitoring logs posted. The surveyor asked the cook to provide a copy of the refrigeration logs and the cook informed the surveyor that the facility had logs, but she could

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not find them in order to document the findings.

4. On 10/5/21 at 12:30 p.m., the surveyor asked the Cook if she monitored and recorded prepared food temperatures. The Cook informed the surveyor that the facility had a book to document prepared food temperatures but the book had been missing since the last Food Service Director left the facility approximately 3 weeks prior. The Cook also informed the surveyor that she had taken temperatures of the food but had not documented or recorded the temperatures. The Cook was unable to provide the surveyor with documented evidence of temperature checks for hot or cold prepared food.

On 10/5/21 at 12:45 p.m., the Cook provided the surveyor with a copy of the facility menu. The Cook explained to the surveyor that the facility menu ran in three-week cycles and that the facility was on week three of the menu cycle. Upon surveyor review of the "Week 3 Menu," the menu showed that the facility had served hot and cold meals that consisted of the following potentially hazardous foods: Chicken Salad, Potato Salad, Baked Chicken, Pork Chops, Beef Chili, and Meatloaf, etc...

On 10/5/21 and 10/6/21, the surveyor interviewed the facility Executive Chef (EC) who informed the surveyor that he had only been working in the facility for four days. He informed the surveyor that he had found the blank facility temperature logs but had not yet gotten that far in correcting the concerns in the kitchen.

The facility was unable to provide the surveyor with any documentation for hot and cold food preparation, refrigeration or freezer, and dishwashing and sanitizing temperatures for the following requested dates: 10/5/21, 10/6/21, and

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A 891	Continued From page 27 10/7/21. See tag 8:36-10.5(c)(10)	A 891		
A 913	8:36-10.5(c)(10) Dining Services (c) Meals shall be planned, prepared, and served in accordance with, but not limited to, the following: 10. All meals shall be served at the proper temperature and shall be attractive when served to residents. Place settings and condiments shall be appropriate to the meal; This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and in accordance with New Jersey Administrative Code (N.J.A.C.) 8:24, it was determined that the facility failed to ensure meals were served at the proper temperature to remain palatable and prevent the risk of foodborne illnesses, placing all residents at risk. This deficient practice was evidenced by the following: Reference: 8:24-3.2(f) "3. Potentially hazardous food that is cooked to safe cooking temperatures, and received hot shall be at a temperature of 135 degrees Fahrenheit or above." 1. On 10/6/21 at 11:40 a.m., the surveyor observed the facility Cook prepare food to be transported to the Assisted Living dining area. The surveyor further observed that the residents were being served meatloaf, mashed potatoes, and mixed vegetables for lunch. In addition, the	A 913		

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surveyor observed the Cook perform temperature checks prior to the food departing from the kitchen that read the following:

a) The meatloaf temperature was 142 degrees Fahrenheit (F).

b) The mashed potatoes temperature was 158 degrees F.

c) The mixed vegetables were in two metal trays the temperatures were 158 degrees F and 165 degrees F.

On 10/6/21 at 11:50 a.m., the Cook transported the prepared pans of food in an open box cart to the Assisted Living (AL) dining area and placed the pans in an electric steam table where Dietary Aides (DA) were waiting to plate the food for serving. The surveyor observed the following:

a) At 11:55 a.m. the Dietary Aides (DA) #1, #2, and #3 started plating food for residents for meal service in their rooms. While the DA's prepared plates for the residents who would eat in their rooms, the DA's also prepared plates for the residents who entered the dining area. The facility used paper and plastic dishware for room service. The surveyor observed that the plates were wrapped with plastic wrap and placed on an open metal serving cart. During plating, the surveyor asked the DA #1 to prepare a plate for the surveyor the same way that the residents' plates were prepared for room service and place the plate on the serving cart.

b) At 12:00 p.m., the surveyor observed residents entering the dining area who were served on china and silverware.

c) The surveyor observed that the prepared

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plates for room service were sitting on the open metal cart until the residents in the dining area had all been served. Also, the surveyor observed that the DA's did not perform temperature checks on plated food.

2. At 12:20 p.m. on 10/6/21, after surveyor observation of the dining area, the surveyor performed meal pass surveillance with DA #3 as she delivered the lunch trays to AL residents on the [redacted] floor who ate in their rooms. The surveyor observed that DA #3 delivered lunch to [redacted] residents. The surveyor asked DA #3 for the surveyor's plate at 12:38 p.m., 48 minutes after the food had left the kitchen to be served to the residents, which was the same time the last resident received their lunch meal from the open food cart. The surveyor monitored the temperatures on the plated food that read the following:

a) The meatloaf was 94 degrees F

b) The mixed vegetables were 96 degrees F

c) The mashed potatoes were 102 degrees F

On 10/5/21 and 10/6/21, the Cook informed the surveyor that the Dietary Aides plated the food but they did not have a thermometer to check food temperatures.

