STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315479	A. BUILDING _____ B. WING _____	01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT LIVINGSTON	68 PASSAIC AVENUE LIVINGSTON, NJ 07039

(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) COMPLETION DATE
F 000	INITIAL COMMENTS Standard Survey: 1/4/22 Census: 85 Sample Size: 21 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. There were deficiencies cited for this survey. A COVID-19 Focused Infection Control Survey was conducted in conjunction with the recertification survey. The facility was found to be in compliance with 42 CFR §483.80 infection control regulations as it relates to the CMS and Centers for Disease Control and Prevention (CDC) recommended practices for COVID-19.	F 000		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility documents, it was determined that the facility failed to maintain accountability for [redacted] therapy for 1 of 1 resident reviewed for [redacted] care, Resident [redacted] The deficient practice was evidenced by the following:	F 695	It is the practice of the facility to maintain accountability for [redacted] therapy. 1. Resident [redacted] physician was notified, and oxygen orders were reviewed and updated according to [redacted]	1/14/22

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

Electronically Signed | 01/12/2022

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F 695	Continued From page 1 On 12/13/21 at 10:39 AM, the surveyor observed Resident [redacted] sitting in the hallway in a wheelchair by the window looking out. The resident was wearing [redacted]). The surveyor was unable to see the [redacted] on the [redacted]. On 12/14/21 at 10:04 AM, the surveyor observed Resident [redacted] in the doorway of their room, seated in a wheelchair, without the [redacted] on, it was hanging off one ear. The surveyor asked the resident if they needed help putting it on. The resident said "[redacted] On 12/14/21 at 10:19 AM, the surveyor observed the resident sitting in their wheelchair at the end of the hall looking out the French doors to the outside field. The resident was wearing the [redacted] at that time that was attached to the [redacted]. The surveyor asked the Unit Manager/Registered Nurse (UM/RN) to confirm the [redacted] on the [redacted] on the back of the resident's wheelchair. The UM/RN checked it and stated it was set at [redacted]. On 12/14/21 at 10:30 AM, the surveyor reviewed the residents electronic medical record which revealed the following: A current physician's order sheet (POS) that read [redacted]." The start date was [redacted] The [redacted] Electronic Medication Administration Record (EMAR) read [redacted]	F 695	recommendations. 2. Residents in [redacted] have the potential to be affected by this practice. "Baseline audit completed by the Director of Nursing for residents receiving [redacted] therapy including orders. No other residents were affected. 3. Nurses were provided additional education by the Facility Educator and Nursing leadership related to [redacted] therapy. Education included policy review and documentation of [redacted] therapy for [redacted] and [redacted] as needed orders. 4. Director of Nursing (DON) and nursing team will continue to monitor [redacted] administration by conducting weekly audits of five patients that are receiving [redacted] for 4 weeks, then monthly times x 2 months related to [redacted] administration and documentation. The DON will forward the results of the audits to the Administrator for submission and review by the Quality Assurance and Performance Improvement Committee) for review monthly at the Quality Assurance and Performance Improvement. The results of these audits will be submitted monthly by the DON to Quality Assurance and Performance Improvement (QAPI) committee for a period of three months. Upon review, the QAPI Committee will review and determine revisions to the plan if needed.	

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F 695	Continued From page 2	F 695		

[redacted] as needed [redacted] There were no signatures on the EMAR that accounted for the resident's [redacted] usage.

On 12/14/21 at 11:39 AM, the surveyor spoke with the Licensed Practical Nurse (LPN) about the [redacted] for Resident[redacted] and where they accounted for its use. The LPN showed the surveyor the EMAR and stated that it was a PRN (used as needed).

The LPN confirmed that she should have signed for it there. She then proceeded to sign for the [redacted] as being used on [redacted] at 7:30 AM. The LPN said the resident usually wore it when out of bed, and when in bed. She further stated "[The resident] has had it on all morning since I came in." The surveyor asked the LPN if they should have been signing for the [redacted] use. She said yes. She didn't know why it hadn't been signed for. She said it was used for comfort.

