STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	030305	A. BUILDING: _____ B. WING _____	09/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE REHABILITATION AND HEALTHCARE C	255 EAST MAIN ST 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
S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. 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 the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interviews and review of other pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios as mandated by the state of New Jersey. This was evident for 18 of 42 shifts reviewed. Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021:	S 560	1. No residents were affected by not meeting the State of NJ minimum staffing requirements 2. All residents could be affected by this area of concern. 3. Recruitment efforts continue to include: a. Job fairs b. Daily staffing meetings c. Sponsored orientees for 45 days toward retention of new hires d. Care Champion mentor program to support retention e. Culture committee to improve and maintain staff morale f. Recruitment bonus and sign-on bonuses offered. 4. To monitor and maintain ongoing	10/9/21

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

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S 560	Continued From page 1 One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties. One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. As per the "Nursing Staffing Report" completed by the facility for the weeks of 8/22/21-8/28/21 and 8/29/21-9/4/21, the staffing to residents' ratios that did not meet the minimum requirement of 1 CNA to 8 residents for the day shift, 10 CNAs for the evening shift, and 14 CNAs for the night shift as documented below: - 8/22/21 had 12 CNAs for 114 residents on the day shift. - 8/23/21 had 11 CNAs for 114 residents on the day shift. - 8/24/21 had 10 CNAs for 114 residents on the day shift. - 8/25/21 had 9 CNAs for 114 residents on the day shift. - 8/26/21 had 12 CNAs for 114 residents on the day shift. - 8/27/21 had 10 CNAs for 114 residents on the day shift. - 8/28/21 had 13 CNAs for 114 residents on the day shift. - 8/29/21 had 9 CNAs for 114 residents on the day shift. - 8/30/21 had 9 CNAs for 113 residents on the	S 560	compliance the DON or designee will monitor staffing daily for 1 week, weekly for 3 weeks and monthly for 2 months. Results will be presented to the QAPI team monthly for continued review and recommendations.	

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S 560	Continued From page 2	S 560		

day shift.
- 8/31/21 had 12 CNAs for 112 residents on the day shift.
- 9/1/21 had 13 CNAs for 112 residents on the day shift.
- 9/2/21 had 10 CNAs for 111 residents on the day shift.
- 9/3/21 had 10 CNAs to 107 residents on the day shift.
- 9/4/21 had 12 CNAs to 107 residents on the day shift.

- 9/2/21 had 7 CNAs to 15 total staff on the evening shift (must be at least ½ CNAs)

- 8/23/21 had 8 total staff for 114 residents on the night shift.
- 8/30/21 had 8 total staff for 113 residents on the night shift.
- 9/4/21 had 8 total staff for 107 residents on the night shift.

During an interview on 09/13/21 at 11:54 AM, CNA#1 stated that he had 15 residents on this day. "We had 6 CNA's scheduled and now we are down to 4."

During an interview on 09/13/21 at 11:59 AM, CNA #2 stated that she had 15 residents in her care on this day, 9 of which are total care.

09/09/21 12:13 PM interview with CNA #3 who said staffing is okay and it depends on a day-to-day basis, it could be up to 16 residents each CNA. She went on to say today she has 10 residents.

During an interview on 9/13/21 at 12:27 PM, the Human Resource/Staffing Coordinator (HR/SC) said that she recruits, interviews, and orients new

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S 560	Continued From page 3 staff and creates the staffing schedules. The HR/SC stated that she is aware of the staffing requirements for CNA's and most of the days we meet the requirements on all three shifts. During the same interview on 9/13/21 at 12:27 PM, the Licensed Nursing Home Administrator (LNHA), and the Regional Director of Operations (RDO) were present. The LNHA and the RDO said they are aware of the minimum staffing ratios requirements. A review of a facility policy titled "Staffing "and dated April 2016 did not include documentation of the required CNA staffing ratios.	S 560		

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F 000	INITIAL COMMENTS STANDARD SURVEY: 9/15/2021 CENSUS: 112 SAMPLE:23 plus 2 closed The facility was not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities. Deficiencies were cited for this survey. In addition a COVID-19 Focused Infection Control Survey was conducted.	F 000		
F 636 SS=B	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being.	F 636		10/9/21

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Electronically Signed | 09/21/2021

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F 636	Continued From page 1 (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the	F 636	1. Resident #103 was not adversely	

