New Jersey Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		03A006	B. WING		12/27/2023
				5 710 0005	12/21/2020
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT	E, ZIP CODE	
CAMBRID	GE ENHANCED SENIOR	LIVING	AIN STREET STOWN, NJ 0805	7	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
A 000	Initial Comments		A 000		
	Initial Comments: TYPE OF SURVEY: COVID 19 CENSUS: 51	Focused Infection Control			
	SAMPLE SIZE: 3				
	was conducted by the 12/27/2023. The facil compliance with the N Code 8:36 infection of	lity was found not to be in New Jersey Administrative ontrol regulations standards ted Living Residences, onal Care Homes and ams and Centers for Prevention (CDC)			
A 269	alternate shall be des the absence of the ad administrator or a des available at all times a facility on a full-time b or more licensed beds in facilities that have f	hall be appointed and an ignated in writing to act in iministrator. The signated alternate shall be and shall be on-site at the pasis in facilities that have 60 s, and on a half-time basis fewer than 60 licensed beds, the definition of "full-time" and	A 269		
	This REQUIREMENT	is not met as evidenced			

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

TITLE

(X6) DATE

03/11/24

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SU COMPLE	
			A. BOILDING			
		03A006	B. WING		12/2	7/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CAMBRID	GE ENHANCED SENIOR	LIVING 255 E MAIN	N STREET OWN, NJ 0805	57		
(X4) ID	SUMMARY ST.	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	N I	(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	COMPLETE DATE
A 269	Continued From page) 1	A 269			
	by: Based on interview, a determined that the fa an Alternate Executive writing and available of Executive Director (E was evidenced by the On 12/27/2023 at 10: interviewed the facility member and inquired Admission's staff mer was not available at the surveyor interview with staff member stated the Alternate Executive D Admission's staff mer a telephone call to the	and record review it was acility failed to ensure that the Director was designated in to act in the absence of the D). This deficient practice the following: 03 a.m., the surveyor y's Admission's staff about the facility's ED. The mber stated the facility's ED the time. During continued the facility did not have an Director. In addition, the mber stated she would place the facility's ED to identify the				
	facility's Infection Constated the facility's ED facility and that the facility's Regional Directors who stated she was a Alternate Executive Difacility's RDO stated facility's ED to inquire designated Alternate At 1:47 p.m., the facilifacility's Long Term C (LTC Administrator) a Executive Director. At	rveyor interviewed the activity of the sare facility's Administrator is the facility's Administrator is the facility's Alternate it that time, the surveyor interviewed the sare facility's Administrator is the facility's Alternate in the facility's LTC				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		03A006	B. WING		12/27/	2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	E, ZIP CODE		
CAMBRID	GE ENHANCED SENIOR	LIVING	N STREET TOWN, NJ 0805	7		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
A 269	Director since Februa At 2:40 p.m., the surv LTC Administrator em a signed and dated do Administrator's, "Dutie which did not include Assisted Living facility Director. At 3 p.m., during the surveyor interviewed she was unable to provide New Jersey Department informing the NJDOH Administrator was the Alternate Executive Design and the Signature of the Administrator responsible for, but not the Alternate of the	y's Alternate Executive ry of 2020. eyor reviewed the facility's aployee file which contained ocument that listed the LTC es and Responsibilities", the duty of being the y's Alternate Executive survey exit conference, the the facility RDO who stated oduce the letter sent to the ent of Health (NJDOH) that the facility's LTC exassisted Living facility's pirector. stration or designee shall be of limited to, the following:	A 269	DEL KOLENOTY		
	This REQUIREMENT	is not met as evidenced				

