STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PREMIER CADBURY OF CHERRY HILL	2150 ROUTE 38 CHERRY HILL, NJ 08002

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F 000	INITIAL COMMENTS COMPLAINT #: 143459 CENSUS: 110 SAMPLE SIZE: 3 THE FACILITY IS NOT IN SUBSTANTIAL COMPLIANCE WITH THE REQUIREMENTS OF 42 CFR PART 483, SUBPART B, FOR LONG TERM CARE FACILITIES BASED ON THIS COMPLAINT VISIT. During a complaint survey conducted on 3/9/2021 and 3/12/2021, it was determined that effective 3/12/2021, the facility was found to have been in Immediate Jeopardy for F600. The New Jersey Department of Health notified the Administrator of the Immediate Jeopardy and provided the Facility with the Immediate Jeopardy Template on 3/12/2021. The Facility failed to provide a safe environment to ensure residents were protected from actual physical/sexual abuse by failing to adequately monitor and supervise a known sexual seeking resident (Resident #1) with a known history of sexual encounters with residents. On 3/12/2021, the New Jersey Department of Health received an acceptable Removal Plan of the Immediate Jeopardy. The IJ ran from 2/20/2021 to 3/5/2021, until	F 000		

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

Electronically Signed | 04/12/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 000	Continued From page 1 Resident #1 was discharged from the facility and the staff were in-serviced on Abuse. The IJ was Past Non-Compliance on 3/12/2021.	F 000		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: COMPLAINT #: 143459 Based on interviews, Medical Record (MR) review, and review of other pertinent facility documents on 3/9/2021 and 3/12/2021, it was determined that the facility staff failed to provide a safe environment to ensure residents were protected from actua[redacted] abuse by failing to adequately monitor and supervise a known [redacted] resident (Resident #1) with	F 600	1a. Facility informed Police Department on 3-12-2021 who stated there was no abuse noted and would not be opening a case. b. IJ was identified by state surveyor on 3-12-2021; facility provided acceptable Removal Plan which included in-servicing of the staff on Abuse, and Reporting of Abuse which removed the Immediacy. c. Resident #1 and Resident #2 no harm was noted to both residents The Root Cause Analysis was done to identify breakdowns in the processes and systems that contributed to the events	3/15/21

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F 600	Continued From page 2 a known history of [redacted] with residents. On [redacted], Resident #1 was observed by the staff in bed with Resident #2, a [redacted] resident, [redacted] from the [redacted]. The facility also failed to follow their policy titled "Abuse Policy" and notify the police for 2 of 3 residents (Resident #1, and Resident #2) sampled for abuse. This placed all residents with [redacted] who were living in the facility in an immediate jeopardy situation. The IJ was identified on 3/12/2021 at 2:27 p.m., when the Administrator (Admin) and the Director of Nursing (DON) were notified of the IJ situation and were provided with the IJ template. The IJ ran from 2/20/2021 to 3/5/2021, until Resident #1 was discharged from the facility and the staff were in-serviced on Abuse. The facility provided an acceptable Removal Plan which included in-servicing of the staff on Abuse, and Reporting of Abuse which removed the Immediacy. The IJ was Past Non-Compliance. 1. According to the Admission Record (AR), Resident #1 was admitted to the facility on [redacted], with diagnoses which included but were not limited to: [redacted] Review of the Minimum Data Set (MDS), an assessment tool dated [redacted], Resident #1 had a Brief Interview of Mental Status (BIMS) score of [redacted] which indicated the resident had [redacted]. The MDS also revealed that Resident #1 required extensive assistance for Activities of Daily Living (ADLs). Review of the Care Plan (CP), revealed a Focus of: "Resident found in bed [redacted] resident," dated [redacted]. Interventions included:	F 600	and how to prevent future events. The Facility conducted an RCA with QAPI committee which includes but not limited to, Medical Director, Director of Nursing, Director of Social Services, Infection Preventionist, Assistant Director of Nursing, Staff Educator, Directors of Recreation, Housekeeping, Maintenance, Rehab, and Administrator. The Root Cause Analysis revealed that due to non-deliberate failure of the facility to monitor a possible [redacted] resident and follow facility policy on Abuse all contributed to the main problem: What Happened? 1. Resident #1 and Resident #2 were both noted in same bed sleeping; Resident #2 went willingly to Resident #1 room. Resident and Resident #2 stated they were [redacted]. Resident #2 states [redacted] felt safe in facility. Resident # 1 was placed on [redacted] on [redacted] on resident was ended weeks later thus determining this to be the Root Cause of this systemic failure. How it Happened? Non-deliberate Action of facility failure to provide a safe environment to ensure residents were protected from actual [redacted] abuse by failing to adequately monitor and supervise a possible [redacted] resident with a history of [redacted] with residents (2) facility failed to follow facility policy Abuse and notify police Corrective Action " Staff/Administrative Staff was educated immediately on 2-22-2021and	