On 10/6/21, DA #3 informed the surveyor that the food delivered to the residents' rooms was sometimes cold and that she, DA #3, would put the meal in the microwave the meal to warm it up for the residents.

The Executive Chef was not available for interview during the time of the meal pass. However, on 10/6/21 at 2:30 p.m., the Executive

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A 913	Continued From page 30 Chef informed the surveyor that he had not yet organized or started the documentation of food temperatures due to his short time at the facility. 3. On 10/7/21 at 12:45 p.m. the surveyor requested the Resident Council Meeting Minutes for the months of July, August, and September. The Business Manager provided the surveyor with a copy of the Resident Council Minutes which under dietary Dietary for the month of September identified, "Needs Improvement-Food Stinks-Looks Bad ...Everything about the food needs to be changed...." The Business Manager was unable to provide the surveyor with a copy of the resident Council Minutes for July and August. The facility failed to provide a response to the residents' food complaints at the time of the survey. See 8:36-10.5(a)	A 913		
A 937	8:36-11.5(a) Pharmaceutical Services (a) The administration of medications is within the scope of practice and remains the responsibility of the registered professional nurse. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documents, it was determined that the facility's	A 937		

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A 937	Continued From page 31 Registered Nurse (RN) failed to ensure that Certified Medication Aides (CMAs) were evaluated and that each had demonstrated adequate knowledge, skills, and competency when delegated the task of medication administration in accordance with N.J.A.C. (New Jersey Administrative Code) 13:37-6.2, Delegation of Selected Nursing Tasks. The RN failed to consistently observe medication pass to ensure the CMA maintained adequate competency to accurately and safely administer medications to residents for 4 of 4 CMAs reviewed. It was determined the provider's non-compliance with one or more requirements of participation had caused, or was likely to cause, serious injury, harm, impairment, or death to residents. This deficient practice was evidenced by the following: Reference: New Jersey Board of Nursing, N.J.A.C. 13:37-6.2, Delegation of Selected Nursing Task states, " ... a) The registered professional nurse is responsible for the nature and quality of all nursing care including the assessment of the nursing needs ... The registered professional nurse may delegate selected nursing tasks in the implementation of the nursing regimen to licensed practical nurses and ancillary nursing personnel. Ancillary nursing personnel shall include but not be limited to: aides, assistants, attendants and technicians. b) In delegating selected nursing tasks to licensed practical nurses or ancillary nursing personnel, the registered professional nurse shall be responsible for exercising that degree of judgment and knowledge reasonably expected to assure that a proper delegation has been made.	A 937		

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A 937	Continued From page 32 A registered professional nurse may not delegate the performance of a nursing task to persons who have not been adequately prepared by verifiable training and education. No task may be delegated which is within the scope of nursing practice ... c) The registered professional nurse shall be responsible for the proper supervision of licensed practical nurses and ancillary nursing personnel to whom such delegation is made. The degree of supervision exercised over licensed practical nurses and ancillary nursing personnel shall be determined by the registered professional nurse based on an evaluation of all factors including: 1) The condition of the patient; 2) The education, skill and training of the licensed practical nurse and ancillary nursing personnel to whom delegation is being made; 3) The nature of the tasks and the activities being delegated; 4) Supervision may require the direct continuing presence or the intermittent observation, direction and occasional physical presence of a registered professional nurse. In all cases, the registered professional nurse shall be available for on-site supervision ...." 1. Surveyor's review of the Medication Administration Record (MAR) of Resident #6 and Resident [redacted] revealed the following: a. On 10/5/21 at 11:00 a.m., the surveyor reviewed Resident [redacted]s [redacted] MAR and noted "RN WEEKLY MAR ASSESSMENT" printed on the MAR. The surveyor observed that there was no RN signature or initials to indicate that an RN reviewed the MAR. The signature area was left blank. b. The surveyor also reviewed Resident [redacted] MAR for [redacted] and noted that the	A 937		

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signature area was also blank and was not signed off by the RN to indicate a review of the MAR was conducted by the RN.

The surveyor interviewed the Licensed Practical Nurse (LPN) and asked if the facility RN reviewed the MARs on a weekly basis. The LPN responded, "No."