INEW JEIS	ey Department of Flea	iui				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
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		03A006	B. WING		12/2	27/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AF	DRESS, CITY, STA	ATE ZIP CODE		
TVAIVIL OF T	NOVIDER OR GOLT EIER			(TE, 211 00BE		
CAMBRID	GE ENHANCED SENIOR	RLIVING	IN STREET			
		MOORES	TOWN, NJ 080	57		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
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TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI	PRIATE	DATE
				BEI IOIEROT)		
A 310	Continued From page	e 3	A 310			
	Continuou i rom page					
	by:					
	Based on interview, a	and record review it was				
	determined that the fa	acility's Executive Director				
		the implementation, and				
	` '	cility's policy and procedure				
		Response Plan" when staff				
	failed to monitor resid					
		<u> </u>				
	• .	nicable diseases for 3 of 3				
		or COVID-19, Resident #'s 1,				
		, the ED also failed to ensure				
		ere monitored for signs and				
	symptoms of a comm	nunicable disease. This				
	deficient practice was	s evidenced by the following:				
	1. On 12/27/23 at 11:	38 a.m., while conducting a				
		ontrol COVID-19 survey, the				
	Surveyor interviewed					
	_	A), CMA #1, who stated that				
		, temperature, respiration				
	-	ure) were not assessed				
		gardless of whether they				
		sitive for COVID-19. CMA#1				
		were only monitored visually				
	for COVID-19 sympto	oms, and that most				
	residents were asymp	otomatic (did not exhibit				
	COVID-19 symptoms) while testing positive for				
	COVID-19.	,				
	At 12:49 p.m., the Su	rveyor interviewed the				
		ntrol Preventionist (IP) who				
	_	that tested negative or				
		9 were not screened for				
	· ·					
		s, and vital signs were not				
	measured.					
		ed the "Progress Notes"				
	section of the medica	I records (MR) of Resident				
	#'s 1, 2, and 3 and ob	served the following:				
		-				
	2. Resident #1 had a	an admission date of NJEX Order. 2645				

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		03A006	B. WING		12	/27/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
CAMBRID	GE ENHANCED SENIOR	LIVING	AIN STREET			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	STOWN, NJ 08057	PROVIDER'S PLAN OF CO	RRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	COMPLETE DATE
A 310	Continued From page	· 4	A 310			
	and diagnoses which NJ EX Order. 264b1 F documented evidence signs, and symptoms monitored.	urther, there was no e that Resident #1's vitals				
	3. Resident #2 had a and diagnoses which NJ EX Order. 264 Further, the evidence that Resider symptoms of SUEX ORDER. 28	included No ex order 2040, and -b1 nere was no documented				
	4. Resident #3 had an admission date of and diagnoses which included NUEX Order 20401, and NJ EX Order 26401 Further, there was no documented evidence that Resident #3's vital signs, and symptoms of NUEX Order 26401 Were monitored. At 1:00 p.m., the Surveyor conducted an interview with the facility's Regional Director of Operations who stated that residents' vital signs were measured daily.					
	indicated, "5. Our fare policies and procedur monitoring of resident signs of a communication in an outbreak. a. Resileast daily for fever are symptoms of COVD-1 infection. b. During an outbreak transmission levels of	Outbreak Response Plan" icility has implemented es to conduct routine is and staff to rapidly identify able disease that may result sidents are evaluated at and other signs and 9 or acute respiratory infectious disease, the				
		ng may be increased." vey, the facility's staff were				

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	03A006	B. WING		12	/27/2023	
NAME OF PROVIDER OR SUPPLIER CAMBRIDGE ENHANCED SENIOR	LIVING 255 E MAI	DRESS, CITY, STAT N STREET FOWN, NJ 0805				
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
employee COVID-19 s the facility's RDO, IP a RN were unable to pro documented evidence assessing for fever, we documented for COVII residents. 5. On 12/27/23 at 11:5 interviewed the facility (CNA), CNA#1, who s not screened for COVI starting their shift. At 12:01 p.m., during s who stated that she we complete an employee to the start of her shift. At 12:04 p.m., the surv Health Aide (HHA), He was not required to co symptom screening pr At 12:34 p.m., during s facility's IP stated that screened for COVID-1 start of their shifts. The facility's Administr provide the Surveyor we screening logs. 6. On 12/27/23 at 10:4 the Surveyor interview Preventionist (IP) and policies related to Infer	Surveyor with resident or screening logs. Additionally, and Clinical Care Consultant ovide the Surveyor with that vital signs, including ere performed and D positive and negative 18 a.m., the Surveyor 18 Certified Nursing Aide stated that employees are ID-19 symptoms prior to 19 surveyor interview CNA #2 as not instructed to be COVID-19 screening prior 10 certified Nursing Aide stated that employees Home HA #1, who stated that she implete a COVID-19 ior to the start of her shift. 19 surveyor interview, the employees were not 9 symptoms prior to the staff were unable to with COVID-19 employee	A 310				

