(X3) DATE SURVEY

COMPLETED

		50A001	B. WING		11/10/2020
	ROVIDER OR SUPPLIER				11/10/2020
	N GARDENS OF EDISON	1801 OAK	DRESS, CITY, STA TREE ROAD	TE, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETE
A 000	Initial Comments		A 000		
A1291	was conducted by the 11/10/2020. The facil compliance with the N Code 8:36 infection of for Licensure of Assis Comprehensive Perso Assisted Living Progra Disease Control and I recommended practic COVID-19. The facility must subr including a completion and ensure that the p to correct deficiencies action in accordance Jersey Administrative Enforcement of Licen 8:36-18.3(a)(1) Infect Services (a) Written policies ar established and imple prevention and contro to, policies and proce 1. In accordance State Sanitary Code, N.J.A.C. 8:57, a reporting, and evaluar infections or dise conditions which may and procedures of	ity was found not to be in lew Jersey Administrative ontrol regulations standards ted Living Residences, onal Care Homes and ams and Centers for Prevention (CDC) tes to prepare for nit a plan of correction, in date for each deficiency lan is implemented. Failure a may result in enforcement with provisions of New Code Title 8, Chapter 43E,	A1291		
LABORATORY I	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE

(X2) MULTIPLE CONSTRUCTION

A. BUILDING:

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

New Jersey Department of Health

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X6) DATE

(X5) COMPLETE DATE

(X3) DATE SURVEY

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:	· · · · · · · · · · · · · · · · · · ·	(3) DATE SURVEY COMPLETED
		50A001	B. WING		11/10/2020
	ROVIDER OR SUPPLIER	1801 O/	ADDRESS, CITY, STATE AK TREE ROAD I, NJ 08820	E, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
A1291		e 1 diseases, or conditions;	A1291		
	by: Based on observation reviews, and New Jer (NJDOH) issued guid Directive, it was deter ensure newly admitte quarantined for 14 da Resident #2, Residen four newly admitted re residents had been ac the last 14 days. This	rsey Department of Health ance and Executive rmined the facility failed to d residents were ys for four (Resident #1, tt #3, and Resident #4) of esidents reviewed. The four dmitted to the facility within deficient practice occurred pandemic, and had the			
	survey was conducted provided to the survey indicated four residen facility during the last information provided in residents in the facility isolation as PUIs (per Reference: NJDOH is 20-026-1, dated 10/20 Cohorting, PPE and T	indicated there were no y under quarantine or sons under investigation). ssued Executive Directive,			

(X2) MULTIPLE CONSTRUCTION

Every Phase: "iv. Facilities must continue to follow current NJDOH orders, guidance and directives on admissions and readmissions. Facilities may receive residents who were tested prior to admission/transfer or shortly thereafter, in

New Jersey Department of Health

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

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If continuation sheet 2 of 7

New Jersey Department of Heal	th

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		50A001	B. WING		11	/10/2020
NAME OF F	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
BRIGHTC	IN GARDENS OF EDISO		K TREE ROAD , NJ 08820			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
A1291	COV/COVID_Cohort Reference: NJDOH g Cohorting COVID-19 Facilities, " dated 10/ Transmission-Based recommended COVII for all patients/reside re-admissions and read "Cohort 4," which "se where persons remain symptoms that may b COVID-19." COVID-1 included, "N95 respir unavailable], eye pro gown." 1. A medical record re was admitted to the f private home. Reside facility 13 days at the laboratory COVID-19 reverse transcription test for the qualitative the Novel Corona Vir Resident #1 on facility. The test result second test for the de Virus was collected w in the facility for for cresult of that test indi On 11/10/2020 at 2:4 observed sleeping in signage or sticker on should be worn in the	POH Guidance: ealth/cd/documents/topics/N ing_PAC.pdf" uidance, "Considerations for Patients in Post-Acute Care 22/2020, indicated, "Full Precautions and all D-19 PPE should be used ints who are: New and ther indicated that new missions are placed in, rves as an observation area n for 14 days to monitor for be compatible with 19 recommended PPE ator or higher [or facemask if tection, gloves, and isolation eview revealed Resident #1 acility on, from a ent #1 had been in the time of the FIC survey. A RT-PCR test (real-time polymerase chain reaction e detection of nucleic acid for us) was collected from , prior to entry to the t indicated, "Negative." A etection of the Novel Corona when the resident had been days, on, and the cated, "Not Detected." 6 PM, Resident #1 was their room. There was no the door indicating full PPE	A1291			