On 12/14/21 at 12:11 PM, the surveyor asked the UM/RN if the nurse should have been accounting for the use of the [redacted] by signing the EMAR. She said she wasn't sure if they were supposed to be signing for the [redacted] when used. The UM/RN further stated that the resident usually used the [redacted] when out of bed, not usually when in bed. The surveyor told the UM/RN that the LPN just said the resident wore the [redacted] when in bed and when out of bed. The surveyor asked her how often the resident wore the [redacted] when out of bed. She said she didn't know.

On 12/16/21 at 2:00 PM, the surveyor spoke with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) about the concern with the facility not accounting for the

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F 695	Continued From page 3 use of the [redacted] for Resident [redacted]. On 12/20/21 at 10:38 AM, the LNHA said the facility clarified the [redacted] order for Resident [redacted] with the doctor. He then stated the doctor changed the order to [redacted] instead of as needed. On 12/20/21 at 11:00 AM the surveyor reviewed the facilities Policy and Procedure titled [redacted] Administration." Under "Purpose" it read "The purpose of this procedure is to provide guidelines for safe [redacted] administration." Under "Documentation" it read; "After completing the [redacted] setup or adjustment, the following information should be recorded in the resident's medical record: 1. The date and time the procedure was performed. 2. The name and title of the individual who performed the procedure. 3. The [redacted], route, and rationale. 4. The frequency and duration of the treatment. 5. The reason for p.r.n. administration. 6. All assessment data obtained before, during, and after the procedure. 7. How the resident tolerated the procedure. 8. If the resident refused the procedure, the reason(s) why and the intervention taken. 9. The signature and title of the person recording the data." NJAC 8:39-27.1 (a)	F 695		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the	F 761		1/14/22

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F 761	Continued From page 4 appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to store medication at the appropriate temperature and failed to store controlled substances in a manner that would prevent loss or diversion. This was found with 1 of 2 medication refrigerators inspected. The deficient practice was evidenced by the following: On 12/14/21 at 11:31 AM, the surveyor inspected the Medication refrigerator in the med room on the [redacted] unit with Licensed Practical Nurse #1 (LPN #1). There was an unopened box that contained one single dose pre-filled syringe of [redacted]	F 761	It is the practice of the facility to store medication at the appropriate temperature and failed to store controlled substances in the matter that prevent loss or diversion. Following manufacturer guidelines and providing a permanent affixed compartment for the storage of control drugs. 1.The unopened box that contained one single dose pre-filled syringe of [redacted] was immediately removed and discarded. The patient did not miss any doses of the medication. A permanently affixed locked box was installed in the refrigerator shelves by maintenance the same day. 2.Residents have the potential to be	

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F 761	Continued From page 5 used to treat [redacted]). On the box the storage instructions read: "Store at room temperature 77 degrees Fahrenheit." The temperature in the refrigerator was 42 degrees. LPN #1 confirmed that the Invega should not have been stored in the refrigerator. Further inspection found a locked narcotic box attached to a shelf that was removable. LPN #1 did not have the key to the narcotic box. LPN # 2 opened the narcotic box. Inside of the box was an unopened [redacted] ml bottle of [redacted] (A schedule [redacted]-controlled liquid [redacted] medication). On 12/14/21 at 2:27 PM, the surveyor spoke with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) about the [redacted] which was improperly stored. The DON said the [redacted] that was in the refrigerator was discarded and there was another box of [redacted] in the medication cart they would use. On 12/20/21 at 2:15 PM, the surveyor reviewed the facility's policy and procedure titled "Storage of Medications." Under "Policy Interpretation and Implementation" it read; "1. Drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light, and humidity controls" and "8. Schedule [redacted] controlled medications are stored in separately locked, permanently affixed compartments." NJAC 8:39-29.4 (h)	F 761	affected by this practice. The Director of Nursing (DON) completed a baseline audit for medication carts and medications rooms. No other residents were affected an no other refrigerators were without an affixed locked box. 3.The Facility Educator and nursing leadership provided education on the storage of medications according to manufacturer□s instructions. Education also including notifying maintenance if the lock box inside the refrigerator is not affixed. 4.Director of Nursing and nursing team will continue to monitor medication rooms, medication carts and medication room refrigerators 3 times weekly x4 weeks then monthly times x 2 months. The results of these audits will be submitted monthly by the DON to Quality Assurance and Performance Improvement (QAPI) committee for a period of three months to determine if the problem is resolved and/or stable. The results will be used for training and systems changes though the QAPI committee.	
F 849 SS=D	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following:	F 849		1/14/22