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NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	•
CAMBRID	GE ENHANCED SENIOR	LIVING	N STREET FOWN, NJ 0809	57	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
A 310	Continued From page	÷ 6	A 310		
	with the facility's Clini Registered Nurse and Operations and again aforementioned polici At 3:00 p.m., during the the facility's IP stated Surveyor the facility's Infection Control polici receive the facility's Clini	d Regional Director of requested the			
A 473	8:36-5.1(g) General F	Requirements	A 473		
	personal care home, shall adhere to applic	g residence, comprehensive or assisted living program able Federal, State, and llations, and requirements.			
	by: Based on interview ardetermined the facility the New Jersey Departacility's Infection Confinection Control Prevention Control Prevention Practice was On 12/27/23 at 10:47	is not met as evidenced and record review it was a failed to retain and provide artment of Health with the atrol Preventionist's (IP) arention credentials. This a evidenced by the following: a.m., and again at 2:24 erviewed the facility's IP and an Control Prevention			

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			D. WING		
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NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE	
CAMBRID	GE ENHANCED SENIOR	LIVING	AIN STREET STOWN, NJ 0805	7	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETE
A 473	Surveyor continued the IP who stated that she her Infection Control. The facility failed to pure dentials of the perase the IP at the time of the person was qualification.	survey exit conference the ne interview with the facility's e would email the Surveyor Prevention credentials. Trovide the Surveyor with son identified by the facility of the survey to show that ied to perform the IP	A 473		
A 511	implement written job all personnel are assi their education, traini in accordance with th This REQUIREMENT	gram shall develop and descriptions to ensure that gned duties based upon ng, and competencies and	A 511		
	determined that the fa written job description implemented to ensur Executive Director (E assigned duties as th	re the facility s Alternate D) was informed of his e Assisted Living Alternate actice was evidenced by the a.m., the Surveyor			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		03A006	B. WING		12	2/27/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	E, ZIP CODE	·	
CAMBRID	GE ENHANCED SENIOR	255 E M	AIN STREET			
CAMBRID	GE ENHANCED SENIOR	MOORE	STOWN, NJ 08057	7		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
A 511	Continued From page	e 8	A 511			
	facility's Admission's s ED was not present in facility's Admission's s facility did not have an At 10:25 a.m., the Su facility's Infection Cor	about the facility's ED. The staff member stated that the in the facility. Further, the staff member stated that the in Alternate ED. In the facility is a stated that the in Alternate ED. In the facility's ED. The facility is a stated that the in Alternate ED. In the facility's ED. The facility is a stated that the interval of the facility is a stated that the				
	At 1:00 p.m., the surveyor interviewed the facility's Regional Director of Operations (RDO) who stated that she was unable to identify the facility's Alternate ED.					
	Long Term Care facili Administrator) as the Alternate ED. At that conducted an intervie	w with the LTC ated that he has been the				
	Administrator's emplo signed and dated doo Administrator's, "Dutie	veyor reviewed the LTC byee file which contained a cument that listed the LTC es and Responsibilities", and bit include the duty of being cility's Alternate ED.				
A 793	8:36-8.2 Nursing Serv	vices	A 793			
	A facility shall have at professional nurse av					
	This REQUIREMENT	is not met as evidenced				