(X3) DATE SURVEY COMPLETED

		50A001	B. WING		11/10/2020
	ROVIDER OR SUPPLIER N GARDENS OF EDISON	1801 OAK ⁻	RESS, CITY, STA TREE ROAD J 08820	TE, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
A1291	was admitted to the fa private home. Reside 14 days at the time of laboratory COVID-19 from Resident #2 on the facility, and the te Detected." A second Novel Corona Virus w resident had been in f and the r "Not Detected." On 11/10/2020 at 2:40 observed reading a n sitting area near the e 3. A medical record re was admitted to the fa nursing home. Reside facility 14 days at the laboratory COVID-19 from Resident #3 on the facility, and the te Detected." A second Novel Corona Virus w resident had been in f "Not Detected." On 11/10/2020 at 11:4 observed in their roor sticker on the door inte protective equipment room. 4. A medical record re was admitted to the fa nursing home. Reside facility days at the	acility on the facility in the FIC survey. A RT-PCR test was collected manual prior to entry to st result indicated, "Not test for the detection of the vas collected when the the facility for days, on esult of that test indicated, 9 PM, Resident #2 was ewspaper in the common elevator on the date floor. eview revealed Resident #3 acility on data floor. eview revealed Resident #3 acility of days, on esult of that test indicated, 45 AM, Resident #3 was n. There was no signage or dicating full personal (PPE) should be worn in the	A1291		

(X2) MULTIPLE CONSTRUCTION

A. BUILDING:

New Jersey Department of Health

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		50A001	B. WING		11/	10/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STATE	, ZIP CODE		
BRIGHTO	N GARDENS OF EDISON	N 1801 OAK EDISON, I	TREE ROAD			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
A1291	Detected." On 11/10/2020 at 12: Preventionist (IP) was residents to the facilit quarantined as a PUI being admitted, a res COVID-19 test. The had been in the facilit COVID-19 test would second COVID-19 test resident could come of On 11/10/2020 at 12: the information the IF IP were asked to pro- practice of releasing a quarantine early base COVID-19 test result On 11/10/2020 at 2:2 (ED) stated they had quarantine of newly a negative COVID-19 te recommendation of the and their experience isolation and quarant also referred to the C Control and Prevention "Discontinuation of er Precautions for Patie SARS-CoV-2 [COVID negative tests could b diagnosis. The ED als "Considerations for C in Post-Acute Care F Department of Health	 ast result indicated, "Not 50 PM, the Infection asked if newly admitted y were isolated or The IP stated prior to ident would have a negative IP stated after the resident asy days, a second be completed. If the ast came back "negative," the off strict quarantine. 50 PM, the ED confirmed had shared. The ED and vide the rationale for the a PUI resident from ad on two negative s. 6 PM, the Executive Director implemented discontinuing indmitted residents after two tests based on the ne facility's Medical Advisor with the negative effects of ine on the elderly. The ED DC's (Center for Disease on) guidelines for the mpiric Transmission-Based nts Suspected of Having 0-19] Infection," where two 	A1291			

New Jersey Department of Health

New Jersey Department of Heal	th
STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIE

		Ith (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		50A001	B. WING		11	1/10/2020
	ROVIDER OR SUPPLIER	N 1801 OA	ADDRESS, CITY, STATE AK TREE ROAD I, NJ 08820	E, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIE!	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETE DATE
A1291	resided in the living residence, was room. There was no s door indicating full PF room. On 11/10/2020 at 2:3 #13 was asked if they PPE when caring for if full PPE was require have a sticker on it in required. Resident # have no sticker indica On 11/10/2020 at 2:4 Coordinator (RC) #14 required to be worn w RC #14 stated Reside test was negative, so under quarantine. On 11/10/2020 at 2:5 resident tested negat facility and then teste facility, they could be not contacted COVID said, "We are a close "tested weekly." The under quarantine unt test comes back negat On 11/10/2020 at 3:4 (ED) acknowledged F results back from a s ED stated the facility implement a 14-day o admitted residents. A facility policy, dated	6 PM, Resident #4, who Unit of the assisted observed sitting in their signage or sticker on the PE should be worn in the 8 PM, Care Manager (CM) were required to wear full Resident #4. CM #13 stated, ed, the resident's door would dicating full PPE was 4's door was observed to ating PPE was required. 0 PM, Reminiscence 4 was asked if full PPE was when caring for Resident #4. ent #4's second COVID-19 the resident was no longer 5 PM, the IP stated, when a ive prior to entering the d negative at days in the confident the resident had 0-19 prior to entry. The IP d system," and the staff was IP stated residents are if their second COVID-19 ative. 5 PM, the Executive Director Resident #4 did not have econd COVID-19 test. The would immediately	A1291			

New Jersey Department of Healt STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC	DNSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BOILDING.				
50A001			B. WING		11	/10/2020	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
BRIGHTO	N GARDENS OF EDISON		K TREE ROAD , NJ 08820				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
A1291	resident has remained quarantine is disconti - The resident remain negative COVID-19 te The pre-move in test and the second test m earlier than 4 days af	discontinued if: ssed since move-in and the d symptom free (note:	A1291				