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F 849	Continued From page 6 (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status.	F 849		

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F 849	Continued From page 7	F 849		

(2) Clinical complications that suggest a need to alter the plan of care.
(3) A need to transfer the resident from the facility for any condition.
(4) The resident's death.
(F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.
(G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs.
(H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.
(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.
(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown

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source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.
(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.

§483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.
The designated interdisciplinary team member is responsible for the following:
(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.
(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.
(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians.
(iv) Obtaining the following information from the hospice:

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F 849	Continued From page 9 (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to consistently provide coordination between facility staff and [redacted] agency staff to meet the resident's nursing needs. The deficient practice was identified for 1 of 2 residents (Resident [redacted]) reviewed for [redacted] care and was evidenced by the following. On 12/13/21 at 11:47 AM, the surveyor observed	F 849	It is the practice of the facility to consistently provide coordination between the facility staff and hospice agency staff to meet the residents needs. 1.Resident [redacted] had printed copies delivered to the center. In addition, the electronic medical record (EMR) was adjusted so that documentation could be uploaded to the EMR. 2.Residents receiving [redacted] services	

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F 849	Continued From page 10 Resident [redacted] awake and alert in bed. A review of the resident's hybrid medical record revealed the following information: According to the Admission Record the resident was admitted with diagnoses including but not limited to [redacted]. The 11/30/21 Admission Minimum Data Set assessment tool indicated the resident was cognitively intact as evidenced by a Brief Interview for Mental Status score of [redacted] and was enrolled in a [redacted] program. The [redacted] facility [redacted] care plan included interventions to provide comfort and supportive care and [redacted] staff visitation to provide care, assistance, and evaluations. The resident's paper chart contained a tab for hospice documentation. The [redacted] Care Face Sheet indicated the resident was admitted to the [redacted] program on [redacted] for diagnoses of [redacted] system. A review of the paperwork failed to reveal a [redacted] agency nursing care plan or [redacted] nurse progress notes. A staff sign in sheet located on the resident record indicated [redacted] nurse visits occurred on [redacted] On 12/16/21 at 10:09 AM, the surveyor interviewed the Registered Nurse Unit Manager (RNUM). When asked where the hospice nursing progress notes and hospice care plan were filed, the RNUM replied, "they usually leave	F 849	have the potential to be affected. A baseline audit was completed for hospice patients by the Administrator and no other residents were affected. 3.The Facility Educator and nursing leadership provided education to the nurses on the location of [redacted] progress notes and care plan. The Administrator provided guidance to the Hospice provider related to the submission of documentation for the center□s [redacted] patients. 4.Director of Nursing and the nursing team will continue to monitor [redacted] progress notes and care plans weekly to ensure that they are captured in the medication record. Up to 3 [redacted] patients will be monitored weekly for 4 weeks, then monthly for two months. The results of these audits will be submitted monthly by the DON to Quality Assurance and Performance Improvement (QAPI) committee for a period of three months to determine that the problem is resolved and/or stable. The results will be used for training and systems changes though the QAPI committee.	

