New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03A006	A. BUILDING: ______ B. WING ______	12/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE ENHANCED SENIOR LIVING	**255 E MAIN STREET MOORESTOWN, NJ 08057**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Initial Comments: TYPE OF SURVEY: Focused Infection Control COVID 19 CENSUS: 51 SAMPLE SIZE: 3 A COVID19 Focused Infection Control Survey was conducted by the State Agency on 12/27/2023. The facility was found not to be in compliance with the New Jersey Administrative Code 8:36 infection control regulations standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19.	A 000		
A 269	8:36-3.1(a) Administration (a) An administrator shall be appointed and an alternate shall be designated in writing to act in the absence of the administrator. The administrator or a designated alternate shall be available at all times and shall be on-site at the facility on a full-time basis in facilities that have 60 or more licensed beds, and on a half-time basis in facilities that have fewer than 60 licensed beds, in accordance with the definition of "full-time" and "half-time" at N.J.A.C. 8:36-1.3. This REQUIREMENT is not met as evidenced	A 269		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 03/11/24

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A 269	Continued From page 1	A 269		

by:
Based on interview, and record review it was determined that the facility failed to ensure that an Alternate Executive Director was designated in writing and available to act in the absence of the Executive Director (ED). This deficient practice was evidenced by the following:

On 12/27/2023 at 10:03 a.m., the surveyor interviewed the facility's Admission's staff member and inquired about the facility's ED. The Admission's staff member stated the facility's ED was not available at the time. During continued surveyor interview with the facility's Admission's staff member stated the facility did not have an Alternate Executive Director. In addition, the Admission's staff member stated she would place a telephone call to the facility's ED to identify the facility's Alternate Executive Director.

At 10:25 a.m., the surveyor interviewed the facility's Infection Control Preventionist (IP) who stated the facility's ED was not present at the facility and that the facility did not have an Alternate Executive Director.

At 1:00 p.m., the surveyor interviewed the facility's Regional Director of Operations (RDO) who stated she was unable to identify the facility's Alternate Executive Director. In addition, the facility's RDO stated she would place a call to the facility's ED to inquire about the facility's designated Alternate Executive Director.

At 1:47 p.m., the facility's RDO introduced the facility's Long Term Care facility's Administrator (LTC Administrator) as the facility's Alternate Executive Director. At that time, the surveyor conducted an interview with the facility's LTC Administrator who stated he has been the

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A 269	Continued From page 2 Assisted Living facility's Alternate Executive Director since February of 2020. At 2:40 p.m., the surveyor reviewed the facility's LTC Administrator employee file which contained a signed and dated document that listed the LTC Administrator's, "Duties and Responsibilities", which did not include the duty of being the Assisted Living facility's Alternate Executive Director. At 3 p.m., during the survey exit conference, the surveyor interviewed the facility RDO who stated she was unable to produce the letter sent to the New Jersey Department of Health (NJDOH) informing the NJDOH that the facility's LTC Administrator was the Assisted Living facility's Alternate Executive Director.	A 269		
A 310	8:36-3.4(a)(1) Administration (a) The administrator or designee shall be responsible for, but not limited to, the following: 1. Ensuring the development, implementation, and enforcement of all policies and procedures, including resident rights; This REQUIREMENT is not met as evidenced	A 310		

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A 310	Continued From page 3	A 310		

by:
Based on interview, and record review it was determined that the facility's Executive Director (ED) failed to ensure the implementation, and enforcement of the facility's policy and procedure titled, "NJ Outbreak Response Plan" when staff failed to monitor residents for signs and symptoms of communicable diseases for 3 of 3 residents reviewed for COVID-19, Resident #'s 1, 2, and 3. Additionally, the ED also failed to ensure that staff members were monitored for signs and symptoms of a communicable disease. This deficient practice was evidenced by the following:

1. On 12/27/23 at 11:38 a.m., while conducting a Focused Infection Control COVID-19 survey, the Surveyor interviewed a facility Certified Medication Aide (CMA), CMA #1, who stated that vital signs (pulse rate, temperature, respiration rate, and blood pressure) were not assessed daily on residents regardless of whether they tested negative or positive for COVID-19. CMA #1 stated that residents were only monitored visually for COVID-19 symptoms, and that most residents were asymptomatic (did not exhibit COVID-19 symptoms) while testing positive for COVID-19.

At 12:49 p.m., the Surveyor interviewed the facility's Infection Control Preventionist (IP) who stated that residents that tested negative or positive for COVID-19 were not screened for COVID-19 symptoms, and vital signs were not measured.