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 255 E MAIN STREET MOORESTOWN, NJ 08957 MIJD CRAPH STATE MIDDRESS MIDRESS MIDDRESS MIDRESS MIDDRESS MIDRESS MIDDRESS MIDDRESS MIDDRESS MIDDRESS MIDDRESS MID	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X: A. BUILDING:		(X3) DATE SURVEY COMPLETED	
CAMBRIDGE ENHANCED SENIOR LIVING X3 10 SUMMARY STATEMENT OF DEFICIENCIES CACAL DEFICIENCY MUST BE PRECEDED BY TILL PREFIX TAG CROSS-REFERENCED TO INCLUDE PROPERTY TAG CROSS-REFERENCED TO INCLUDE PROPERTY TAG CROSS-REFERENCED TO INCLUDE PROPERTY TAG CACAL TAG CONFERENCE PLAN OF CORRECTION BE CARGOS-REFERENCED TO INCLUDE PROPERTY TAG CACAL TAG C			03A006	B. WING		12/27/2023		
CAMBRIDGE ENHANCED SENIOR LIVING MOORESTOWN, NJ 98057	NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE			
A 793 A 793 Continued From page 9 by: Based on interview, and record review it was determined that the facility failed to ensure that a Registered Nurse (RN) was available to the facility at 11 times at 100 mm and that the facility is Director of Nursing (DON). The Admission's staff member and inquired about the facility. The Admission's staff member stated that the facility did not have a DON and that the new DON was supposed to the previous DON transferring to a different facility, and interviewed the facility did not have a Director of Nursing (DON). The Admission's staff member stated that the facility of more previous DoN transferring to a different facility. At 10:47 a.m., the surveyor interviewed the facility's Infection Control Preventionist (IP) who stated that the facility did not have a Director of Nursing (DON) at the time due to the previous DON transferring to a different facility. At 11:32 a.m., the surveyor interviewed the facility's Licensed Practical Nurse (LPN), LPN #1 who stated that the facility's DON transferred to a different facility approximately	CAMBRID	GE ENHANCED SENIOR	LIVING		57			
by: Based on interview, and record review it was determined that the facility failed to ensure that a Registered Nurse (RN) was available to the facility at all times. This deficient practice was evidenced by the following: On 12/27/23 at 10:03 a.m., the Surveyor interviewed the facility's Admission's staff member and inquired about the facility's Director of Nursing (DON). The Admission's staff member stated that the facility did not have a DON and that the new DON was supposed to begin employment with the facility on At 10:47 a.m., the surveyor interviewed the facility's Infection Control Preventionist (IP) who stated that the facility did not have a Director of Nursing (DON) at the time due to the previous DON transferring to a different facility. At 11:32 a.m., the surveyor interviewed the facility's Licensed Practical Nurse (LPN), LPN #1 who stated that the facility BON transferred to a different facility approximately weeks prior to the survey, LPN #1 stated that the facility did not have an RN always available and that the direct care staff would call the Long Term Care facility attached to the Assisted Living facility and request an RN. At 1:00 p.m., the Surveyor interviewed the Regional Director of Operations (RDO) who stated that the facility did not have a DON. The RDO also stated the facility did not have a DON. The RDO also stated the facility did not have a DON for approximately weeks prior to the date of survey. In addition the RDO stated the new DON	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE COMPLETE		
was supposed to start employment on approximately Additionally, the RDO stated that the facility's Executive Director (ED) is	A 793	by: Based on interview, a determined that the fa Registered Nurse (RN facility at all times. Th evidenced by the follo On 12/27/23 at 10:03 interviewed the facility member and inquired of Nursing (DON). Th stated that the facility that the new DON wa employment with the At 10:47 a.m., the sur facility's Infection Cor stated that the facility Nursing (DON) at the DON transferring to a At 11:32 a.m., the sur facility's Licensed Pra who stated that the fa different facility appro to the survey. LPN #1 not have an RN alway direct care staff would facility attached to the request an RN. At 1:00 p.m., the Surv Regional Director of C stated that the facility RDO also stated the for approximately survey. In addition the was supposed to star approximately	and record review it was acility failed to ensure that a N) was available to the his deficient practice was owing: a.m., the Surveyor y's Admission's staff about the facility's Director e Admission's staff member did not have a DON and as supposed to begin facility on the facility on the facility on the facility on the facility. The entrol Preventionist (IP) who did not have a Director of time due to the previous a different facility. The entrol Preventionist (IP) who did not have a Director of time due to the previous a different facility. The entrol Preventionist (IP) who did not have a Director of time due to the previous a different facility. The entrol Preventionist (IP) who did not have a Director of time due to the previous a different facility did yeaks prior a stated that the facility did yeaks and that the did call the Long Term Care and the Assisted Living facility and the preventions (RDO) who did not have a DON. The facility did not have a DON weeks prior to the date of the RDO stated the new DON the employment on Additionally, the RDO	A 793				

