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
	Q4VDWW	A. BUILDING: ______ B. WING ______	09/26/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR TERRACE SHREWSBURY	**864 SHREWSBURY AVENUE TINTON FALLS, NJ 07724**

(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) COMPLETE DATE
A 000	Initial Comments Initial Comments: TYPE OF SURVEY: Standard CENSUS: 121 SAMPLE SIZE: 9 The facility is not in substantial compliance with all of the standards in the New Jersey Administrative Code 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs. 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		
A 765	8:36-7.4(c)(1) Resident Assessments and Care Plans (c) Written policies and procedures shall be developed and implemented to ensure, but not be limited to, the following: 1. Assessment of all residents with a general service plan at least semi-annually, and those residents who have a health service plan shall be reassessed at least quarterly and more often on an as needed basis, including and upon the resident's return to the facility from the hospital;	A 765		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 10/21/19

New Jersey Department of Health

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A 765	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined that the facility failed to reassess a resident's condition upon return from a hospitalization in order to determine the resident's medical needs for Ex of Exec residents reviewed for care and services, Resident Execu. This deficient practice was evidenced by the following: On 9/25/19 the surveyor reviewed the medical record of Resident Execu and observed that he/she moved into the facility in Executive Order 26, 4.b. with diagnoses which included Executive Order 26, 4.b., Executive Order 26, 4.b. . According to review of the Charting Notes (CN) on Executive Order 26, Executive Order 26, 4.b. the resident had a Executive Order 26, 4.b. Executive Order 26, 4.b., Executive Order 26, 4.b., sat down in a chair, Executive Order 26, 4.b. for a while, Executive Order 26 and was Executive Order 26, 4.b.. The surveyor observed in the CN that the resident returned to the facility on Executive Order 26, 4.b. p.m. however, the Executive Order 26, 4.b. note was written by a Licensed Practical Nurse. The surveyor did not observe any documentation in the CN by a Registered Nurse (RN) after the resident's Executive Order 26, 4.b. to the facility. The surveyor reviewed the facility document titled, "Assessment and Service Plan Services Library" and observed that the most current assessment was dated Executive Orde. The surveyor observed that there was no documented assessment after that assessment, including no assessment after the resident Executive Order 26, 4.b. Executive Order 26, on Executive Order 26, The surveyor interviewed the RN who stated that he/she thought the facility had 30 days to do an	A 765		

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A 765	Continued From page 2 assessment when a resident returned to the facility from the hospital. On 9/26/19 during the exit conference both the Executive Director and the RN confirmed that the resident's condition should have been reassessed by an RN.	A 765		
A 891	8:36-10.5(a) Dining Services (a) The facility and personnel shall comply with the provisions of N.J.A.C. 8:24, Retail Food Establishments and Food and Beverage Vending Machines Chapter XII of the New Jersey Sanitary Code. This REQUIREMENT is not met as evidenced by: Based on observation it was determined the facility failed to maintain sanitary practices in the kitchen as required by the New Jersey Sanitary Code 24. This failure placed all residents at risk for illness. This deficient practice was evidenced by the following: On 9/25/19 at 9:43 a.m., during the tour of the building, in the presence of the facility's Food Services Director (FSD), the surveyor inspected the kitchen and observed the following sanitary issues: 1. At 9:50 a.m., the surveyor observed inside the	A 891		

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A 891	Continued From page 3 of the plastic bin used for bulk flour storage (1) one 6 inch in diameter stainless steel bowl stored in the flour product. 2. At 9:51 a.m., the surveyor observed inside of the plastic bin used for bulk sugar storage (1) one plastic scoop stored with the handle in the sugar product. At that time, the surveyor interviewed the FSD who agreed that the scoops should not be stored in the bulk dry products.	A 891		
A 939	8:36-11.5(b)(1)(i-ii) Pharmaceutical Services (b) The registered professional nurse may choose to delegate the task of administering medications in accordance with N.J.A.C. 13:37-6.2 to certified medication aides, as defined in this chapter. 1. A unit-of-use/unit dose drug distribution system shall be developed and implemented whenever the administration of medication is delegated by the registered professional nurse to a certified medication aide; i. Over-the-counter (OTC) solid and liquid dosage forms may be dispensed in a non unit-of-use or non unit-dose medication distribution system. ii. Prescription liquid medications (that is, conventional bottles, concentrates) may be dispensed in a non unit-of-use, non unit-dose, or conventional medication distribution system.	A 939		