On 10/5/21 at 11:20 a.m., along with the Regional Human Resource (HR) Manager, the surveyor interviewed an RN via the telephone who stated that she was asked to cover the facility for any emergencies and to answer CMAs questions. The RN then stated that she was available to the facility by phone and had never entered the facility.

On 10/5/21 at 12:30 p.m., the surveyor interviewed the LPN who confirmed that the RN was available by phone. In addition, the LPN stated that she transcribed physicians' orders which included new or revised orders onto the MARs that had not been reviewed by an RN.

2. On 10/6/21 at 10:30 a.m., the surveyor reviewed the facility's "Medication Pass Observations Tickler" which revealed that the facility employed four (4) CMAs. This was confirmed upon review of the certified employees list provided by the Regional HR Manager.

The surveyor reviewed the medication pass observation book and noted a form titled, "CMA Quarterly Observation" which revealed that 4 of the 4 CMAs were not consistently observed for medication administration competency by the delegating RN. The surveyor's review of this form (CMA Quarterly Observation) revealed the following:

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A 937	Continued From page 34 a. CMA#1 was observed by the RN on 5/27/20 and 9/1/20 b. CMA#2 was observed by the RN on 10/19/20. c. CMA#3 was observed by the RN 10/26/20. d. CMA#4 was observed by the RN 11/1/20. On 10/6/21 at 11:15 a.m., the surveyor interviewed CMA#1 who stated, "It had been a while since I was last observed by the RN during a medication pass, it was over a year ago."	A 937		
A 939	8:36-11.5(b)(1)(i-ii) Pharmaceutical Services (b) The registered professional nurse may choose to delegate the task of administering medications in accordance with N.J.A.C. 13:37-6.2 to certified medication aides, as defined in this chapter. 1. A unit-of-use/unit dose drug distribution system shall be developed and implemented whenever the administration of medication is delegated by the registered professional nurse to a certified medication aide; i. Over-the-counter (OTC) solid and liquid dosage forms may be dispensed in a non unit-of-use or non unit-dose medication distribution system. ii. Prescription liquid medications (that is, conventional bottles, concentrates) may be dispensed in a non unit-of-use, non unit-dose, or conventional medication distribution system. This REQUIREMENT is not met as evidenced	A 939		

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A 939	Continued From page 35 by: Based on observation, interview and record review, it was determined that the delegating Registered Nurse (RN) failed to ensure that medications administered by Certified Medication Aides (CMAs) were dispensed in a unit of use/unit dose distribution system (where each medication is individually and separately packaged and labeled) for 2 of 4 residents, Resident's [redacted] and [redacted] reviewed for medication administration. This deficient practice was evidenced by the following: 1. On 10/05/21 at 9:50 a.m., the surveyor along with the Licensed Practical Nurse (LPN) inspected the medication cart located on the [redacted] floor. The surveyor observed that Resident [redacted] had prescription medications dispensed in multimode medication bottles which were labeled "[redacted] milligram (mg)" with an instruction to take "one tablet every evening" and a second multimode bottle labeled [redacted] mg" with instructions to take "one tablet by mouth twice daily" stored in the medication cart. Both medications were prescribed to treat [redacted] At that time, the surveyor interviewed the LPN who stated that resident's medications were "administered by a nurse" during the day but at nighttime the CMA administered the [redacted] and [redacted] from the multimode bottles. The surveyor and the LPN confirmed the initials of the CMA on the medication administration record (MAR). The LPN stated that she was aware that medications should be in a unit of use distribution system in order for the CMA to be able to administer the medications. On 10/05/20 at 10:40 a.m., the surveyor reviewed Resident [redacted]'s MAR for the month of [redacted]r [redacted] and observed that the resident received 30	A 939		

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A 939	Continued From page 36 doses of [redacted] and 60 doses of [redacted], of which 11 doses of each medication were documented as administered by the CMA. 2. On 10/6/21 at 9:30 a.m., the surveyor, along with the CMA, inspected the medication cart located on the [redacted]d floor and observed that Resident [redacted] had prescribed medications that were in multimode bottles stored in the medication cart. The CMA explained to the surveyor that she was aware that she should not administer prescription medications from a bottle and that a nurse should have administered the medications. At that time, the CMA confirmed her initials on the MAR dated [redacted], for Resident [redacted] The surveyor reviewed Resident [redacted]'s MAR for [redacted] and observed that the CMA administered [redacted] mg tablet, an anti-diabetes medication. The medication was ordered to be given one tablet by mouth twice daily. Also, the surveyor observed another medication, "[redacted] mg" tablet that had an instruction to give one tablet every 12 hours (used for [redacted]). Both medications were dispensed in multimode bottles. Further review of the MAR on 10/6/21, revealed that the CMA documented and signed both medications as given in the MAR. The CMA administered [redacted] four (4) times out of 13 doses and [redacted] four (4) times out of 13 doses to the resident from the multimode bottles in the medication cart. The RN failed to ensure that the CMAs who were delegated the task of administering medications were only provided a unit of use/unit dose distribution system for medication administration.	A 939		