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CAMBRID	GE ENHANCED SENIOR	LIVING 255 E MAIN MOOREST	N STREET OWN, NJ 080!	57	
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A 793	Continued From page	: 10	A 793		
	also a RN who was currently working in both titles as the facility's Director of Nursing, and Executive Director, although she was not present in the facility.				
A1299	8:36-18.3(a)(5) Infecti Services	on Prevention and Control	A1299		
	established and imple prevention and contro to, policies and proce 5. Techniques to resident contact, inclu	ad procedures shall be emented regarding infection oil, including, but not limited dures for the following: be used during each adding handwashing before or a resident;			
	by: Based on observation review it was determined.) implement an effect and control program at the spread of the COV ensure staff and visited during an active COV prevent cross contamnon - disposable trays positive for COVID-19 develop and maintain listing (a document the about each case in ar 19 outbreak. This define videnced by the follows.	owing.			
	1. On 12/27/23 at 10:	11 a.m., while conducting a			

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		03A006	В.	WING		12/2	7/2023
NAME OF P	ROVIDER OR SUPPLIER	STF	REET ADDRES	S, CITY, STAT	E, ZIP CODE		
CAMBRID	GE ENHANCED SENIOR	LIVING	E MAIN ST		_		
			ORESTOW	,			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
A1299	Continued From page	: 11	A	1299			
Alzas	Focused Infection Coobserved two mainter Maintenance Director Staff Member (MSM), down a hallway. The was wearing the facial MSM #1 was walking facial mask in place. At 10:31 a.m., the sur MD as he walked down his mask not covering At 10:33 a.m., the Sur MD as he walked down his mask under his micellular device. At 11:08 a.m., the sur Infection Control Previously's staff should vibroughout the facility utilizing a facial mask. At 11:22 a.m., the sur walk down a hallway walk into a room laber utilizing a mask. At 11:41 a.m., the sur who stated he should mask. At that time MS	ntrol survey, the Surveyor nance employees, (MD) and a Maintenance MSM #1 as they walked Surveyor observed that MD all mask under his nose and alongside the MD with no veyor observed the facility's hallway with the facility hallway with the facility hallway with the facility with the facility hallway	s 's	(1233)			
	interview with the faci	lity Certified Nursing Aide stated that employees and					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
03A006		B. WING		12/27/2023		
		LIVING 255 E MAII	N STREET			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETE DATE
A1299	DGE ENHANCED SENIOR LIVING SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		A1299			