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A 939	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility Registered Nurse (RN) failed to ensure that tasks delegated to the Certified Medication Aide (CMA) were appropriately supervised. The facility also failed to ensure that a unit of use/unit dose distribution system was utilized whenever the administration of medication was delegated to the CMA's for [Exe] of [Exe] residents reviewed, Resident [Executi] Resident [Execu], Resident [Execu], Resident [Execu], Resident [Execu] and Resident [Executive] This deficient practice was evidenced by the following: On 9/25/19 the surveyor inspected the medication cart and observed the several multiple dose bottles of medication stored inside. The medications were not in unit of use packaging in order for the CMAs to administer medications as follows: 1. Resident [Execu] had a bottle of [Executive Order 26] and a bottle of [Executive Order 26] stored in the medication cart. 2. Resident [Execu] had a bottle of [Executive Order 26, 4.b] stored in the medication cart. 3. Resident [Execu] had a bottle of [Executive Order 26] stored in the medication cart. 4. Resident [Execu] had a bottle of [Executive Order 26] stored in the medication cart. 5. Resident [Execu] had a bottle of [Executive Order 26] stored in the medication cart. 6. Resident [Execu] had a bottle of [Executive Order 26] stored in the medication cart. At that time, the surveyor observed that the facility used an electronic Medication Administration Record (eMAR) system to record	A 939		

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A 939	Continued From page 5	A 939		

medications administered. The surveyor reviewed the eMARs for Executive Order 26, 4.b. and observed that CMAs signed out the medications as administered that were stored in multiple dose bottles.

The surveyor interviewed a CMA who stated that the Nurse gave the medications from the bottles. The surveyor then asked the CMA to explain why his/her initials were documented on the eMAR as the person that administered the medications. The CMA further stated that he/she was signed onto the computer and that the Nurse that administered the medication did not sign onto the computer and that is why his/her (Nurse) initials were not on the eMAR.

The surveyor interviewed the Registered Nurse (RN) who stated that the medication in the bottles was administered by the Licensed Practical Nurse (LPN). The RN further stated that she was aware that the CMAs were not allowed to administer medications from a multiple dose bottle. The RN also stated that the Nurse should have logged onto the computer so that the eMAR would have recorded his/her initials as the person that administered the medications.

The surveyor requested a copy of the resident's eMARs and confirmed with the RN that medications that were in multiple dose bottles was signed off by the CMAs.

The facility failed to ensure that the CMAs were delegated the task of administering medications from a unit of use/unit dose distribution system and failed to ensure that the CMAs were only provided with a unit of use/unit dose distribution system for medication administration.

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A 981	Continued From page 6	A 981		
A 981	8:36-11.7(a)(4) Pharmaceutical Services (a) The administrator shall provide an appropriate and safe medication storage area, either in a common area or in the resident's unit, for the storage of medications that are not self-administered by the residents. The storage area requirement may be satisfied through the use of a locked medication cart. 4. Each resident's medications shall be kept separated within the storage area, with the exception of large volume medications which may be labeled and stored together in the storage area. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility nursing staff failed to store ointments and creams separately for each resident within the medication cart. This deficient practice was evidenced by the following: On 9/26/19 at 9:45 a.m., in the presence of the Registered Nurse (RN), the surveyor inspected the medication cart on the Executive Order 26, 4 and observed that creams, ointments and powders were stored together with eye drops inside the medication cart. At that time the surveyor interviewed the RN who stated that the creams and ointments should not be stored with the eye drops in the same area. The RN agreed that the creams, ointments and powders should have been stored in the designated treatment cart.	A 981		