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F 849	Continued From page 11 their notes, but I don't see them. I'll get back to you." The RNUM did not provide the notes to the surveyor. On 12/16/21 at 12:09 PM, the facility Administrator provided the surveyor with hospice agency progress notes and care plan which had been sent to the facility by the [redacted] agency several minutes earlier. On 12/21/21 the surveyor reviewed the facility policy for the [redacted] Program, revised 7/2017, provided by the Administrator. The policy indicated the facility will communicate and collaborate with the [redacted] representatives and coordinate care between the facility and the hospice agency. "The most recent [redacted] plan of care specific to each resident" must be obtained by the facility. NJAC 8:39-27.1(a)	F 849		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections	F 880		2/6/22

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	315479	A. BUILDING _____ B. WING _____	01/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT LIVINGSTON	68 PASSAIC AVENUE LIVINGSTON, NJ 07039

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F 880	Continued From page 12	F 880		

and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.

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F 880	Continued From page 13 Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to follow appropriate measures to prevent and control the spread of infection. This deficient practice was observed with 1 of 1 Lab Technician and 1 of 1 dietary aide and was as evidenced by the following: On 12/14/21 at 9:10 AM, the surveyor observed a Lab Technician (LT) enter a resident's room wearing two surgical masks and no eye protection. The LT placed a large bag which contained her supplies on the bed next to the resident. The LT put gloves on her hands with no hand hygiene first and then drew the resident's blood. The LT then took her cell phone out of her pocket with her gloved hand and put it to her face to answer a phone call. The LT placed the phone back into her pocket and removed her gloves. The LT did not perform hand hygiene when she removed her gloves. The LT took the bag of supplies and walked down the hallway to another resident's room. At 9:15 AM, the surveyor observed the LT enter another resident's room, still wearing two surgical masks and no eye protection. The LT put on new gloves without any hand hygiene, grabbed supplies, the LT drew the resident's blood. The LT removed her gloves, and this time did perform hand hygiene with alcohol-based hand rub	F 880	It is the practice of the facility to establish and maintain infection prevention and control program to follow appropriate measures to prevent and control the spread of infections. 1.Lab technician and Dietary Aide were In-service immediately about the appropriate procedure for handwashing, Personal Protective Equipment (PPE) usage, Droplet precautions. Competencies were completed. Director of Nursing and Administrator collaborated with the hospital team members related to any other Lab Technicians who enter the center an guidance was provided related to infection control practices at our center. 2.Residents have the potential to be affected. 3.The Facility Educator and Nursing leadership provided in-services to center staff, vendors, and contractors on Handwashing, PPE Usage and Droplet Precautions. Education included return demonstration for competency of handwashing, PPE donning and doffing for center staff and lab technician. 4.Infection Preventionist will chair a team of facility employees to continue to	

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F 880	Continued From page 14 (ABHR). At 9:22 AM, the surveyor interviewed the LT who stated, "I don't work here, I work with the hospital and I have one more resident's blood to draw." The surveyor asked about hand hygiene before and after wearing gloves, the LT stated that she should have performed hand hygiene before and after wearing gloves and that she forgot. The LT stated that she should not have grabbed her phone with her soiled gloved hands. At 9:50 AM, the surveyor observed the LT enter another resident's room, who was on droplet precautions which was identified with a sign outside the resident's door indicating "Quarantine droplet/contact precautions." There was also Personal Protective Equipment (PPE) outside of the resident's room. The droplet/contact precautions sign indicated that a person entering the room must wear a gown, gloves, N95 respirator mask and eye protection. The surveyor observed the LT put on gloves, gown, a face shield and did not put on a N95, she only had two surgical masks on. The LT entered the resident's room and closed the door and prior to exiting the room the LT removed the gown, gloves and face shield and performed hand hygiene with ABHR. At 10:00 AM, the surveyor interviewed the LT who stated that she is fit tested for a N95 mask but that she did not have the N95 mask with her. The LT stated that she had two surgical masks on and that should be enough to wear into the resident's room who is on droplet/contact precautions. At 10:06 AM, the surveyor discussed the above concerns with Administrator, Director of Nursing (DON) and the Infection Preventionist (IP), who stated that the LT should have performed proper	F 880	monitor handwashing practices, PPE usage and Droplet Precautions guidance by conducting 20 observations a week and weekly infection control rounds for 4 weeks, then monthly for two months. The results of these observations will be submitted monthly by the Infection Preventionist to Quality Assurance and Performance Improvement (QAPI) committee for a period of three months to determine that the problem is resolved and/or stable. The results will be used for training and systems changes though the QAPI committee. 5)Root Cause Analysis (RCA). 1. Employee/Individual: S#1 Laboratory technician (Contract), & S#2 Dietary Aide 2. Factor (s) that contributed to the event/situation: (examples below) Staff # 1. The Laboratory Technician when spoken to, acknowledged that she didnt follow the appropriate procedure for handwashing and PPE Usage. The lab tech was aware of the procedure for droplet precautions, PPE usage and hand washing and demonstrated proper technique when competencies were performed. Staff #2. The Dietary Aide was unsure of the process regarding PPE usage but did recognize the fact that she should have washed her hands upon exiting the residents room. She was receptive to education and demonstrated proper technique when performing a return demonstration and competency.	