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F 600	Continued From page 3 Resident agreeable to be separated, Social Worker spoke with resident in regard to the incident. consult placed. Resident sent to for evaluation and will be place on upon return. The CP for Resident #1 also showed a Focus of: " Resident noted with peer in his/her bed in resident's room sleeping, dated . Interventions included: every 15-minute monitoring until seen by and . The CP for Resident #1 also showed a Focus of: " dated . Interventions included: Monitor behavior closely for signs and symptoms of engaging in inappropriate relations. Ensure resident and other resident are not in close proximity. Review of the Progress Notes for Resident #1 dated at 8:07 a.m., documented by the Advanced Registered Nurse Practitioner (ARNP), revealed the following: Under : Patient is now here for Long-term Care. Resident has adjusted well, still with behavior issues at times. Resident can be to staff and other residents. Now on to redirect from these episodes. Review of a progress note for Resident #1 dated at 10:16 a.m., documented by the ARNP, revealed the following: Under "Mental	F 600	following days " Additional In-services for Abuse Prevention and Peggy□s law provided 3/09/21, 3/12 3/13, 3/14, 3/15, 3/16 " In-services for accidents and incidents provided to staff 3/13, 317 " In-services for staff on behavior 3/09/21, 3/12, 3/13, 3/14, 3/16 3/17 " Resident #1 and Resident #2 were both seen by and with no follow up " Facility gives Abuse In-service to all new hires " Facility educated line workers and Administrative staff on Abuse, Behavior and Accidents " In order to ensure staff has knowledge of facility Abuse Policy facility staff will be in-serviced on Abuse weekly/monthly -Findings will be reported to the QAPI committee monthly and recommendations will be made based upon outcomes. -All staff will continue to receive on-going education on Abuse. Responsible Individual Staff Educator will be responsible for maintaining education for staff on Abuse 2b. Resident #1 was discharged from facility on Resident after incident was immediately placed on . behavior monitoring on a unit until discharge from facility on	

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F 600	Continued From page 4 Status:" He/she is alert. Mental status is at baseline. He/she is [redacted]. Patient with [redacted], also issues with outbursts and aggression. He/she had [redacted] for several weeks but it appears to have ended at this time. 2. According to the AR, Resident #2 was admitted to the facility on [redacted], with diagnoses which included but were not limited to: [redacted]. Review of the MDS, an assessment tool dated [redacted], Resident #2 had a BIMS score of [redacted], which indicated the resident had [redacted] The MDS also revealed that Resident #2 required extensive assistance for ADLs. According to the CP, Resident #2 had [redacted] BIMS with [redacted] Interventions included but were not limited to: Use task segmentation to support [redacted] deficits. Cue, reorient and supervise as needed. The CP also showed a Focus of: "Potential for Abuse" dated [redacted], and "Resident noted lying in [redacted] peer's bed. [redacted]) and [redacted] prn (as needed), every [redacted] monitoring until seen by [redacted], to monitor resident for any s/s (signs or symptoms) of distress and overall mood and behavior." Review of the progress notes for Resident #2 dated [redacted], revealed the following documentation by the [redacted] Nurse Practitioner/Advanced Registered Nurse Practitioner (ARNP): Patient had a recent	F 600	Resident #2 [redacted] was immediately placed on [redacted]. behavior monitoring and transferred to another unit (no other resident was affected). 2. Others having the potential to be affected by the deficient practice: a. All residents on the unit to have the potential to be affected by this deficient practice were interview immediately after incident on [redacted]. No other resident was affected. b. The Staff Educator will provide in-service to staff on Abuse. The facility will continue with Abuse education for all new hires and on an ongoing basis 3. Facility will educate all new hires on Abuse and policy will be presented at weekly staff education meetings X 3 months. " in-service training to staff will be validated by attendance sheets signed and maintained by Staff Educator System Changes The facility will educate all New Hires on Abuse and will be presented at weekly staff education meetings X 3 months Monitoring The Staff Educator will continue to give in-service on Abuse to hew hires and ongoing basis. Any Facility failure to adhere to facility Abuse Policy will be reviewed, and	

