STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	55A008	A. BUILDING: _____ B. WING _____	03/31/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE ASSISTED LIVING OF WALL	2600 ALLAIRE ROAD WALL, NJ 07719

(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: Census: 55 Sample size: 3 A COVID-19 Focused Infection Control survey was conducted by the State Agency on 3/31/21. 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:	A 310		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 310	Continued From page 1 Based on interview and record review, it was determined that the Executive Director (ED) failed to develop a policy that ensured the implementation of resident screening in Phase 0 of reopening, in accordance with the requirements of the New Jersey Department of Health (NJDOH) Executive Directive No. 20-026, to minimize sources and transmission of COVID-19 virus for 3 of 3 residents reviewed for infection prevention and control, Resident #'s 1, 2, and 3. This deficient practice was evidenced by the following: Reference: NJDOH Executive Directive No. 20-026, updated 1/6/21, indicated the following: " ...Phase 0: Any facility with an active outbreak of COVID-19, as defined by the Communicable Disease Service (CDS) ... Section IV. Required standards for services during each phase. 1. Phase 0 ... iv. Facilities shall screen all residents at minimum during every shift with questions and observations for signs or symptoms of COVID-19 and by monitoring vital signs. Vital signs recorded shall include heart rate, blood pressure (BP), temperature and pulse oximetry ...." During interview on 3/31/21 at 10:00 a.m., the ED stated that Resident #1 was Executive Order 26, 4.b. in the month of Executive Order 26, 4.b.. The ED further stated that Resident #1 was Executive Order 26, 4.b. and placed Executive Order 26, 4.b. in his/her room. In addition, the ED stated that two staff members were COVID-19 positive on 3/21/21 and 3/24/21 from home exposure and that the facility was in Phase 0. The surveyor asked the ED how the facility screened the staff and residents for COVID-19. The ED stated that the staff were tested for COVID-19 twice a week and the residents were tested once a week and the facility used a	A 310		

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	55A008	A. BUILDING: _____ B. WING _____	03/31/2021

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SUNRISE ASSISTED LIVING OF WALL	2600 ALLAIRE ROAD WALL, NJ 07719

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A 310	Continued From page 2	A 310		

screening tool to monitor the residents.

The surveyor interviewed the Health and Wellness Director (HWD) at 11:15 a.m., who stated that the residents were tested weekly for COVID-19 and added that the facility used a screening tool that was completed twice a day. The HWD further stated that the screening tool titled, "COVID-19 Screening - V6" prompted the user to provide the temperature, but not a full set of vital signs. She also stated that the facility performed full sets of vital signs twice a day and that the facility does not wake residents up for vital signs during the overnight shift.

The surveyor requested to review the resident monitoring and screening documents for three shifts. The surveyor was provided with a copy of the "COVID - 19 Screening - V6" and the "Weights and Vitals Summary" forms for the dates of 3/29 - 3/30/21, which displayed a full set of vital signs were completed twice daily for all facility residents.

At 12:15 pm the surveyor reviewed Resident #1's "Progress Notes" section of the medical record and observed documented by the Registered Nurse (RN) on [redacted] that Resident #1 was tested for COVID - 19 on [redacted] and the results [redacted]. In addition, surveyor review of Resident #'s 1, 2 and 3 "Weights and Vitals Summary" forms indicated that the facility performed vital signs once a day from 1/20/21 through 2/4/21 after a positive COVID-19 result in the facility, which placed the facility in Phase 0.

The surveyor observed that there was no documented evidence that the required screening process of a temperature, blood pressure, pulse, oxygen saturation, and screening for signs and

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A 310	Continued From page 3 symptoms of COVID-19 was consistently performed three times a day during the facility's COVID-19 outbreak period.	A 310		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
55A008		5/18/2021

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNRISE ASSISTED LIVING OF WALL	2600 ALLAIRE ROAD WALL, NJ 07719

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0310 Reg. # 8:36-3.4(a)(1) LSC	Correction Completed 05/21/2021	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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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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 3/31/2021	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			

 EVENT ID: SVQW12