STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	90103	A. BUILDING: _____ B. WING _____	06/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE ASSISTED LIVING OF OLD TAPPAN	195 OLD TAPPAN ROAD OLD TAPPAN, NJ 07675

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Initial Comments: Census: 54 A Covid-19 Focused Infection Control Survey was conducted by the State Agency on 6/24/20. The facility was found not to be in compliance with the New Jersey Administrative Code 8:36 infection control regulations standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19.	A 000		
A 310	8:36-3.4(a)(1) Administration (a) The administrator or designee shall be responsible for, but not limited to, the following: 1. Ensuring the development, implementation, and enforcement of all policies and procedures, including resident rights; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility records, it was determined that the facility Executive Director (ED) failed to ensure the development and implementation of comprehensive policies and procedures to address, manage, and control the spread of	A 310		

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	90103	A. BUILDING: _____ B. WING _____	06/24/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS CITY STATE ZIP CODE
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A 310	Continued From page 1 Covid-19 in accordance with April 4, 2020 instructions issued by the Commissioner of the Department of Health. (DOH) This deficient practice was evidenced by: On 6/24/20 at 10:35 a.m. during an interview with the Director of Nursing (DON), the surveyor was told that the facility staff performed checks of each resident's temperature twice a day and each resident was screened for symptoms of Covid-19. The DON further stated that residents, unless symptomatic, had their vital signs checked only on a monthly basis. The DON also disclosed that if a resident demonstrated symptoms of Covid-19, vital signs would be obtained. The surveyor reviewed with the DON the DOH April 4 instructions which stated "The Facility shall actively screen its residents, minimally, at each shift change for Covid-19 symptoms, which includes a cough or shortness of breath, fever (evidenced by a temperature check of the resident taken by the Facility), sore throat, or GI (gastrointestinal) symptoms, and take each resident's vital signs, including heart rate, blood pressure, pain and pulse oximetry." Review of resident electronic medical records confirmed that resident temperatures were being obtained however there was no documented evidence that residents other vital signs including blood pressure, pulse, pain level and pulse oximetry (a test where a sensor is attached to a finger to determine the amount of oxygen in the blood) were being obtained by facility staff. At 2:00 p.m., the surveyor the facility policy, dated 3/18/2020, "Covid Mitigation and Response Plan." The facility policy provided instructions to the staff for " ...Communities with a confirmed case of Covid-19: Residents are screened at least twice daily for fever and symptoms of Covid-19 ..."	A 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 310	Continued From page 2 The ED failed to ensure that the facility policy followed infection control and prevention instructions issued by the Commissioner of the DOH on April 4, 2020.	A 310		

SUNRISE
SENIOR LIVING

A 310 8:36-3.4 (a)(1) Administration

1. All residents were actively screened for symptoms of COVID-19 to include Pulse Oximetry. All residents in the entire community had a pulse oximetry screen. No residents found to be affected by this deficient practice. (completed 6/24/20 and will continue daily).

2. Executive Director will complete an audit and review 10 random Covid-19 screens to ensure all information is complete and accurate. (Completion date 9/24/20)

3. Nursing staff including DON/RCD, RN/WN and LPN's were educated on symptoms of Covid-19 to include cough, shortness of breath, fever (evidenced by a temperature check taken by the facility), sore throat, GI (gastrointestinal) symptoms. In addition to Sunrise's responsibility to screen each resident daily including screening vital signs (blood pressure, heart rate, pain and pulse oximetry). Screenings will occur daily, each shift and documented in PCC. (Completion date 8/8/20)

4. ED (or designee) will review 5% of Covid-19 screenings on a monthly basis to ensure proper documentation. In addition, during monthly Town Hall meetings, this information will be shared with team members (Began 7/19/20 and ongoing)

[redacted]