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F 636	Continued From page 2 medical record and review of other facility documentation, it was determined that the facility failed to ensure that an accurate Minimum Data Set (MDS), an assessment tool, was completed. This deficient practice was identified for 1 of 23 sampled residents, (Resident). This deficient practice was evidenced by the following: During the initial tour of the Unit on 9/08/21 at 11:03 AM, Resident was observed lying in bed on an A review of the Electronic Medical Record (EMR) revealed Resident 3 was admitted to facility with diagnoses including but not limited to A review of the Admission Nursing Assessment dated , included documentation of . There was no documentation of a . A review of an interim form dated did not include documentation of a . A review of the admission MDS dated revealed under that the Resident has and was present upon admission/entry or reentry. There was no documentation of the on the MDS. A review of a progress note dated at 15:20 (3:20 PM) indicated "called to room by CNA (Certified Nursing Assistant) noted with	F 636	affected by the error in documentation. The admission and quarterly MDS for resident were audited that day and MDS corrections were completed and submitted. 2. No other residents were affected by this error in documentation. 3. MDS staff were educated on accuracy of MDS completion and timing. 4. To monitor and maintain ongoing compliance the regional MDS consultant or designee will audit MDS accuracy weekly for one month and then monthly for 2 months. Results will be presented to the QAPI team monthly for continued review and recommendations.	

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F 636	Continued From page 3 [redacted] noted." A review of Interim [redacted] dated [redacted] indicated new [redacted]. A review of a [redacted] care consult dated [redacted] indicated Resident # [redacted] had a [redacted] on [redacted] A review of a weekly [redacted] progress report dated [redacted], revealed resident [redacted] has facility acquired [redacted] r on the [redacted] A review of a [redacted] care consult dated [redacted], revealed Resident [redacted] had a [redacted] injury. A review of the Quarterly MDS dated [redacted], revealed under [redacted] that the resident has [redacted] that was present on admission/entry or reentry. During an interview with the MDS Coordinator (MDSC) on 9/14/21 at 9:35 AM, she confirmed Resident # [redacted] had [redacted] and no [redacted] according to the Nursing Admission Assessment. The MDSC also confirmed the admission MDS and the [redacted] Quarterly MDS was coded incorrectly. During a follow-up interview on 09/14/21 at 10:43 AM, the MDSC said the resident came in with [redacted] She went on to say that Resident [redacted] day 2 [redacted] check had no [redacted] identified. "The admission MDS should have been coded correctly with the [redacted] and no [redacted]. The quarterly MDS should have indicated that the [redacted] was facility acquired." NJAC 8.39-11.1	F 636		

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F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to handle potentially hazardous food and maintain sanitation in a safe and consistent manner to prevent food borne illness. This deficient practice was evidenced by the following: On 9/8/2021 from 9:14 AM to 10:12 AM the surveyors, accompanied by the Director of Dining Services (DODS) observed the following in the kitchen: 1. During observation of the high temperature dish machine the surveyor observed unidentified debris on the top of the dish machine, on the temperature gauge panel and below the power	F 812	1. No residents were adversely affected by the observed sanitation concerns. The following concerns were immediately corrected: a. Dish machine was cleaned. b. Wet and greasy pans were washed and dried correctly. c. Dishes and bowls were washed and stored in the inverted position and properly covered. d. Dented cans were removed from rack and placed in the designated area for return to vendor. e. Egg carton with broken egg was discarded. f. Freezer floor was cleaned to remove	10/9/21

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F 812	Continued From page 5 and motor switches. Unidentified white, dried, splash type stains were observed on the door of the machine. When interviewed the DODS stated, "It gets cleaned weekly but should be wiped down daily." Review of the facility provided Daily/Weekly Cleaning Schedule for the kitchen revealed that cleaning of the dish machine is not listed as a daily procedure and is delimed on a weekly basis. 2. A stack of approximately 15 cleaned and sanitized sheet pans were on the drying rack and were in the inverted position. The surveyor lifted the top sheet pan and determined that the surface of the pan below was wet and greasy to the touch, generally termed wet nesting (occurs when wet dishes or pots and pans are stacked, preventing them from drying, and creating conditions that are ripe for microorganisms to grow). The surveyor requested the DODS to also touch the sheet pans. The DODS responded, "They are a little wet and greasy." 3. (3) cleaned and sanitized casserole dishes and (4) bowls used to serve resident meals were observed on the drying rack. The 3 plates and 4 bowls were not covered or stored in the inverted position and had the food contact surfaces exposed. On interview the DODS stated, " They need to be covered or inverted when not in use to prevent contamination." 4. On a lower rack of the canned storage rack/cart, (2) cans of [redacted] Cocktail had significant dents on the lower seams. The DODS removed the cans to the designated dented can area and stated. "They must have missed those when they were received."	F 812	any/all debris. g. All food products in the [redacted] pantry were discarded if not properly wrapped and labeled. h. Open box of crackers and opened bag of pretzels were discarded. i. Beverage carafe and clear pitcher were cleaned and dried in the inverted position. j. Plates and plate warmer were cleaned. k. Staff were immediately educated to proper handwashing and food handling procedures 2. All residents could be affected by the observed areas of concern. 3. Kitchen staff received education on the following: a. Dish machine cleaning b. Wet nesting and drying/storage procedures c. Dented cans d. Proper storage and labeling of food e. Freezer cleaning f. Labeling food in pantries, refrigerators, and freezers g. Plates and plate warmer cleaning. h. Handwashing and food handling procedures 4. To monitor and maintain ongoing compliance the Food Service Director, Administrator or Designee will audit the kitchen and perform handwashing surveillance weekly for one month and then monthly for 2 months. Results will be presented to the QAPI team monthly for continued review and recommendations.	