The Surveyor reviewed the "Progress Notes" section of the medical records (MR) of Resident #'s 1, 2, and 3 and observed the following :

2. Resident #1 had an admission date of NJ EX Order. 264b

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A 310	Continued From page 4 and diagnoses which included NJ EX Order. 264b1, and NJ EX Order. 264b1 Further, there was no documented evidence that Resident #1's vitals signs, and symptoms of NJ EX Order. 264b1 were monitored. 3. Resident #2 had an admission date of NJ EX Order. 264b1, and diagnoses which included NJ EX Order. 264b1, and NJ EX Order. 264b1 Further, there was no documented evidence that Resident #2's vital signs and symptoms of NJ EX Order. 264b1 were no monitored. 4. Resident #3 had an admission date of NJ EX Order. 264b1 and diagnoses which included NJ EX Order. 264b1, and NJ EX Order. 264b1 Further, there was no documented evidence that Resident #3's vital signs, and symptoms of NJ EX Order. 264b1 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. Surveyor review of the facility's policy and procedure titled, "NJ Outbreak Response Plan" indicated, "...5. Our facility has implemented policies and procedures to conduct routine monitoring of residents and staff to rapidly identify signs of a communicable disease that may result in an outbreak. a. Residents are evaluated at least daily for fever and other signs and symptoms of COVD-19 or acute respiratory infection. b. During an outbreak or increase in community transmission levels of infectious disease, the frequency of monitoring may be increased." At the time of the survey, the facility's staff were	A 310		

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A 310	Continued From page 5	A 310		

unable to provide the Surveyor with resident or employee COVID-19 screening logs. Additionally, the facility's RDO, IP and Clinical Care Consultant RN were unable to provide the Surveyor with documented evidence that vital signs, including assessing for fever, were performed and documented for COVID positive and negative residents.

5. On 12/27/23 at 11:58 a.m., the Surveyor interviewed the facility's Certified Nursing Aide (CNA), CNA #1, who stated that employees are not screened for COVID-19 symptoms prior to starting their shift.

At 12:01 p.m., during surveyor interview CNA #2 who stated that she was not instructed to complete an employee COVID-19 screening prior to the start of her shift.

At 12:04 p.m., the surveyor interviewed Home Health Aide (HHA), HHA #1, who stated that she was not required to complete a COVID-19 symptom screening prior to the start of her shift.

At 12:34 p.m., during surveyor interview, the facility's IP stated that employees were not screened for COVID-19 symptoms prior to the start of their shifts.

The facility's Administrative staff were unable to provide the Surveyor with COVID-19 employee screening logs.

6. On 12/27/23 at 10:49 a.m., and at 12:34 p.m., the Surveyor interviewed the facility's Infection Preventionist (IP) and requested all facility policies related to Infection Control, COVID 19, COVID 19 vaccination, and Outbreak Response Plan.

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A 310	Continued From page 6 At 1:00 p.m., the Surveyor conducted an interview with the facility's Clinical Care Consultant Registered Nurse and Regional Director of Operations and again requested the aforementioned policies. At 3:00 p.m., during the survey exit conference, the facility's IP stated that she would email the Surveyor the facility's COVID-19 policies, and the Infection Control policy. The surveyor did not receive the facility's COVID-19 policies nor the facility's Infection Control policy during the time of the survey.	A 310		
A 473	8:36-5.1(g) General Requirements (g) The assisted living residence, comprehensive personal care home, or assisted living program shall adhere to applicable Federal, State, and local laws, rules, regulations, and requirements. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to retain and provide the New Jersey Department of Health with the facility's Infection Control Preventionist's (IP) Infection Control Prevention credentials. This deficient practice was evidenced by the following: On 12/27/23 at 10:47 a.m., and again at 2:24 p.m., the Surveyor interviewed the facility's IP and requested her Infection Control Prevention	A 473		

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A 473	Continued From page 7 credentials. At 3 p.m., during the survey exit conference the Surveyor continued the interview with the facility's IP who stated that she would email the Surveyor her Infection Control Prevention credentials. The facility failed to provide the Surveyor with credentials of the person identified by the facility as the IP at the time of the survey to show that the person was qualified to perform the IP position. Reference: Senate, No. 2798 State of New Jersey 219th Legislature	A 473		
A 511	8:36-5.5(a) General Requirements (a) The facility or program shall develop and implement written job descriptions to ensure that all personnel are assigned duties based upon their education, training, and competencies and in accordance with their job descriptions. This REQUIREMENT is not met as evidenced by: Based on interview, and record review it was determined that the facility failed to ensure that a written job description was developed and implemented to ensure the facility's Alternate Executive Director (ED) was informed of his assigned duties as the Assisted Living Alternate ED. 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	A 511		