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CAMBRIDGE ENHANCED SENIOR	LIVING 255 E MAIN MOOREST	N STREET OWN, NJ 0809	57		
PREFIX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
were served meals or served the chinaware that is returned to the stated that he believed regard to whether or in positive or negative, retray. At 12:56 p.m., the survey a plastic serving room that tested positive placed it on a holding to the kitchen. At 1:15 p.m., the survey who confirmed that the COVID-19 negative replastic serving trays the kitchen after use to be serving trays the kitchen after use to be serving tray tray tray tray tray tray tray tray	o stated that the residents of disposable chinaware but on a plastic serving tray kitchen for sanitizing. DA #1 dd that all residents, without not they were COVID-19 eccived the plastic serving veyor observed CNA #2 ng tray from a residents' ive for COVID-19 and rack to be transferred back eyor interviewed the FSD e COVID-19 positive and esidents were served on that are sent back to the esanitized. 25 a.m., and again at 12:49 erviewed the facility's IP and is line listing for the current of the IP stated that she on the sanity and was not the sanity and was not the state of the sanity and was not the state of the sanity and was not the state of the sanity and was not the sanity a	A1299			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ECONSTRUCTION	(X3) DATE SURVEY COMPLETED				
		03A006	B. WING		12	/27/2023			
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE									
CAMBRID	CAMBRIDGE ENHANCED SENIOR LIVING 255 E MAIN STREET MOORESTOWN, NJ 08057								
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE			
A1299	The Surveyor did not	receive a completed and e listing during the survey.	A1299						

	sey Department of Hea	lth			COMMA	FINOVED
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		03A006	B. WING		12/27/2	2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AC	DRESS, CITY, ST	ATE, ZIP CODE	······	
CAMBRID	GE ENHANCED SENIOR	CHUNG	IN STREET TOWN, NJ 080	957		
(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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE C	(X5) COMPLETE DATE
A 000	Initial Comments		A 000			
	COVID 19	Focused Infection Control				
	CENSUS: 51					
	was conducted by the 12/27/2023. The facil compliance with the N Code 8:36 infection or	lity was found not to be in lew Jersey Administrative ontrol regulations standards ted Living Residences, onal Care Homes and ams and Centers for Prevention (CDC)				
	alternate shall be desi the absence of the ad administrator or a des available at all times a facility on a full-time b or more licensed beds in facilities that have fi in accordance with the "half-time" at N.J.A.C.	hall be appointed and an ignated in writing to act in ministrator. The ignated alternate shall be and shall be on-site at the asis in facilities that have 60 s, and on a half-time basis ewer than 60 licensed beds, a definition of "full-time" and 8:36-1.3.	A 269			
	This REQUIREMENT	is not met as evidenced				

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

TITLE

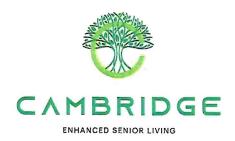
(X6) DATE

STATE FORM

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T6YO11

If continuation sheet 1 of 1

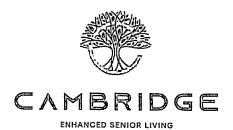


A 269 8:36-3.1(a) Administration

- How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.
 The licensed nursing home administrator is the Alternative Executive Director and this is place as of 12/28/2023.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
 All Residents had the potential to be affected by this deficient practice.
- What measures will be put into place or systemic changes made to ensure that the
 deficient practice will not recur.
 Regional Director of operations educated the Executive Director on ensuring an
 alternative is designated in writing. This will be audited yearly.
- 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes.

The Regional Director of Operations performed a weekly audit for one month and this was completed March 10,2024 to ensure that there will always be a designated alternative to the Executive Director. This will be audited on a yearly and whenever there is a change basis by ensuring the file is up to date.

Completion date January 2, 2024.



A310 A 310 8:36-3.4(a)(1) Administration

- How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.
 Resident #1, 2, and 3 are all currently covid -19 free but were affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
 All residents have the potential to be affected by the deficient practice.
- 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.
 All Nurses, medication technicians and aids were educated on checking vital signs and were trained on the "NJ Outbreak Response Plan" on 2/12/2024. Vitals will be taken as per protocol.

Regional Director of Operations educated Executive Director on "NJ Outbreak Response Plan" on 2/12/24.

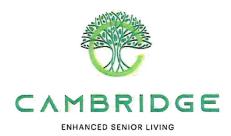
The regional director or designee will audit yearly to ensure the staff and Executive Director is properly trained

4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes.