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A 999	8:36-11.7(e) Pharmaceutical Services (e) Discontinued or expired medications shall be destroyed within 30 days in the facility, or, if unopened and properly labeled, returned to the pharmacy for credit, if allowable, and in conformance with N.J.A.C. 13:39 and other State and Federal laws, codes, and regulations. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility failed to destroy expired medications and remove expired medications from the active medication storage area, for Exe of Exe residents reviewed, Resident Execu. This deficient practice was evidenced by the following: On 9/25/19 at 11:20 a.m., in the presence of the Registered Nurse (RN), the surveyor counted the narcotics with the Certified Medication Aide (CMA). The surveyor observed medication that was stored in the narcotic box and dispensed in a Bingo card (a medication delivery system designed to deliver unit of use doses of a medication in a compartment or bubble). The surveyor observed Executi tablets of Executive Order 26, 4.b. Executive Order 26, 4.b. tablets that had expired Executive Order 26, 4.b. The Executive Order 26, 4.b. tablets were stored with the active inventory of controlled medications. At that time the surveyor reviewed the electronic Medication Administration Record and observed that Resident Execu was administered expired medication on Executive Order 26, 4.b. During surveyor interview the RN stated that the medication should have been removed and destroyed. The surveyor observed the Nurse	A 999		

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A 999	Continued From page 8 separate the Bingo card from the active inventory and stated that the medication would be reordered for the resident. The surveyor reviewed the facility's policy titled, "Medication Management" which documented, "Medications will be checked for expiration dates and expired drugs pulled at least once monthly." The facility failed to remove and destroy expired medication from the active inventory of medication and as a result, administered expired medication to Resident	A 999		
A1097	8:36-16.6 Physical Plant All facilities shall be provided with a fire suppression system in accordance with the Uniform Construction Code, N.J.A.C. 5:23. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to provide fire sprinkler coverage to all areas in the facility as required by the New Jersey Uniform Construction Code N.J.A.C. 5:23, for use group I-2 (health care) use occupancy and National Fire Protection Association (NFPA) 13 Installation of Sprinkler	A1097		

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A1097	Continued From page 9 Systems. This deficient practice was evidence by the following: On 9/25/2019 at 9:31 a.m., during the entrance conference with the Administrator and Maintenance Director, the surveyor requested a copy of the facility lay out which identifies the various rooms in the facility to be inspected. At 10:42 a.m., in the presence of the Maintenance Director, the surveyor toured the building and inspected the Executive Order 26, 4.b., Executive Order 26, 4.b. Executive Order 26, 4.b., Executive Order 26, 4.b. The surveyor observed that the facility failed to provide adequate fire sprinkler protection in the following locations: 1. At 10:56 a.m., there was no evidence of fire sprinkler coverage inside the Executive Order 26, 4.b. 19 feet by 10 feet main Executive Order 26, 4.b.. At that time the surveyor interviewed the Maintenance Director who confirmed that there was no fire sprinklers in the room. 2. At 11:04 a.m., there was no evidence of fire sprinkler coverage inside the Executive Order 26, 4.b. 7 feet by 5 feet sprinkler control valves room, located next to the elevator. At that time the Maintenance Director confirmed that there were none in the room. Reference #1: Uniform Construction Code, Special detailed requirements based on use and occupancy section 407 group I-2, [F] 407.5 Automatic sprinkler system. Smoke compartments containing patient sleeping units shall be equipped throughout with an automatic fire sprinkler system in accordance with Section 903.3.1.1. The smoke compartment shall be equipped with approved quick-response or	A1097		

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A1097	Continued From page 10 residential sprinklers in accordance with section 903.3.2.	A1097		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
Q4VDWW Y1	A. Building B. Wing Y2	12/4/2019 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ARBOR TERRACE SHREWSBURY	864 SHREWSBURY AVENUE TINTON FALLS, NJ 07724