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A1009	Continued From page 37	A1009		
A1009	8:36-11.7(j) Pharmaceutical Services (j) Needles and syringes shall be stored, used, and disposed of in accordance with N.J.S.A. 26:24-5.10 et seq. N.J.A.C. 8:43E-7, 7:26-3A, 29 CFR 1910.1930, and a record shall be maintained of the purchase, storage, and disposal of needles and syringes. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to properly store and dispose of used needles and syringes on a consistent basis for 2 of 3 medication carts on the second floor as evidenced by the following: On 10/12/2021 and 10/13/2021 in the presence of the Facility Director (FD), the surveyor observed the following syringes with needles that were accessible to Residents, staff or passers by in the following locations: 1. On 10/12/2021 at 9:08 a.m., on the [redacted] floor [redacted] Unit, the surveyor observed a medication cart next to Resident Apartment [redacted] that had a sharps container attached to the cart. The surveyor observed one used [redacted] stored in the drop-down tray but not deposited into the one way container. The Sharps container is a one-way container where syringes can be deposited into it but can not be removed from it. At this time the surveyor requested the FD to get the Licensed Practical Nurse (LPN). When the LPN arrived, the surveyor pointed to the used [redacted] that was lying in the drop-down tray of the Sharps container and the LPN	A1009		

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A1009	Continued From page 38 deposited the [redacted] into the Sharps container where it was no longer retrievable. There were no residents in the area at the time of inspection. 2. On 10/13/2021 at 10:53 a.m., in the presence of the FD, during a tour of the [redacted] floor [redacted] Unit, the surveyor observed a medication cart next to Resident Apartment [redacted] with the Sharps container attached to the cart and with a used [redacted] stored on top of the sharps container. The surveyor again asked the FD to get the LPN. When the LPN arrived, the surveyor asked the LPN, if the [redacted] should be on top of the sharps container. The LPN responded saying "this is not my cart." She then picked up the [redacted] and deposited it into the sharps container. 3. On 10/12/2021 at 11:44 a.m., on the [redacted] floor [redacted] Unit, the surveyor observed the door leading into the Nursing office was propped open 3 inches with a rubber wedge. The surveyor went inside the Nursing office and observed an unlocked medication cart with the following items unlocked, accessible and not stored safely in the bottom drawer of the med cart: - One box of [redacted]. - One bag with [redacted].	A1009		
A1059	8:36-15.5(a)(1) Resident Records (a) A register which contains a current census of all residents, along with other pertinent information, shall be maintained by each assisted living residence, comprehensive personal care home, or assisted living program. The following standards for maintaining the register shall apply:	A1059		

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A1059	Continued From page 39 1. The administrator or the administrator's designee shall make all entries in the register and shall be responsible for its maintenance and safe-keeping This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure that an Administrator/Executive Director or his/her designee entered pertinent resident information, maintained a current resident list/census, and kept the facility register safe and secured at the facility. This deficient practice was evidenced by the following: On 10/5/21 at 9:45 a.m., during an interview with the Licensed Practical Nurse (LPN) and the scheduler/Certified Home Health Aide (CHHA), both told the surveyor that the Administrator and the Registered Nurse (RN)/Director of Nursing (DON) resigned in September, and that they "do not have replacements yet." They stated that a corporate representative, an Human Resource (HR) person was in the building. The surveyor requested a copy of the facility census with a list of residents and their room/apartment numbers from the LPN and the scheduler At 10:15 a.m., the scheduler/CHHA provided the surveyor a copy of a list with residents' names and their apartment numbers. The surveyor conducted a tour of the facility	A1059		

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A1059	Continued From page 40	A1059		

between 10:20 a.m.- 11:30 a.m. that revealed that the facility-provided census list with residents' names and room numbers was not current and had not been updated. The list did not include two residents, Resident [redacted] (admitted to the facility on [redacted] and a resident who was not included in the survey's resident sample. "Vacant" was identified next to the two residents' apartment numbers on the resident census list.

