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
	60a000	A. BUILDING: ______ B. WING ______	C 05/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKDALE FLORHAM PARK	**8 JAMES STREET FLORHAM PARK, NJ 07932**

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A 000	Initial Comments Initial Comments: TYPE OF SURVEY: Focused Covid 19 Infection Control and Complaint COMPLAINT #: NJ136228 CENSUS: 59 SAMPLE SIZE: 3 A Covid-19 Focused Infection Control Survey was conducted by the State Agency on (date). 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. 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 provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations.	A 000		
A1273	8:36-18.1(b) Infection Prevention and Control Services (b) The licensed professional nurse, in coordination with the administrator, shall be responsible for the direction, provision, and quality of infection prevention and control services. The health care services director, in coordination with the administrator, shall be responsible for, but not limited to, developing and maintaining written objectives, a policy and	A1273		

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

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A1273	Continued From page 1	A1273		

procedure manual, and an organizational plan for the infection prevention and control service.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and review of facility records, it was determined that the facility Director of Nursing (DON) failed to ensure the implementation of policies and procedures to manage and control the spread of Covid-19 in accordance with Centers for Disease Control Guidelines and the facility internal guidelines.

This deficient practice was evidenced by:

On 5/19/20 at 9:15 a.m. the surveyor observed the Concierge wearing a black cloth mask. The Concierge was screening employees and was seated at a table with surgical masks and hand sanitizer. The Concierge stated that she had access to surgical masks however the cloth mask was more comfortable.

At 9:30 a.m., the surveyor observed the [redacted] [redacted] Coordinator [redacted] wearing a yellow cloth mask. The [redacted] was interacting with residents who were not wearing any type of face mask. The [redacted] told the surveyor that she thought wearing cloth masks in a health care setting was permitted.

At 10:40 a.m. the surveyor interviewed the DON regarding the use of cloth face masks in a health

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A1273	Continued From page 2 care setting and requested the facility policy on the use of these masks. The surveyor was provided with the facility policy "Communicable Disease Control" updated 4/2020. Item 3 revealed "If a serious outbreak of a highly contagious disease occurs within the community, strict adherence to standard precautions, use of personal protective equipment (gloves, gowns, masks, etc) should be used and implemented according to the most current Center for Disease Control (CDC) and Prevention recommendations. The surveyor reviewed CDC guidelines with the DON which reveal that cloth face masks are not considered personal protective equipment. At 12:57 p.m. the DON provided the surveyor with instructions that the facility received from their Corporate office which revealed "...all associates providing direct and indirect care will be assigned one surgical mask per shift to be disposed of at the end of the shift..." and "Two cloth masks will be provided for all associates to be worn traveling to and from work." The DON agreed that the facility staff should have been wearing surgical masks and not cloth masks.	A1273		
A1357	8:36-19.4(b)(3) Alzheimer's/Dementia Programs (b) A facility that advertises or holds itself out as having an Alzheimer's/dementia program shall, pursuant to N.J.S.A. 26:2M-7.1, provide a member of the public seeking placement of a person diagnosed with Alzheimer's and/or related disorders in the facility with a clear and concise written list that indicates: 3. The safety policies and procedures and any security monitoring system that is specific to residents diagnosed with Alzheimer's and	A1357		

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A1357	Continued From page 3 related disorders. This REQUIREMENT is not met as evidenced by: COMPLAINT # NJ00136228 Based on observation, interview, and review of facility documents it was determined that the facility failed to provide and implement safety policies and procedures to prevent the unsupervised and undetected exit of 3 of 3 residents diagnosed with symptoms of [redacted] Resident #1, #2, and #3. This deficient practice was evidenced by the following: On 5/19/20 at 9:50 a.m. the surveyor reviewed the medical record of Resident #1 which revealed that he/she was admitted to the assisted living section of the facility on [redacted] with medical diagnoses including [redacted]. Further review of the record revealed that on 5/3/20 at 7:05 p.m., the resident was observed walking in the hallway. At 7:15 p.m. a housekeeper observed the resident outside the front entrance and the resident appeared to be trying to cross the street. The housekeeper notified nursing staff at 7:25 p.m. and the resident was located at 7:30 p.m. across the street sitting on the ground without injury. On 5/19/20 at 11:00 a.m., the surveyor observed the main entrance door which was monitored by the concierge. The door was observed to be equipped with a delayed egress bar (a locking feature that delayed the opening of the door.) The	A1357		

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A1357	Continued From page 4 surveyor interviewed the concierge who stated that until recently the front door was monitored and left unlocked continuously between 9 a.m. and 7 p.m. The concierge further disclosed that when the concierge went home at 7 p.m., the door alarm was activated. Anyone trying to enter or exit through the front door would cause an audible alarm in addition to an alarm notification appearing on the pagers that were carried by the care staff. At 11:05 a.m. the surveyor reviewed the medical record of Resident #2 which revealed that he/she was admitted to the assisted living section of the facility on [redacted] with medical diagnoses that included [redacted] Further review of the record revealed that on [redacted] the resident was brought to the facility at 2:15 p.m. by the local police department. The resident was found at a gas station approximately 1/2 mile away from the facility and was not able to recall how to return to the facility. The medical record did not document the time the resident left the building nor did the medical record document how the resident left the building. At 1:00 p.m. the surveyor reviewed the medical record for Resident #3 which revealed that he/she was admitted to the assisted living section of the facility on [redacted] with diagnoses that included [redacted] [redacted]. Further review of the record revealed that on [redacted] the resident was demonstrating wandering behaviors and was verbalizing a desire to go home. On [redacted] the resident was found by the local police department at a gas station near the facility. The police called the facility and a staff member picked the resident up and returned him/her to the facility at 7:30 a.m. The medical record did not document the time the	A1357		

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resident left the facility nor did the medical record indicate how the resident left the facility undetected.

Additional review of the medical record revealed that Resident #3 was transferred to the secure dementia unit. On [redacted] at 11:52 p.m. the resident was verbalizing a desire to go home, became agitated and threw a table into a stationary side panel window at the exit door. The staff returned the resident to his/her room. The record then revealed that the resident was again observed to be at the exit door and pushed on the delayed egress bar. The resident was again returned to his/her room however the door alarm was not reset. At 12:21 a.m. resident was determined to be missing from the [redacted] [redacted] unit and the police were notified. The resident was located by the local police department approximately 2 miles from the facility at 3:27 a.m.

At 2:00 p.m. the Health and Wellness Director (HWD) provided the surveyor with the policy "Resident Call System and Door Alarm Response." Review of the policy did not disclose any procedures to prevent the unsupervised or undetected exit of residents through alarmed doors. The surveyor was also provided with the policy "Missing Resident Policy" which revealed steps to follow in the event a resident was determined to be missing. There were no instructions in this policy to provide for the the safety of residents by monitoring resident location to prevent elopement for residents with the symptoms of [redacted].

At 2:30 p.m. the surveyor interviewed the Executive Director (ED) and Health and Wellness Director (HWD). The ED stated that all doors in

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A1357	Continued From page 6 the facility were equipped with delayed egress bars. The ED told the surveyor that when the bar was pushed, the door lock released after a preset time (20 seconds) an audible alarm continuously sounded and the door remained unlocked until reset with a code. The ED and HWD were unable to disclose to the surveyor how Resident #1, 2, or 3 were able to exit undetected from the building through alarmed doors. In addition, the facility was not aware that the Resident # 2 or #3 were missing until the facility was notified by the local police department that they had been found. The ED and HWD were not able to provide the surveyor with safety policies/procedures to prevent residents with symptoms of dementia from leaving the facility through alarmed doors without detection.	A1357		