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0765 Reg. # 8:36-7.4(c)(1) LSC	Correction Completed 09/27/2019	ID Prefix A0891 Reg. # 8:36-10.5(a) LSC	Correction Completed 09/27/2019	ID Prefix A0939 Reg. # 8:36-11.5(b)(1)(i-ii) LSC	Correction Completed 09/27/2019
ID Prefix A0981 Reg. # 8:36-11.7(a)(4) LSC	Correction Completed 09/26/2019	ID Prefix A0999 Reg. # 8:36-11.7(e) LSC	Correction Completed 09/27/2019	ID Prefix A1097 Reg. # 8:36-16.6 LSC	Correction Completed 10/04/2019
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO
9/26/2019	

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
Q4VDWW (Y1)	A. Building B. Wing (Y2)	12/4/2019 (Y3)

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REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 9/26/2019	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			

New Jersey Department of Health

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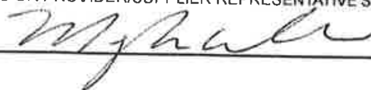
A 765	8:36-7.4(c)(1) Resident Assessments and Care Plans (c) Written policies and procedures shall be developed and implemented to ensure, but not be limited to, the following: 1. Assessment of all residents with a general service plan at least semi-annually, and those residents who have a health service plan shall be reassessed at least quarterly and more often on an as needed basis, including and upon the resident's return to the facility from the hospital;	A 765		

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



TITLE Executive Director. (X6) DATE 10/21/19.

ARBOR TERRACE SHREWSBURY

Plan of Correction

PLAN OF CORRECTION:

Area Observed: 981 8:36-11.7 (a) (4) Pharmaceutical Services.

1. Corrective Action:

A. LPN to ensure all ointments, topical creams and other prescribed treatments are secure in the treatment cart.
B. The carts were assessed and corrected immediately to prevent cross contamination.
C. Inservice all nurses and CMAs on infection control and medication storage.
D. Utilize both medication carts for each assignment in AL to ensure there is adequate space to house all medications properly.
E. RCD/MCD will audit the carts to ensure compliance on each neighborhood, weekly X 4 weeks, monthly X3 months, transitioning to quarterly. This is in addition to the pharmacy consultant's report.

2. **Identification of Other Residents**:

A. All other residents had potential to be affected.
B. All medication carts were audited to ensure all other medications and treatments were properly stored and were found to be in compliance.

3. **Systematic Changes**:

A . Reeducation was completed with all clinical staff on the policy and procedure regarding storage of medications. Ensure there is a plastic divider between medication groups of different administration routes (I.E. EYE DROPS, EAR DROPS, SUPPOSITORIES, ETC). Treatment supplies will be kept on the treatment cart with individual dividers.

4. Monitoring of Corrective Action:

A. Audits will be completed by the Resident Care Director weekly times four weeks, then monthly for compliance.

Estimated completion Date: Completed 9/26/2019 and ongoing monitoring and education

Area Observed: 939 8:36-11.5 (b) (1) (i-ii) Pharmaceutical Services. The facility Registered Nurse (RN) failed to ensure that tasks delegated to the Certified medication Aide (CMA) were appropriately supervised. The facility also failed to ensure that a unit of use/ unit dose distribution system was utilized whenever the administration of medication was delegated to the CMA's for [redacted] of [redacted] residents reviewed, Resident [redacted] Resident [redacted] Resident [redacted] Resident [redacted] Resident [redacted] and Resident [redacted]

PLAN OF CORRECTION:

1. Corrective Action:

A. Resident [redacted] the physician was notified and all medications were moved to the LPN medication cart. Resident [redacted] the physician was notified and all medications were moved to the LPN's medication cart. Resident [redacted] physician was notified and all of the residents' medications were moved to the LPN's medication cart. Resident [redacted] the physician was notified and all of the residents' medications were moved to the LPN's medication cart. Resident [redacted] the physician was notified and all of the residents' medications were moved to the LPN's medication cart. Resident [redacted] the physician was notified and the medications in vials were ordered on the 3-11 shift when the LPN is on the medication cart.