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F 812	Continued From page 6	F 812		

5. In the walk-in refrigerator on a lower shelf, a carton contained shell eggs used for resident meal service. An egg in the carton was broken and the contents of the egg were exposed. The DODS stated, "That must have just happened because we used these eggs this morning for breakfast."

6. During the tour of the walk-in freezer the floor of the freezer was observed to be littered with unidentifiable debris under the food storage racks. The DODS stated on interview, "It gets cleaned weekly or as needed." The surveyor questioned whether this was currently an as needed situation. The DODS stated, "Yes."

On 9/13/2021 from 9:19 to 9:29 AM the surveyor, accompanied by the Certified Nursing Assistant (CNA) observed the following in the [redacted] unit pantry:

1. On a middle shelf in the rear of the pantry refrigerator an unidentified food product wrapped in paper (sub-like) had no name, room number or use by date. When interviewed the CNA stated "That is going to be thrown away. It has no name and no dates. It was just put in there last night though."

On 9/13/2021 from 9:31 to 9:43 AM the surveyor, accompanied by the Assistant Director of Nursing/Infection Control Preventionist (ADON/ICP), observed the following on the Stanwick-Glen unit pantry:

1. In an upper cabinet above the pantry sink the surveyor observed an opened box that contained a sleeve of crackers. The sleeve of crackers was opened, and the crackers were exposed. The top

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F 812	Continued From page 7	F 812		

of the box was also opened and exposed the crackers. The crackers had no use by date, name, or room number. In addition, on the same shelf an opened, individual size bag of whole wheat pretzels was opened, and the pretzels were exposed. The bag had no name, dates, or room number. The ADON stated, "I'm throwing them in the trash."

On 9/14/2021 from 11:20 AM to 12:04 PM the surveyors, accompanied by the DODS observed the following in the kitchen:

1. On an upper shelf of the drying rack 3 cleaned and sanitized beverage carafes and 1 clear plastic beverage pitcher used for residents were not stored in the in the inverted position and were exposed. On interview the Dietary Aide (DA #1) stated, "They were cleaned last night." On interview the DODS stated, "They should be inverted."

2. The surveyor observed the DODS perform handwashing at the designated handwashing sink. The DODS turned on the faucet and wet his hands under running water. The DODS then applied soap and performed vigorous handwashing for 11 seconds by the surveyor's count. The DODS then rinsed their hands under running water and then proceeded to turn off the faucet with his bare hand. The DODS then grabbed a hand towel from the dispenser and dried his hands and threw the hand towel in the waste receptacle beneath the handwashing sink. The DODS provided the surveyor with a copy of the Employee Education Attendance Record with a topic of in-service identified as: 2021 Handwashing Procedure. The DODS signature indicated that he had been in-serviced for

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F 812	Continued From page 8	F 812		

handwashing on 9/13/21.

3. At 11:36 AM during lunch meal preparation DA #2 was observed to open a bag of shredded cheese in preparation for the lunch meal. DA #2 opened the bag of cheese then proceeded to don a single, disposable blue glove. The DA did not perform hand washing prior to donning the disposable glove. DA #2 then proceeded to reach into the bag of shredded cheese with the gloved hand and apply cheese to what appeared to be cheese lasagna. On interview the DODS stated "Staff are to perform handwashing before donning gloves, yes."

4. At 11:50 AM during lunch meal preparation the surveyors observed DA #2, who hadn't performed handwashing, carry two 1/3 pans that contained broccoli. The DA had no gloves and was carrying the two 1/3 pans with his fingers on the internal surface of the pan.