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A 511	Continued From page 8 member and inquired about the facility's ED. The facility's Admission's staff member stated that the ED was not present in the facility. Further, the facility's Admission's staff member stated that the facility did not have an Alternate ED. At 10:25 a.m., the Surveyor interviewed the facility's Infection Control Preventionist (IP) who stated that the facility did not have an Alternate ED. 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. At 1:47 p.m., the facility's RDO introduced the Long Term Care facility's Administrator (LTC Administrator) as the Assisted Living facility's Alternate ED. At that time, the Surveyor conducted an interview with the LTC Administrator who stated that he has been the Assisted Living facility's Alternate ED since February of 2020. At 2:40 p.m., the Surveyor reviewed the LTC Administrator's employee file which contained a signed and dated document that listed the LTC Administrator's, "Duties and Responsibilities", and observed that it did not include the duty of being the Assisted Living facility's Alternate ED.	A 511		
A 793	8:36-8.2 Nursing Services A facility shall have at least one registered professional nurse available at all times. This REQUIREMENT is not met as evidenced	A 793		

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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 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 NJ EX Order 26. 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 NJ EX Order 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 for approximately NJ EX weeks prior to the date of survey. In addition the RDO stated the new DON was supposed to start employment on approximately NJ EX Order 2 Additionally, the RDO stated that the facility's Executive Director (ED) is	A 793		

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A 793	Continued From page 10 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.	A 793		
A1299	8:36-18.3(a)(5) Infection Prevention and Control Services (a) Written policies and procedures shall be established and implemented regarding infection prevention and control, including, but not limited to, policies and procedures for the following: 5. Techniques to be used during each resident contact, including handwashing before and after caring for a resident; This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record review it was determined that the facility failed to a.) implement an effective infection prevention and control program and techniques to prevent the spread of the COVID-19 virus, b.) failed to ensure staff and visitors utilized facial masks during an active COVID-19 outbreak; c.) failed to prevent cross contamination by serving meals on non - disposable trays to residents that tested positive for COVID-19, and lastly, d.) failed to develop and maintain an accurate COVID-19 line listing (a document that contains key information about each case in an outbreak) during a COVID 19 outbreak. This deficient practice was evidenced by the following. 1. On 12/27/23 at 10:11 a.m., while conducting a	A1299		

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Focused Infection Control survey, the Surveyor observed two maintenance employees, Maintenance Director (MD) and a Maintenance Staff Member (MSM), MSM #1 as they walked down a hallway. The Surveyor observed that MD was wearing the facial mask under his nose and MSM #1 was walking alongside the MD with no facial mask in place.

At 10:31 a.m., the surveyor observed the facility's MD as he walked down the facility's hallway with his mask not covering his nose.

At 10:33 a.m., the Surveyor observed the facility's MD as he walked down the facility's hallway with his mask under his mouth while talking on a cellular device.

At 11:08 a.m., the surveyor interviewed the facility Infection Control Preventionist who stated that the facility's staff should wear facial masks throughout the facility. The IP was observed utilizing a facial mask.

At 11:22 a.m., the surveyor observed MSM #2 walk down a hallway not utilizing a mask.

At 11:28 p.m., the surveyor observed MSM #2 walk into a room labeled, "Electric Room" not utilizing a mask.

At 11:41 a.m., the surveyor interviewed MSM #2 who stated he should have been utilizing a facial mask. At that time MSM #2 removed a mask from his back pocket and stated he would apply the mask to his face.

At 11:51 a.m., the surveyor conducted an interview with the facility Certified Nursing Aide (CNA), CNA #1 who stated that employees and

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A1299	Continued From page 12 visitors are required to wear masks in the facility. CNA #1 was observed utilizing a facial mask. At 12:04 p.m., the surveyor interviewed the facility's Home Health Aide (HHA), HHA #1 who stated that the facility's staff and visitors are instructed to wear facial masks. HHA #1 was observed utilizing a facial mask. At 12:14 p.m., the surveyor observed five kitchen staff employees as they prepared lunch for the facility, none were wearing facial masks. At 12:15 p.m., the surveyor interviewed the facility's Dietary Aide (DA), DA #1 who stated that the kitchen staff were not required to wear facial masks while in the kitchen. At 12:34 p.m., the surveyor interviewed the facility's IP who stated that the staff members in the facility's kitchen should have been utilizing facial masks. At 12:58 p.m., the surveyor observed a vendor Hospice Aide not utilizing a mask while in the NJ EX Order. 264b1 dining area. At 1:00 p.m., the surveyor interviewed the facility's Regional Director of Operations (RDO) who stated that all staff were encouraged to utilize a facial mask. At 1:15 p.m., the surveyor interviewed the facility's Food Service Director (FSD) who stated that kitchen staff were instructed to utilize facial masks when on the floor (in residents' areas) and not while in the kitchen. At the time of the survey the facility had NJ EX residents that were positive for COVID-19.	A1299		

