

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 03A006	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/18/2020
--------------------------------------------------	-------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER CAMBRIDGE ENHANCED SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 255 E MAIN STREET MOORESTOWN, NJ 08057
-----------------------------------------------------------------------------	--------------------------------------------------------------------------------------------

(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	<p>Initial Comments</p> <p>Initial Comments: Census 39</p> <p>A Covid-19 Focused Infection Control Survey was conducted by the State Agency on 6/18/20. 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.</p>	A 000		
A 310	<p>8:36-3.4(a)(1) Administration</p> <p>(a) The administrator or designee shall be responsible for, but not limited to, the following:</p> <p>1. Ensuring the development, implementation, and enforcement of all policies and procedures, including resident rights;</p> <p>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</p>	A 310		

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

TITLE

(X6) DATE

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 03A006	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/18/2020
--------------------------------------------------	-------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER CAMBRIDGE ENHANCED SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 255 E MAIN STREET MOORESTOWN, NJ 08057
-----------------------------------------------------------------------------	--------------------------------------------------------------------------------------------

(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 310	<p>Continued From page 1</p> <p>Covid-19 in accordance with April 4, 2020 instructions issued by the Commissioner of the Department of Health. (DOH)</p> <p>This deficient practice was evidenced by:</p> <p>On 6/18/20 at 11:00 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." The surveyor further reviewed with the DON that the requirement had been changed effective 6/15/20 to the require facilities to monitor vital signs once daily. Review of resident screening tools confirmed that resident temperatures 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 however there was no documented evidence that residents other vital signs including blood pressure, pulse and pain level were being obtained by facility staff on a daily basis.</p> <p>At 2:00 p.m., the surveyor the facility policy, dated 3/4/20 and last updated 4/17/20 "Covid 19</p>	A 310		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 03A006	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/18/2020
--------------------------------------------------	-------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER CAMBRIDGE ENHANCED SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 255 E MAIN STREET MOORESTOWN, NJ 08057
-----------------------------------------------------------------------------	--------------------------------------------------------------------------------------------

(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 310	Continued From page 2 Protocols." The facility policy provided instructions "Residents will be monitored daily for temperature and signs of Covid-19." The facility policy did not provide instructions for the facility to obtain and record resident other vital signs and pain level to screen for Covid-19. 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		
A 473	8:36-5.1(g) General Requirements (g) The assisted living residence, comprehensive personal care home, or assisted living program shall adhere to applicable Federal, State, and local laws, rules, regulations, and requirements. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to ensure compliance with Covid-19 testing in accordance with Executive Directive No 20-013 issued by the Commissioner of the Department of Health on 5/12/20. The Executive Directive stated that the Commissioner of the Department of Health "...pursuant to the powers afforded to me under the Emergency Health Powers Act, hereby ORDER and DIRECT the following..." "Testing Shall Occur as follows... b. Retesting of individuals who test negative at baseline within 3-7 days after baseline testing."	A 473		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 03A006	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/18/2020
--------------------------------------------------	-------------------------------------------------------------------------	-----------------------------------------------------------------------	-----------------------------------------------------

NAME OF PROVIDER OR SUPPLIER CAMBRIDGE ENHANCED SENIOR LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 255 E MAIN STREET MOORESTOWN, NJ 08057
-----------------------------------------------------------------------------	--------------------------------------------------------------------------------------------

(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 473	<p>Continued From page 3</p> <p>On 6/18/20 at 2:00 p.m. during review of employee Covid testing, the surveyor determined that 20 of 21 employees did not receive the second set of testing within the 3-7 day timeline. Further review of employee testing revealed that 1 employee was retested at 13 days, one at 14 days, 3 employees retested at 15 days, 1 at 18 days, 2 employees at 23 days, 1 employee at 25, and 1 employee at 26 days. In addition, 9 of 21 employees did not undergo retesting since their initial test which was completed at the end of May.</p> <p>The surveyor then reviewed the facility policy "Universal Testing Protocol" which stated in Item #3 "Retesting of all staff will be completed weekly." The Executive Director agreed that the employee testing did not meet the criteria as established in the Executive Order issued by the Commissioner of the Department of Health.</p> <p>During survey a Plan of Correction (POC) was provided to the surveyor by the Executive Director.</p> <p>A followup survey was completed on 7/8/20 and the POC had been implemented.</p>	A 473		



CAMBRIDGE

REHABILITATION & HEALTHCARE CENTER

Cambridge Enhanced Senior Living

Provider Number: 03A006

Date of Survey: June 18th survey

A310 8:36-3.4 (a)(1) Administration

On June 18, 2020, the RN Wellness Director immediately obtained and documented a complete set of vital signs for all residents to include heart rate, blood pressure, pulse ox, respirations, and pain. In addition to the vital signs, all residents were screened for cough, shortness of breath, fever, sore throat, GI symptoms or other changes from baseline. No abnormal findings were noted.

1. All residents have the potential to be affected.
2. Facility policy was updated to reflect the need to obtain and document a complete set of vital signs and COVID-19 symptom screenings daily on each resident. The RN Wellness Director educated the Assisted Living staff on the updated policy and the need to obtain and document a complete set of vital signs and COVID-19 symptom screenings daily on each resident until further guidance is received from the Commissioner of the Department of Health.
3. The RN Wellness Director will audit the residents' vital signs and COVID-19 screenings for compliance daily x 2 weeks, biweekly x 6 weeks, then weekly x 4 weeks.
4. Results of the audits will be presented to the QAPI committee for further review and action as appropriate.

Date of Compliance: July 24, 2020

A473 8:36-5.1 (g) General Requirements

All staff COVID-19 test results were audited on June 18, 2020 to identify those that were out of compliance. Retesting of all active staff started on June 18, 2020 and continued every 3-7 days thereafter.



CAMBRIDGE

REHABILITATION & HEALTHCARE CENTER

1. All residents have the potential to be affected.
2. Staff COVID-19 testing is completed every 3-7 days for all Assisted Living staff and will continue no less than weekly until further guidance is received from the Commissioner of the Department of Health.
3. The Assisted Living Administrator will audit staff COVID-19 testing weekly x 3 months for compliance. Results of the audits will be presented to the QAPI committee for further review and action as appropriate.

Date of Compliance: July 24, 2020

VCRobinson

Assisted Living Administrator

7/24/20

Date