When there are Covid19 positive residents within the community The Director of Wellness will check with Infection Control Preventionist daily and the Executive Director will audit weekly to ensure the response plan is being effectively followed.

This will be in effect whenever there is a Covid19 outbreak in the community.

Completion date February 12, 2024.

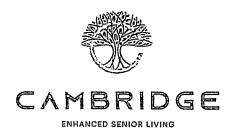


A 473 8:36-5.1(g) General Requirements

- 1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.
 - Acquired the IC credentials and placed in a file and the file is kept in the Excetive Director office.
- 2. How the facility will identify other residents having the potential to be affected by the same deficient practice.
 - All residents have the potential to be affected by the deficient practice.
- 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.
 - Infection Preventionist completed the Northeastern Infection Control Educators course on 12/4/2020. The current Executive Director is certified in the CDC "Nursing Home Infection Prevention Training Course" as an alternative.
 - Regional Director of Operations has educated the Executive Director beginning on Jan2nd one month to on ensure credentials of employees are readily available upon request.
- 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes.
 - Executive Director will audit weekly for 1 month Infection Preventionist's file to ensure credentials are available compliance date March 10th 2024. The executive director will check this yearly.
 - Completion date: January 2nd

A 511 8:36-5.5(a) General Requirements

- 1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.
 - Ensured the alternate executive director received their updated job description and received and it is kept in the employee file of the Alternative Executive Director in writing on 12/28/2023.



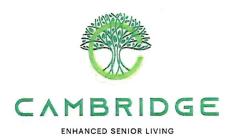
- 2. How the facility will identify other residents having the potential to be affected by the same deficient practice.
 - All residents have the potential to be affected by the deficient practice.
- 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.
 - Regional Director of Operations educated the Executive Director on ensuring an Alternate ED has reviewed and signed the "Duties and responsibilities" job description completed 12/28/2023. Any changes with the alternate Executive Director will be submitted to the Department of Health.
- 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes.

The Executive Director will audit weekly for 1 month the Alternate ED to ensure there is a signed "Duties and Responsibilities" job description on file. Files will be reviewed yearly as needed.

Completion date December 28, 2023.

A 793 8:36-8.2 Nursing Services

- 1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.
 - Staff educated on who the designated RN is and how to contact the RN The facility inservice the staff and posted a memo for all staff noting current designated RN with their name and contact number completed on 12/28/2023.
- 2. How the facility will identify other residents having the potential to be affected by the same deficient practice.
 - All resident had the potential to be affected by the deficient practice.
- 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.



The facility full time Wellness Director, RN, started on 2/12/2024. All staff in-service and a Memo was permanently placed for all staff and residents and family noting the current designated RN with name and contact information.

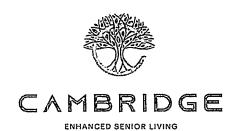
4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes.

Executive Director will audit weekly for one month staff knowledge of who is the current RN covering at the community and how to contact them. Staff educated upon hiring and on a yearly basis.

Completion Date: February 15th 2024.

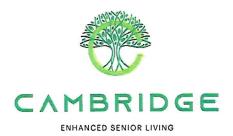
A1299 8:36-18.3(a)(5) Infection Prevention and Control Services

- 1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.
 - a. Alternative Infection Contol Preventist is in place
 - b. Concierge in-service on advising guests and visitors to use face masks
 - c. Dining staff will utilize all disposable items during Covid 19 outbreaks.
 - d. Line list will be maintained during outbreak status.
- 2. How the facility will identify other residents having the potential to be affected by the same deficient practice.
 - a. All residents had the potential to be affected by the deficient practice but the Regional Director of Operations will educate Executive Director on "CDC Guidance Management of Residents with suspected or confirmed actid 19 Infection" policy.
 - Management of Residents with suspected or confirmed covid-19 Infection" policy completed by January 31, 2024.
- 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.
 - Executive Director will educate maintenance, dietary, nursing, activities and administration on "CDC Guidance Management of Residents with suspected or confirmed covid-19 Infection" policy completed by January 31, 2023.
 - a. Infection Control Program will meet during QAPI monthly meetings and address any issues.
 - b. Cross Contamination will be prevented by only taking disposable paper goods into resident rooms during the delivery of meals during a Covid 19 outbreak. Dining staff will be monitored by the Dining Room Director.