On 10/6/21 at 11:00 a.m., the surveyor requested the HR person provide documented evidence of a facility register that included the facility admissions and discharges. The HR person told the surveyor that she would ask the scheduler and the LPN for the register. At 1:30 p.m., two and a half hours after the initial request, the surveyor interviewed the scheduler/CHHA and asked if she was aware of where the facility kept its register. She told the surveyor that she was not aware where it was kept and stated that she "did not think that there was one."

On 10/7/21 at 11:30 a.m., the surveyor asked the HR person if the facility maintained a register and she replied, "No."

At 2:00 p.m., at the nurses' station, the scheduler/CHHA told the surveyor that they were not able to locate the register, but that they would try to provide the surveyor's requested information, including the number of admissions, discharges, and deaths for the year [redacted]. At 2:50 p.m., the scheduler/CHHA and the HR person provided the surveyor with the number of admissions and deaths for the year [redacted] However, there was no information on the number of residents discharged from the facility. The HR person told the surveyor that they were unable to locate where the record with the number of residents discharged from the facility

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A1059	Continued From page 41 was kept.	A1059		
A1071	8:36-15.6(a)(4) Resident Records (a) Each resident's record shall include at least the following: 4. A copy of the resident's general service plan and/or health service plan, if applicable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to provide documented evidence that a general service plan (GSP) and a health service plan (HSP) was maintained and kept in the resident's record for 1 of 6 residents reviewed for service plans, Resident [redacted] This deficient practice was evidenced by the following:z On 10/6/21 at 9:55 a.m., during the tour of the facility's [redacted] Unit, Resident [redacted] was observed in a wheelchair in the resident's room. The surveyor interviewed Resident [redacted] who recalled just having been admitted to the facility but could not remember the current month. Resident [redacted] told the surveyor that he/she ate slowly and that the food had to be chopped to ease [redacted]. Resident [redacted] also stated that occasionally the resident experienced [redacted] n of the [redacted] r. The resident told the surveyor that because of this [redacted], the resident needed assistance with dressing, as well as assistance with showers, toileting, and transfers	A1071		

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A1071	Continued From page 42 from bed to chair and vice versa. On 10/6/21, the surveyor reviewed Resident [redacted] medical record which revealed that the resident was admitted to the facility on [redacted] with diagnoses that included, but not limited to, [redacted] Resident [redacted]s medical record contained a prescriber's order dated [redacted] for a physical therapist (PT) to evaluate and treat the resident and a speech therapist (ST) order dated [redacted] to evaluate and treat the resident's [redacted] Further review of the resident's medical record revealed no documented evidence of a GSP to address the care needs of the resident with regard to Resident [redacted]s activities of daily living (ADL), including assistance with showering, toileting, and transfer needs. Additionally, Resident [redacted]s medical record did not contain documentation of an [redacted] for the treatment and therapies ordered for the resident in accordance with the prescriber's orders for physical therapy and speech therapy. On 10/6/21 at 10:25 a.m., the surveyor interviewed the License Practical Nurse (LPN) at the nurses' station of the secured unit and asked for Resident [redacted]. The LPN pointed to the binders on top of a cabinet inside the nurses' station and told the surveyor that HSPs were kept there. Inside one of the binders the surveyor observed a two page list of residents receiving physical therapy including Resident [redacted] One of	A1071		

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A1071	Continued From page 43 the two pages indicated that services provided to the resident included PT, ST, and Occupational therapy (OT) and that the resident was discharge from therapy on [redacted]. The other page identified that Resident [redacted] received PT only on [redacted] with no discharge date. The facility failed to ensure that a GSP and HSP had been developed for Resident [redacted] and that documentation of these plans were kept and maintained as part of the resident's medical record to ensure that the facility was providing appropriate healthcare services and assistance to meet the resident's needs and in accordance with prescriber's orders.	A1071		
A1089	8:36-16.3(b) Physical Plant (b) Means of ventilation shall be provided for every bathroom or water closet (toilet) compartment. Ventilation shall be provided either by a window with an openable area or by mechanical ventilation. This REQUIREMENT is not met as evidenced by: Based on observation and interview on 10/12/2021, it was determined the facility failed to consistently ensure that ventilation was present and functioning properly in the bathrooms of 3 of 6 resident apartment bathrooms that did not have	A1089		