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A1299	Continued From page 13 2. On 12/27/23 at 12:15 p.m., the surveyor interviewed DA #1 who stated that the residents were served meals on disposable chinaware but served the chinaware on a plastic serving tray that is returned to the kitchen for sanitizing. DA #1 stated that he believed that all residents, without regard to whether or not they were COVID-19 positive or negative, received the plastic serving tray. At 12:56 p.m., the surveyor observed CNA #2 remove a plastic serving tray from a residents' room that tested positive for COVID-19 and placed it on a holding rack to be transferred back to the kitchen. At 1:15 p.m., the surveyor interviewed the FSD who confirmed that the COVID-19 positive and COVID-19 negative residents were served on plastic serving trays that are sent back to the kitchen after use to be sanitized. 3. On 12/27/23 at 10:25 a.m., and again at 12:49 p.m., the surveyor interviewed the facility's IP and requested the facility's line listing for the current COVID-19 outbreak. The IP stated that she returned to the facility on NJ EX Order. 264b1, and was not present in the facility during the outbreak. She stated that the line listing did not include the symptoms of the residents and staff members that tested positive during the outbreak. The IP further stated that she assessed every resident who contracted COVID-19, however, she had not completed updating the line listing at that time. At 1:47 p.m., the surveyor interviewed the Long Term Care Administrator who stated the facility's Executive Director made updates to the line listing while working from home.	A1299		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03A006	A. BUILDING: ______ B. WING ______	**12/27/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE ENHANCED SENIOR LIVING	**255 E MAIN STREET MOORESTOWN, NJ 08057**

(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
A1299	Continued From page 14 The Surveyor did not receive a completed and update copy of the line listing during the survey.	A1299		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	03A006	A. BUILDING: ______ B. WING ______	12/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE ENHANCED SENIOR LIVING	255 E MAIN STREET MOORESTOWN, NJ 08057

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Initial Comments: TYPE OF SURVEY: Focused Infection Control COVID 19 CENSUS: 51 SAMPLE SIZE: 3 A COVID19 Focused Infection Control Survey was conducted by the State Agency on 12/27/2023. The facility was found not to be in compliance with the New Jersey Administrative Code 8:36 infection control regulations standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19.	A 000		
A 269	8:36-3.1(a) Administration (a) An administrator shall be appointed and an alternate shall be designated in writing to act in the absence of the administrator. The administrator or a designated alternate shall be available at all times and shall be on-site at the facility on a full-time basis in facilities that have 60 or more licensed beds, and on a half-time basis in facilities that have fewer than 60 licensed beds, in accordance with the definition of "full-time" and "half-time" at N.J.A.C. 8:36-1.3. This REQUIREMENT is not met as evidenced	A 269		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: K Taylor — TITLE: Executive Director — (X6) DATE: 3/20/24

A 269 8:36-3.1(a) Administration

1. 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.

2. 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.

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 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.

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<u>A310 A 310 8:36-3.4(a)(1) Administration</u>

1. 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.

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.
   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.

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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.

<u>A 793 8:36-8.2 Nursing Services</u>

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 in-service 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 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.

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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.

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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

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
03A006	A. Building B. Wing	4/2/2024

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE ENHANCED SENIOR 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 Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0269 Reg. # 8:36-3.1(a) LSC	Correction Completed 01/02/2024	ID Prefix A0310 Reg. # 8:36-3.4(a)(1) LSC	Correction Completed 02/12/2024	ID Prefix A0473 Reg. # 8:36-5.1(g) LSC	Correction Completed 01/02/2024
ID Prefix A0511 Reg. # 8:36-5.5(a) LSC	Correction Completed 12/28/2023	ID Prefix A0793 Reg. # 8:36-8.2 LSC	Correction Completed 02/15/2024	ID Prefix A1299 Reg. # 8:36-18.3(a)(5) LSC	Correction Completed 01/12/2024
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
12/27/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO