lew lerse	/ Department of Health	
1011 101 101		

STATEMENT	ey Department of Hea OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
90144		B. WING		11	11/16/2020	
NAME OF PF	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	, ZIP CODE		,10,2020
SUNRISE	ASSISTED LIVING OF W	VESTEIELD	INGFIELD AVENUE ELD, NJ 07090	E		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE
A 000	Initial Comments		A 000			
	Initial Comments: Census: 58					
	was conducted by the 11/16/2020. The facil compliance with the l Code 8:36 infection of for Licensure of Assis Comprehensive Pers Assisted Living Progr Disease Control and recommended praction This facility must sub- including a completion and ensure that the p to correct deficiencies action in accordance	lity was found not to be in New Jersey Administrative control regulations standards sted Living Residences, sonal Care Homes and rams and Centers for Prevention (CDC) ce to prepare for COVID-19. omit a plan of correction, on date for each deficiency blan is implemented. Failure s may result in enforcement with provisions of New e Code Title 8, Chapter 43E,				
A 891	the provisions of N.J. Establishments and I	Services ersonnel shall comply with .A.C. 8:24, Retail Food Food and Beverage Vending II of the New Jersey Sanitary	A 891			
	by:	Γ is not met as evidenced n, interview, and document				

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

TITLE

(X6) DATE

New Jersev	Department of Health	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			SURVEY PLETED
			A. BUILDING.			
		90144	B. WING		11	/16/2020
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE,	, ZIP CODE		
SUNRISE	ASSISTED LIVING OF W	240 SPF	RINGFIELD AVENUE	I		
SUNNISE		WESTFI	IELD, NJ 07090			
(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 AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
A 891	temperatures for the I machine were monitor maintained. This had residents who resided practice occurred dur pandemic. Findings included: 1. The "Kitchen Clear dated, documented: " temperatures are rea [Fahrenheit] during the [degrees] F during the [degrees] F during the The dish machine ten was reviewed. The o temperatures were re Dishwasher #1 had in rinse cycle temperatu 11/12/2020 at 8:00 AI 11/12/2020 at 12:00 F 11/12/2020 at 5:00 PI On 11/16/2020 at 11:: Director was asked if that dish machine ten on any day during 11, He stated, "No." He s some of the temperature When asked if Dishw the rinse cycle temper rinse cycle temper rinse cycle temper rinse cycle temper the rinse cycle temper	ed to ensure hot water high heat sanitizing dish red, recorded, and I the potential to affect all 58 d in the facility. The deficient ing the COVID-19 hing Procedure Guide," not Ensure the dish machine ching 150 [degrees] F e wash cycle and 180 e rinse." nperature log for 11/2020 nly date the dish machine recorded was 11/12/2020. Indicated the dish machine res were as follows: M - 156 degrees F PM - 156 degrees F PM - 156 degrees F M - 180 degrees F 40 AM, the Dining Services there was documentation nperatures had been taken /2020 other than 11/12/2020. Istated he had destroyed ure logs. When asked if the ure of 156 degrees F was ze dinnerware, he stated, e should be 180 degrees." asher #1 had informed him rature was too low for the /2020 at 8:00 AM and 12:00 d not told him about the low	A 891			

(X3) DATE SURVEY COMPLETED

		90144	B. WING		11/16/2020
	ROVIDER OR SUPPLIER ASSISTED LIVING OF W	240 SP	ADDRESS, CITY, STAT RINGFIELD AVENU FIELD, NJ 07090		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / 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)	
A 891	and recording dish ma maintaining the dishw When asked what his stated dietary staff sh machine temperature morning, at lunch, and temperature on the di log. He stated he work him or the environment rinse cycle temperature degrees F. He stated machine temperature 8:36-18.3(a)(4) Infection Services (a) Written policies and established and imple prevention and contro- to, policies and proces 4. Surveillance te sources and transmiss This REQUIREMENT by: Based on interview ar	was no policy for observing achine temperatures and asher temperature logs. expectations were, he ould check the dish three times per day in the d at dinner and record the sh machine temperature uld expect staff to inform ntal services director if the re did not reach 180 he should maintain the dish logs. on Prevention and Control d procedures shall be emented regarding infection d, including, but not limited dures for the following:	A 891		
	failed to screen all res every shift, with quest signs or symptoms of monitoring vital signs. of reopening. This det	The facility was in Phase 0 icient practice occurred pandemic and affected all			

(X2) MULTIPLE CONSTRUCTION

A. BUILDING:

STATE FORM

New Jersey Department of Health

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

NI I	
New Jersev Department of Health	

	ey Department of Hea						
STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
0			A. BUILDING:				
		90144	B. WING		11	/16/2020	
NAME OF PF	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE				
	ASSISTED LIVING OF W	ESTFIELD	RINGFIELD AVENUE				
		WESTF	IELD, NJ 07090				
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN O		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO		COMPLETE DATE	
IAG			IAG	DEFICIEN			
A1297	Continued From page	e 3	A1297				
	Findings included:						
	5						
	Reference: New Jers	sey Department of Health					
		ective No, 20-026-1, dated					
	10/20/2020, revealed						
		ds for services during each					
	phase.						
	1. Phase 0						
	iv. Facilities shall scre	een all residents, at					
		y shift, with questions and					
		s or symptoms of COVID-19					
		al signs. Vital signs recorded					
	shall include heart rat	-					
	temperature, and puls	se oximetry.					
		9:51 AM, the infection control					
	coordinator was aske	-					
		for identifying, tracking,					
	•	orting fever, respiratory					
		ymptoms of COVID-19. She					
		vital signs with a pulse					
		e completed daily and a en again later in the day.					
	lemperature was take	en again later in the day.					
	On 11/16/2020 at 1.1	7 PM, during a telephone					
		es director stated the facility					
	was in Phase 0 of rec						
		ש					