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A1089	Continued From page 44 a window to the outside. This deficient practice was evidenced by the following: During the tour of the building on 10/12/21, starting at 11:14 a.m., in the presence of the Facility Director (FD), the surveyor inspected six (6) resident apartment bathrooms. The surveyor observed that when tested by placing a piece of single ply tissue paper across the 6 inch by 6 inch exhaust grills, three (3) residents' bathroom exhaust systems did not function properly in the following locations: 1. At 12:47 p.m., in the bathroom of Resident Apartment [redacted] 2. At 12:50 p.m., in the bathroom of Resident Apartment [redacted] 3. At 1:04 p.m., in the bathroom of Resident Apartment [redacted] The surveyor interviewed the FD, who confirmed that the bathroom exhaust systems were not working properly. These bathrooms had no windows with an area that would open and vent to the outside and relied solely on mechanical ventilation. All apartments were occupied by residents at the time of survey.	A1089		
A1225	8:36-17.3(b)(8)(i-ii) Housekeeping-Sanitation-Safety-Maintenance (b) The following safety conditions shall be met: 8. An electrician licensed in accordance with N.J.A.C. 13:31 shall annually inspect and provide a written statement that the electrical circuits and wiring in the facility are satisfactory	A1225		

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A1225	Continued From page 45 and in safe condition; i. The written statement shall include the date of inspection, and shall indicate that circuits are not overloaded, that all wiring and permanent fixtures are in safe condition, and that all portable electrical appliances, including lamps, are Underwriters Laboratories (U.L.) approved; and ii. The written statement shall be available for review by the Department during survey. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documents on 10/12/2021, it was determined that the facility failed to ensure that a Licensed Electrician conducted an annual inspection of the facility to ensure that wiring in the facility remained in safe condition for the health and safety of all its residents. The evidence of this deficient practice includes the following: During the survey entrance conference on 10/12/21 at 8:49 a.m., the surveyor asked the Facility Director (FD) to provide the completed copy of the "Affidavit of Compliance Physical Environment" (ACPE) sheet (page 5) for review. Later, the surveyor reviewed the ACPE dated 10/5/2021 which was completed and signed by	A1225		

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A1225	Continued From page 46 the FD, and identified that the last annual electrical inspection performed at the facility was in 3/2018. At 9:48 a.m., the surveyor asked the FD if an electrical inspection had been conducted since 3/2018. The FD told the surveyor that there had not been any electrical inspection since then (3/2018), over three and one-half years ago. Electrical circuits and wiring are required to be inspected annually by a licensed electrician in accordance with this state regulation, N.J.A.C. 8:36-17.3(b)(8)(i-ii).	A1225		
A1233	8:36-17.5(a)(2) Housekeeping-Sanitation-Safety-Maintenance (a) The heating and air conditioning system shall be adequate to maintain the required temperature in all areas used by residents. Residents may have individually controlled thermostats in residential units in order to maintain temperatures at their own comfort level. 2. The facility or residents shall not utilize portable heaters. This REQUIREMENT is not met as evidenced by: Based on observation and interview on 10/12/2021 in the presence of facility management, it was determined that the facility failed to prohibit the use of portable electric heaters at the facility. This deficient practice was evidenced by the following:	A1233		

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A1233	Continued From page 47 During the building tour starting at 11:14 a.m., in the presence of the Facility Director (FD), the surveyor inspected six (6) Resident apartments, offices, common areas of the [redacted] floor and the kitchen. During the tour, the surveyor observed two (2) portable electric heaters in the following locations: 1. The surveyor inspected inside the [redacted] Nursing office and observed one [redacted] portable electric heater under one desk that was plugged into an electrical outlet and turned to the "On" position. 2. The surveyor also observed one portable electric heater under a second desk that was plugged into an electrical outlet. The surveyor then asked the FD if those were electric heaters, referring to the portable heaters under the two desks in the office. The FD confirmed that those were both electric heaters. These were fire safety hazards.	A1233		
A1249	8:36-17.7 Housekeeping-Sanitation-Safety-Maintenance The building and grounds shall be well maintained at all times. The interior and exterior of the building shall be kept in good condition to ensure an attractive appearance, provide a pleasant atmosphere, and safeguard against deterioration. The building and grounds shall be kept free from fire hazards and other hazards to resident's health and safety.	A1249		