- c. Staff, family members, and visitors will be educated and or advised use of PPE during Covid19 outbreak.
- d. Director of Wellness and the Executive Director will verify the proper usage of PPE, and the use of disposable paper goods by doing walk throughs in the community.
- 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes.
 - a. The Infection Control Program will be monitored quarterly by the Executive Director.
 - b. Food Service Director will in-service staff on a as needed basis during the break with findings brought to QAPI.
 - c. The Executive Director will ensure ICP is reviewing protocol with all staff on the proper use of PPE on a quarterly basis.
 - d. Director of Wellness and the Executive Director will verify the proper usage of PPE by doing walk throughs in the community. This will be monitored monthly for the year and increased during Covid 19 Outbreaks. Dining staff will be monitored by the Food Service Director.

Completion Date: January 12, 2024.



- c. Staff, family members, and visitors will be educated and or advised use of PPE during Covid19 outbreak.
- d. Director of Wellness and the Executive Director will verify the proper usage of PPE, and the use of disposable paper goods by doing walk throughs in the community.
- 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes.
 - a. The Infection Control Program will be monitored quarterly by the Executive Director.
 - b. Food Service Director will in-service staff on a as needed basis during the break with findings brought to QAPI.
 - c. The Executive Director will ensure ICP is reviewing protocol with all staff on the proper use of PPE on a quarterly basis.
 - d. Director of Wellness and the Executive Director will verify the proper usage of PPE by doing walk throughs in the community. This will be monitored monthly for the year and increased during Covid 19 Outbreaks. Dining staff will be monitored by the Food Service Director.

Completion Date: January 12, 2024.

STATE FORM: REVISIT REPORT

	O IX LET ORIMINE	VIOIT RELIGIRE		
PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISIT	Ī
IDENTIFICATION NUMBER	A. Building			
03A006 _{Y1}	B. Wing	Y2	4/2/2024	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
CAMBRIDGE ENHANCED SENIO	R LIVING	255 E MAIN STREET		
		MOORESTOWN, NJ 08057		

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	DATE	ITEM		DATE	ITEM		DATE
Y4	Y5	Y4		Y5	Y4		Y5
ID Prefix A0269 Reg. # LSC A0269 8:36-3.1(a)	Correction Completed 01/02/2024	_	310 6-3.4(a)(1)	Correction Completed 02/12/2024	ID Prefix Reg. # LSC	A0473 8:36-5.1(g)	Correction Completed 01/02/2024
ID Prefix A0511 Reg. # 8:36-5.5(a) LSC	Correction Completed 12/28/2023	_	793 6-8.2	Correction Completed 02/15/2024	ID Prefix Reg. # LSC	A1299 8:36-18.3(a)(5)	Correction Completed 01/12/2024
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC		Correction	ID Prefix Reg. # LSC		Correction Completed
ID Prefix Reg. # LSC	Correction	ID Prefix Reg. # LSC		Correction	ID Prefix Reg. # LSC		Correction Completed
ID Prefix Reg. # LSC	Correction	ID Prefix Reg. # LSC		Correction	ID Prefix Reg. # LSC		Correction Completed
REVIEWED BY STATE AGENCY REVIEWED BY CMS RO	REVIEWED BY (INITIALS) REVIEWED BY (INITIALS)	DATE	TITLE	OF SURVEYOR			DATE DATE
FOLLOWUP TO SURVEY COMPLETED ON 12/27/2023		_		ECTED DEFICIENCIES CIES (CMS-2567) SENT			YES NO

Page 1 of 1 EVENT ID: T6YQ12