5. The surveyors observed the plate warmer cart prior to the start of the lunch meal. The top of the cart adjacent to the clean and sanitized plates to be used for the resident lunch meal was observed to be covered with a white, unidentified powdery substance. When interviewed the DODS stated,"That should be cleaned prior to loading clean plates in there." The DODS then instructed the cook to remove all plates and wipe the plate warmer cart top surface.

6. The surveyor observed DA #2 perform hand washing at the designated hand washing sink. DA #2 turned on the faucet and wet his hands under running water. DA #2 then applied soap and vigorously washed his hands for 10 seconds by 2 surveyors counts. DA #2 then rinsed his hands

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under the running water and proceeded to turn off the faucet with his bare hands. DA #2 then dried his hands with a paper towel and threw the hand towel in the waste basket below the sink. On interview the DODS stated, "Hand washing should be performed for a minimum of 20 seconds." The surveyor made DODS aware that staff were turning the faucet off with bare hands after performing hand washing. The DODS stated, "Oh, really?"

The surveyor reviewed the facility policy titled Dishwashing Machine Use, undated. The following was revealed under the heading Policy Interpretation and Implementation:
1. The following guidelines will be followed when dishwashing:
j. "After running items through entire cycle, allow to air-dry."
k. "Clean dishwashing machine after each meal."

The surveyor reviewed the facility provided policy titled Handwashing/Hand Hygiene, version 2.3 (H5MAPL0362). The Policy Statement revealed: "This facility considers hand hygiene the primary means to prevent the spread of infection." Under the heading Policy Interpretation and Implementation, the following was revealed:
1. "All personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections."

2. "All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors."

Under the Procedure heading the following was

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revealed:

Washing Hands

1. "Wet hands first with water, then apply an amount of product recommended by the manufacturer to the hands."

2. "Rub hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers."

3. Rinse hands with water and dry thoroughly with a disposable towel.'

4. "Use towel to turn off faucet."

Under the heading Applying and Removing Gloves the following was revealed:

1. "Perform hand hygiene before applying non-sterile gloves."

5. "Perform hand hygiene." (after removing gloves).

The surveyor reviewed the facility titled Dented Cans Policy, undated. The Policy Statement revealed, "All cans must be inspected for dents/damages and place into designated dented can area or discarded."
Under the heading Policy Interpretation and Implementation, the following was revealed:

1. "During delivery, inspect cans for dents, bulges, and dings by visually inspecting and placing hand around the can while rotating all the way around. Discard into waste area or place into dented can area."

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The surveyor reviewed the facility policy titled Preventing Foodborne Illness - Employee Hygiene and Sanitary Practices, undated. The Policy Statement revealed "Food and nutrition services employees will follow appropriate hygiene and sanitary procedures to prevent the spread of foodborne illness." The following was revealed under the heading Policy Interpretation and Implementation:

1. "All employees who handle, prepare or serve food will be trained in the practices of safe food handling and preventing foodborne illness. Employees will demonstrate knowledge and competency in these practices prior to working with food or serving food to the residents."

6. Employees must wash their hands:

a. After personal body functions, (i.e., toileting, blowing/wiping nose, coughing, sneezing, etc.)

b. After using tobacco, eating, or drinking.

c. Whenever entering or re-entering the kitchen.

d. Before coming in contact with any food surfaces.

e. After handling raw meat, poultry, or fish and when switching between working with raw food and working with ready-to-eat food.

f. After handling soiled equipment or utensils.

g. During food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; and or

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F 812	Continued From page 12 h. After engaging in other activities that contaminate the hands. 8. "Contact between food and bare (ungloved) hands is prohibited." 9. "Food service employees will be trained in the proper use of utensils such as tongs, gloves, deli paper and spatulas as tools to prevent foodborne illness." The surveyor reviewed the facility policy titled Foods Brought by Family/Visitors, version 2.0 (H5MAPL0337). The following was revealed under the heading Policy Interpretation and Implementation: 6. Food brought by family/visitors that is left with the resident to consume later will be labeled and stored in a manner that is clearly distinguishable from facility-prepared food. b. Perishable foods must be stored in re-sealable containers with tightly fitting lids in a refrigerator. Containers will be labeled with the resident's name, the item and the "use by" date. 7. The nursing staff will discard perishable foods on or before the "use by" date. 8. The nursing and/or food service staff will discard any foods prepared for the resident that show obvious signs of potential foodborne danger (for example, mold growth, foul odor, past due package expiration dates). N.J.A.C. 8:39-17.2(g)	F 812		

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