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A1249	Continued From page 48 This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to maintain 9 of 25 battery back up emergency lights, battery back up exit signs, and battery back up combination emergency light/illuminated exit signs in proper working condition. The evidence includes the following: During the survey entrance conference with the Facility Director (FD) at 8:49 a.m., the surveyor asked the FD if the facility had an emergency generator and if the facility relied on battery back up for emergency lights and for Illuminated exit signs. The FD told the surveyor that they do not have a generator, but that they have battery back up for the exit signs and emergency lights. The FD also told the surveyor that there were four (4) or five (5) emergency lights that were out and not working, and that they were waiting on an order for batteries. The surveyor then requested the FD to provide a copy of the purchase order for review. At 11:14 a.m. on 10/12/21, the surveyor started the tour of the facility in the presence of the RFD. During the tour, the surveyor observed some battery-back up emergency lights and battery-back up illuminated exit signs that failed to function properly in the following locations: On the [redacted] floor [redacted]" Unit 1. At 11:41 a.m., one battery back up emergency light above the double smoke doors next to Resident apartment [redacted] 2. At 12:10 p.m., one battery back up emergency light above the double smoke doors next to	A1249		

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A1249	Continued From page 49 Resident apartment [redacted] 3. At 12:12 p.m., one battery back up emergency light above the double smoke doors next to Resident apartment [redacted] On the [redacted] floor [redacted] Unit 4. At 12:21 p.m., one combination battery back up emergency light/ Illuminated exit sign above the double security doors in the [redacted] dining room leading to the main entrance/ lobby area. 5. At 12:26 p.m.,, one battery back up emergency light in the Activity office. 6. At 12:29 p.m., one battery back up emergency light next to Resident apartment [redacted]. 7. At 12:37 p.m., one combination battery back up emergency light/ Illuminated exit sign above the exit access door leading out to the [redacted] units [redacted]. 8. At 12:51 p.m., one battery back up emergency light in the center of the corridor Resident apartment [redacted] 9. At 12:53 p.m., one battery back up illuminated exit sign above the exit discharge door next to Resident apartment [redacted] Fire and safety hazards.	A1249		
A1273	8:36-18.1(b) Infection Prevention and Control Services (b) The licensed professional nurse, in coordination with the administrator, shall be responsible for the direction, provision, and quality of infection prevention and control services. The health care services director, in coordination with the administrator, shall be responsible for, but not limited to, developing and maintaining written objectives, a policy and procedure manual, and an organizational plan for the infection prevention and control service.	A1273		

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A1273	Continued From page 50	A1273		

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, it was determined that the facility failed to ensure that a Registered Nurse (RN) coordinated with the facility Administrator/Executive Director (ED) in the provision and implementation of a safe and quality infection control services throughout the facility. The facility did not ensure that a qualified Infection Control Preventionist (ICP) was contracted and/or retained to provide an on-site management of the facility's Infection Prevention and Control (IPC) program and at least perform infection surveillance, competency-based training of staff and audits of adherence to the recommended infection prevention and control practices, in accordance with the Executive Directives 020-026 and the Senate No 2798, State of New Jersey 219th Legislature.

It was determined the provider's non-compliance with one or more requirements of participation had caused, or was likely to cause, serious injury, harm, impairment, or death to residents.

This was evidenced by the following:

References:
A. Executive Directive No. 020-026 states, "
...The provisions in this Directive apply to all residential healthcare facilities Long-Term Care Facilities, Assisted Living Residences, Comprehensive Personal Care Homes,

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A1273	Continued From page 51 Residential Health Care Facilities, and Dementia Care Homes (collectively 'LTCFs' or 'facilities'); as defined in N.J.S.A. 26:2H-12.872 ; and N.J.A.C. 8:43, N.J.A.C. 8:39, N.J.A.C. 8:36 and N.J.A.C. 8:37 ... II. Required Core Practices for Infection Prevention and Control. 1. Regardless of a facility's current reopening phase, core infection prevention and control practices must be in place at all times. Maintaining core infection prevention and control practices is key to preventing and containing outbreaks and is crucial in ensuring the delivery of quality, safe care ... ii. All facilities, except for facilities with ventilator-dependent residents, are required to have one or more individuals with training in infection prevention and control employed or contracted on a full-time basis or part-time basis to provide on-site management of the Infection Prevention and Control (IPC) program. The requirements of this Directive may be fulfilled by: a. An individual certified by the Certification Board of Infection Control and Epidemiology or meets the requirements under N.J.A.C. 8:39-20.2; b. A physician who has completed an infectious disease fellowship; c. A healthcare professional licensed and in good standing by the State of New Jersey, with five (5) or more years of infection control experience... iii. The facility's designated individual(s) with training in infection prevention and control shall assess the facility's IPC program by conducting internal quality improvement audits ...." B. Senate No. 2798 State of New Jersey 219th Legislature [Fourth Print) Introduced on August 3, 2020, requires and states, " ... f (1) An infection preventionist assigned to a long term care facility's infection prevention and control committee pursuant to subsection e. of this section shall be a managerial employee and	A1273		