B. All medications in vials in AL were immediately placed on LPN medication cart to avoid potential for additional error.

C. All new admissions in AL that bring medications in vials must automatically be placed on the LPN cart.

D. All memory care residents that have medications in vials were identified. The physicians were called and new orders were received to administer the medications on 3-11 shift when LPN is present and passing medications from the memory care medication cart. Residents who have medication in vials must be scheduled on 3-11 shift for LPN to administer if possible and MD/Pharmacist is in agreement.

E. For Memory care residents that have medication in a vial which cannot be administered on 3-11 medication in a vial which cannot be administered on 3-11 shift, the CMA must call the LPN or RN to administer with no exception, LPN and or RN must sign medication administration record.

F. CMA's were re-in serviced on proper protocol and procedures

G. CMA's and RNs to continue to attend quarterly cluster meetings to stay current on regulations and best practices.

H. The Arbor Terrace Team will stress during admission process the benefits of using in house pharmacy and unit dose packaging. Give alternative pharmacies that use unit dose if residents do not want to use in house pharmacy.

I. Encourage all future admissions to use in house pharmacy to reduce the risk.

2. Identification of Other residents:

A. All other residents had potential to be affected.

B. Audits of the medication carts for medications in vials to identify those who have specific orders and transfer these resident' medications to the LPN cart was completed.

3. Systematic Changes:

A. All new admission into assisted living that have medications in vials must automatically be placed on the medication cart designated for LPN use.

B. All memory care residents that have medications being dispensed from bottles must either have the medication scheduled to be given between hours of 3-11 when LPN is doing the medication pass if possible and MD/Pharmacist in agreement.

C. For those memory care residents that have medications in vials which cannot be given between hours of 3pm to 11pm, the CMA must call the LPN or RN to administer with no exception. The LPN or R.N that then dispensed the medication must be the staff member that signs the MAR.

4. Monitoring of Corrective Action:

A. Inservice was completed with all LPN's and CMA's. It included ensuring all LPN's are aware that when RN's are not in the building to administer a vial medication in Memory Care they must personally go to Memory Care to administer and log it into QuickMar to document the administration.

B. RN to review MARS weekly to ensure compliance.

Estimated completion Date: Completed September 27, 2019 and ongoing monitoring and education

ARBOR TERRACE SHREWSBURY

Area Observed: A 999 8:36-11.7(e) Pharmaceutical Services. Surveyor reviewed the electronic Medication Administration Record and observed that Resident [redacted] was administered expired medication on 9/4, 9/11, 9/18 and 9/25/19. The facility failed to remove and destroy expired medication from the active inventory of medication and as a result, administered expired medication to Resident [redacted]

PLAN OF CORRECTION:

1. Corrective action:

1. Resident [redacted] physician was notified, no negative effects notified. Medication was removed from cart and a new prescription was received.
2. Inservice nursing staff on proper narcotic count, including checking for expiration date, including checking for expiration date with each count. Maintain written documentation of in-service as well as policy. Include in orientation process.
3. Request increased monthly focus from pharmacy consultant on medication and narcotic expiration dates.
4. Scheduled cart audits by the RN – weekly X 4 and then Monthly Noting all narcotics with upcoming expiration dates in the month ahead.
5. RN to review PRN Narcotic Administration on a weekly basis and collaborate with physician in order to discontinue any PRN medications not being used to limit the possibility of narcotic expiration.
6. Physician notified that resident was administered expired medications on dates above.

2. Identification of other areas/ residents:

A. All other residents had potential to be affected.

B. An audit of the medication carts was completed to identify any expired medications for medication that are expired.

3. Systematic Changes:

A. All narcotics will be counted and focus will be placed on both the front of the bingo card as well as the back of the bingo card to ensure the medications are not expired.