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F 880	Continued From page 15 hand hygiene before and after wearing gloves, the LT should not have touched her phone with gloved hands and the LT should have worn a N95 mask when entering a resident's room who is on droplet/contact precautions. At 1:05 PM, the surveyor observed a Dietary Aide (DA) bring a tray of food to a resident's room who was droplet/contact precautions. The DA knocked on the door and entered room with only a surgical mask on, no eye protection, no gown and no gloves. The DA placed the tray on bedside next to resident and asked the resident if there was anything else needed, the DA then exited the room and closed door. There was no observed hand hygiene. At 1:07 PM, the surveyor interviewed the DA, who stated that she does only brings trays into the resident's room when a tray is ordered between mealtimes. The DA stated that she did not think that PPE should have been worn since there is no COVID positive resident in the building. The surveyor pointed out the sign on the resident's door which read droplet/contact precaution wear gown, gloves, eye protection and N95 respirator when entering the room. The DA said that she should have worn all the proper PPE, including eye protection, N95, gown and gloves. The DA also state that she should have cleaned her hands after leaving the room as well. At 1:15 PM, the surveyor interviewed the Licensed Practical Nurse (LPN) who stated that the DA should not have been passing out trays and that the nursing staff are the ones who pass out the trays, the LPN stated that the DA should have worn a N95, gown, gloves and eye protection if entering a resident's room who is on quarantine with droplet/contact precautions.	F 880	3. POC to prevent it from happening again. Training for topline staff included Nursing Home Infection Preventionist Training Course. Module 1 " Infection Prevention & Control Program", Module 5: Outbreaks", Module 7 "Hand Hygiene" Module 6:A- "Principles of Standard Precaution", Module 6:B- "Principles of Transmission Based Precautions" and Module 4: "Infection Surveillance". Infection Preventionist completed Module 1 " Infection Prevention & Control Program", Module 5: Outbreaks", Module 7 "Hand Hygiene" Module 6:A- "Principles of Standard Precaution", Module 6:B- "Principles of Transmission Based Precautions" and Module 4: "Infection Surveillance" and the CDC Videos COVID-19 Prevention Messages for Front Line Long-Term Care Staff. Keep COVID-19 Out!. Line staff were included in the Nursing Home Infection Preventionist Training Course; Module 7 "Hand Hygiene"; Module 6A "Principles of Standard Precautions"; and Module 6B "Principles of Transmission Based Precautions. Frontline staff received also CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff. Keep COVID-19 Out! 4.Staff completed competency paperwork on handwashing and infection control and prevention protocols.	