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A1273	Continued From page 52 shall be employed at least part-time at a long-term care facility with a licensed bed capacity equal to 100 beds or less or full-time at a long-term care facility with a licensed bed capacity equal to 101 beds or more and shall be employed: (a) in the case of a long-term care facility with a licensed bed capacity equal to 100 or fewer beds, on at least a part time basis ... {1} The department shall require each assisted living facility to establish an infection prevention and control committee and assign ... an individual designated as the infection preventionist who is a licensed health care provider and who possesses five years of experience in infection control, or an individual who has successfully completed an online infection prevention course through the federal Centers for Disease Control and Prevention or the American Health Care Association course with a valid certificate ... (2) The infection preventionist shall report directly to the administrator of the assisted living facility and shall provide the administrator quarterly reports detailing the effectiveness of the assisted living facility's infection prevention policies. (3) The infection preventionist shall be responsible for: (a) contributing to the development of policies, procedures, and a training curriculum for assisted living facility staff based on best practices and clinical expertise; (b) monitoring the implementation of infection prevention and control policies and recommending disciplinary measures for staff who routinely violate those policies; {c) assessing the facility's infection prevention at such intervals as determined by the Department. An assisted living facility that is unable to hire an infection preventionist on a full-time or part-time basis may contract with an infection preventionist on a consultative basis until October 1, 2021 ...	A1273		

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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) COMPLETE DATE
A1273	Continued From page 53 February 1, 2022 ...." This was evidenced by the following: 1. On 10/5/21, 10/6/21 and 10/7/21, throughout the survey, the surveyors observed that the facility did not consistently have a person to instruct, monitor and screen staff and visitors upon entering the facility. The surveyors observed that the facility reception desk had blank screening forms that were to be filled out by staff and visitors upon entering the facility. Also observed was a digital thermometer scanner secured to a wall across from the reception desk and on the side wall by the facility's main door entrance for temperature check prior to entering the facility. On 10/5/21 at 10:20 a.m., the scheduler/CHHA told the surveyor that she was designated to be at the reception desk to unlock and allow visitors in, check and instruct visitors to check their temperatures using the thermometer scanner on the wall and to have them fill out the screening form. She also stated that due to insufficient staff, she was not able to consistently stay in the reception area to ensure proper screening and monitoring of people entering the facility. On 10/6/21, when the surveyor asked who was in-charge of the infection control monitoring at the facility, the HR person replied that it was the former DON/RN. The surveyor asked if the former DON/RN had infection control certification to which she responded, "yes." The HR representative was unable to locate and provide a copy of the former DON/RN ICP certification. The surveyor then asked the HR person if the facility hired another ICP, after the former DON/RN left employment on 9/20/21 for which she responded, "no."	A1273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	j6tdgc	A. BUILDING: _____ B. WING _____	10/13/2021

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A1273	Continued From page 54 2. On 10/12/2021 at 9:08 AM on the [redacted] floor [redacted] Unit, the surveyor observed a medication cart next to Resident apartment [redacted] that had a sharps container attached to the cart with one [redacted] with an attached [redacted] stored in the drop down tray but not deposited into the one way container. The Sharps container is a one-way container where [redacted] can be deposited into it but cannot be removed from it. At this time the surveyor requested the FD to get the Licensed Practical Nurse (LPN). When the LPN arrived, the surveyor pointed to the [redacted] that was lying in the drop down tray of the Sharps Container and the LPN deposited the [redacted]e into the sharps container where it was no longer retrievable. 3. On 10/13/2021 in the presence of the FD during a tour of the [redacted] unit at 10:53 AM, the surveyor observed a medication cart next to Resident apartment [redacted] with a sharps container attached to the cart with a used [redacted] with an attached [redacted] stored on top of the sharps container. The surveyor again asked the FD to get the LPN. When the LPN arrived, the surveyor asked the LPN, if the [redacted] should be on top of the Sharps container. The LPN responded saying "this is not my cart." She then picked up the [redacted] and deposited it into the Sharps container. Residents, visitors and staff did have access to this hallway. The facility failed to have an Infection Control Preventionist to ensure the facility was maintaining infection control practices throughout	A1273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	j6tdgc	A. BUILDING: _____ B. WING _____	10/13/2021

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A1273	Continued From page 55 the facility.	A1273		