4. Monitoring of Corrective Action:

A. Audits to be conducted by the RN on a weekly basis X four weeks and then monthly. Pharmacy consultant to due regular audits.

Estimated completion Date: Completed September 27, 2019 and ongoing monitoring and education

ARBOR TERRACE SHREWSBURY

Area Observed: A765: 8:36-7.4(c) (1) Resident Assessments and Care Plans.

PLAN OF CORRECTION:

1. Corrective Action:

A. Resident ███ physician was notified and residents medical record is now up to date.

B. RN to bring 24 hour report binder to morning meeting daily to share information including but not limited to admissions, re-admissions, hospital transfers ect. with interdisciplinary team.

C. RN to audit wellness notes in QUICKMAR daily, review for completeness and ensure all issues are noted in 24 and 72 hour reports for documentation

D. Once 72 hour reporting is completed by Wellness staff, RN to document in Quick Mar a follow up note which will address admissions, readmissions, ETC. and highlight on 72 hour report to show it has been addressed by RN.

E. RN to log all re-admissions, admissions and hospitalizations on white board and adjust as needed.

F. In addition to utilizing the72 hour log daily, RN to review weekly to ensure all RN notes and RN assessments on admission and or re-admission are completed.

G. Audit will be completed on a weekly basis indefinitely.

2. Identification Of other residents:

A. All other residents had potential to be affected.

B. Audit of residents' medical records completed.

3. Systematic Changes:

A. RN to bring 24 hour and 72 hour report to daily morning meeting to ensure items do not get over looked.

B. Audits being done weekly by RN to ensure all resident assessments and reassessments are being completed timely.

C. Audits will also include review of nursing notes to ensure all RN notes are completed in the medical record timely.

4. Monitoring of Corrective Action

A. Monthly audits of the charts of all residents admitted and readmitted to the community will be completed by the Executive Director and Regional Nurse to ensure that an RN assessment is completed within 72 hours of the event.

Estimated completion Date: Completed September 27, 2019 and ongoing monitoring and education

ARBOR TERRACE SHREWSBURY

Area Observed: A 1097: All facilities shall be provided with fire suppression system in accordance with the Uniform Construction Code, N.J.A.C. 5:23.

PLAN OF CORRECTION:

1. Corrective Action:

A. Both areas identified the basement and sprinkler control valve room had the appropriate sprinkler heads installed, ensuring adequate coverage is provided.

2. Identification of other areas:

A. A walk through of the entire building was conducted by the Maintenance Director and Executive Director to identified any other possible areas. No additional areas where identified.

3. Systematic Changes:

A. Two sprinkler heads were installed increasing coverage in areas identified.

B. See invoice and pictures attached

4. Monitoring of Corrective Action

A. Quarterly and annual inspections to be completed by the fire and safety equipment company and Maintenance Director.

Estimated completion Date: Installation completed on 10/4/2019 and monitoring will be on going.

ARBOR TERRACE SHREWSBURY

Area Observed: A 891:36-10.5 (a) Dining Services

PLAN OF CORRECTION:

1. Corrective Action:

A. All bins with scoopers were disposed of same day.

B. All dietary staff in-serviced on proper storage techniques.

C. All staff in-services on proper storage, proper sanitary practices and the new process

2. Identification of other areas:

A. All other residents had potential to be affected.

B. Thorough check of all storage areas done by Dining Director and Executive Director to ensure all storage areas requiring a scoop were disposed of.

3. Systematic Changes:

A. 5-pound bags of flour and sugar where purchased. The cooks will pour out from the small bags what they need. The bags will then be wrapped, labelled and dated accordingly. The bags are too small to fit a scoop inside eliminating the issue and ensure proper sanitary practices.

4. Monitoring of Corrective Action

A. Area to be monitored on monthly rounds by Dining Director and Executive Director.

Estimated completion Date: Completed September 27 2019 and ongoing monitoring and education