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F 880	Continued From page 16 At 12/14/21 on 2:15 PM, the surveyor discussed above concerns with Administrator and DON, who stated that the DA should not be passing trays out to residents and that if she had to enter the resident's room, she needed to wear proper PPE. The surveyor reviewed the policy and procedure titled "Handwashing/ Hand Hygiene" which was reviewed 1/20/21. The policy and procedure indicated that hand hygiene is to be performed before and after applying gloves. The surveyor reviewed the stop sign placed on resident's door which was titled "Quarantine Droplet/Contact Precautions." The sign indicated that personnel entering the room must clean hands when entering and exiting, wear gown, N95 respirator, eye protection and gloves. N.J.A.C. 8:39-19.4(a)	F 880		

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	306301	A. BUILDING: _____ B. WING _____	01/04/2022

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S 000	Initial Comments THE FACILITY WAS 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 observation, interview, and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. This deficient practice was evidenced by the following: Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes. Be It Enacted by the Senate and General Assembly of the State of New Jersey: C.30:13-18 Minimum staffing requirements for nursing homes	S 560	It is the practice of maintain the required minimum direct care staff-to-resident ratios as mandated by the State of New Jersey. 1.The facility leadership team has met on an on-going basis and will continue to identify staffing challenges and areas of improvement for certified nursing assistants (C.N.A.). 2.Residents have the potential to be affected. 3.Measures a)The facility has implemented a significant above market rate for C.N.A.	1/14/22

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

Electronically Signed | 01/12/22

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S 560	Continued From page 1 effective 2/1/21. 1. a. Notwithstanding any other staffing requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff -to-resident ratios: (1) one certified nurse aide to every eight residents for the day shift; (2) 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 certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties; and (3) 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 certified nurse aide and perform certified nurse aide duties b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census. c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth place. (2) If the application of the ratios listed in subsection a. of this section results in other than a whole number of direct care staff, including certified nurse aides, for a shift, the number of required direct care staff members shall be rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher. (3) All computations shall be based on the midnight census for the day in which the shift begins.	S 560	which also includes a sign-on bonus when appropriate. b)Recruitment continues to be a focus and interviews are conducted timely and contingency offers are made the same day as the interview. Our onboarding process is being expedited with the Human Resources department team. c)Additional agencies have been explored and added to continue to support open positions. 4.Monitoring a)The Director of Nursing (DON) and/or Assistant Director of Nursing reviews staffing daily and coordinates with the staffing coordinator the needs of the center. The DON will audit call outs and staffing ratios weekly related to C.N.A. staff members and summarize for the Administrator. b)The results of these audits will be submitted weekly by the DON to Quality Assurance and Performance Improvement (QAPI) committee for a period of one month, then twice monthly for two months for further review and revision if needed to the plan.	

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S 560	Continued From page 2 d. Nothing in this section shall be construed to affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum ... A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the weeks of 11/28/21 and 12/5/21 revealed the following: The facility was deficient in CNA staffing for residents on 9 of 14 day shifts and deficient in CNA staffing for residents on 2 of 14 evening shifts as follows: - 11/28/21 had 10 CNAs for 82 residents on the day shift, required 11 CNAs. - 11/29/21 had 9 CNAs for 82 residents on the day shift, required 11 CNAs. - 12/01/21 had 10 CNAs for 82 residents on the day shift, required 11 CNAs. - 12/02/21 had 8 CNAs for 82 residents on the day shift, required 11 CNAs. - 12/03/21 had 8 CNAs for 87 residents on the day shift, required 11 CNAs. - 12/04/21 had 8 CNAs for 87 residents on the day shift, required 11 CNAs. - 12/06/21 had 10 CNAs for 87 residents on the day shift, required 11 CNAs. - 12/06/21 had 9 CNAs to 19 total staff on the evening shift, required 10 CNAs. - 12/10/21 had 7 CNAs for 86 residents on the day shift, required 11 CNAs. - 12/10/21 had 8 CNAs to 17 total staff on the evening shift, required 9 CNAs. - 12/11/21 had 9 CNAs for 86 residents on the day shift, required 11 CNAs.	S 560		

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S 560	Continued From page 3 On 12/9/21 at 12:00 PM, the surveyor discussed the staffing ratios concerns with the Administrator and Director of Nursing, who stated they were aware of the staffing ratio criteria and they are attempting to hire new CNAs and offer incentives.	S 560		