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F 600	Continued From page 5 incident, was found in a [redacted] resident's room [redacted]. Resident was confused, had poor judgment and insight, attention and concentration were poor, and was easily distracted. Currently on [redacted] for a [redacted] According to the documentation on the Facility's Reportable Event Record/Report (FRE), reported to the New Jersey Department of Health (NJDOH) by the Administrator on [redacted], with an event date and time of [redacted] at 11:30 p.m., the "Type of Incident," as "Other: two residents found in bed together." The Narrative included: On [redacted], at approximately 11:30 p.m., Resident #2 was found in Resident #1's bed. Both have a diagnosis of [redacted]. Resident #2 had propelled the wheelchair to the room of Resident #1. According to the witness statements with the FRE with an event date and time of [redacted] at 11:30 p.m., the nurse documented that on [redacted] at 11:30 p.m., she was alerted that Resident #2 was not in bed, the staff proceeded to look for the resident, Resident #2 was found in Resident #1's room in the bed. Both residents were [redacted] and were asleep. The residents were separated, and Resident #2 was taken to his/her room, evaluated and placed in bed. Resident #2 was placed on every [redacted] safety checks. The Supervisor was notified and also witnessed the incident. According to the FRE the following interventions were put in place: Resident #2 was taken back to his/her room. A body check was completed on both residents, no apparent injuries were noted. Both residents were able to express themselves	F 600	presented to monthly QAPI committee x 3 months Recommendations will be based upon outcomes. The facility was cited for past non-compliance and was in compliance on 3/12/2021. The corrective actions and competencies mentioned above were completed by 3-15-2021 to ensure the deficient F600 SS=J practices will not reoccur.	

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F 600	Continued From page 6 separately, verbally, and nonverbally and neither showed any expressions or signs of pain, discomfort or fear. Both residents were placed on every [redacted] checks until evaluated by [redacted] and [redacted]. The FRE also indicated that the Medical Doctor and the Ombudsman were notified of the event, however, there was no documentation that the Local Law Enforcement was notified of the alleged abuse. Review of the Investigation Summary dated [redacted], revealed Resident #1 had a diagnosis of [redacted]). Review of the Investigation Summary dated [redacted], revealed Resident #2 diagnosis of [redacted] Further review of the Investigation Summary dated [redacted], under "Incident," revealed the following: Resident #2 was observed on [redacted], in Resident #1's room in bed together. They were observed lying next to each other [redacted]. Room light was not on. Both residents appeared to be sleeping when the staff entered the room. Resident #1 was observed with a shirt on but no pants. Resident #2 was observed with a shirt on but with pants down above the knees. Both residents stated, [redacted]." Resident #2 reported that he/she propelled the wheelchair to Resident #1's room and Resident #1 assisted him/her into the bed.	F 600		

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F 600	Continued From page 7 According to the FRE "Conclusion" dated [redacted], documented by the Regional Director of Nursing (RDON) who had been covering for the DON, revealed the following: "It is my professional opinion that no neglect, abuse or mistreatment has occurred. Both residents remain safe. Nursing will continue to monitor resident for safety." Review of the Safety Check Logs for Resident #2 verified that the every [redacted] safety checks were in place from [redacted] until [redacted], then discontinued. Review of the progress notes for Resident #2 dated [redacted] at 12:07 a.m., revealed the following documentation by the Licensed Practical Nurse (LPN#1). On [redacted] at 11:30 p.m., Resident #2 was found in Resident #1's room, both residents clothes were [redacted] Residents were asleep. No signs of sexual activity observed. Resident #2 was removed from Resident #1's bed, evaluated and taken back to his/her room and placed in bed. Both residents placed on every [redacted] checks until further notice. Review of the Safety Check Logs for Resident #1 verified that the every [redacted] safety checks were in place from [redacted] until [redacted] at 11:00 p.m., then discontinued. Review of the progress noted for Resident #1 revealed documentation by [redacted] ARNP dated [redacted] at 2:51 p.m., as follows: Staff reported resident exhibits inappropriate [redacted] and can be [redacted] towards staff and peers. Easily annoyed and angered. Can be difficult to redirect.	F 600		

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Reduction of [redacted] mediation is clinically contraindicated at this time and would likely result in decompensation, impairment of the patients functions and an increase in emotional distress and behaviors.

According to the progress notes dated [redacted] at 5:34 p.m., documented by the RDON, Resident #2 was observed by the staff during rounds in bed with a [redacted] resident in his/her room. Staff observed both residents [redacted] from the [redacted]. Both residents appeared to be sleeping when the staff entered the room. Resident #1 was observed with a shirt on but no pants. Resident #2 was observed with a shirt on but with pants down above the knees. Both residents reported they were cuddling and lying down. Both residents stated no interaction was made they just cuddled and slept. Resident #2 reported feeling safe in the facility. The residents were separated, Resident #2's room was changed to another unit, and both residents were placed on every [redacted] monitoring until seen by [redacted].

Review of the medical doctor's progress note for Resident #2 dated [redacted] at 7:48 a.m., revealed the following documentation by the physician: On [redacted], Patient was found in bed with a [redacted] resident and the resident reported wheeling down to Resident #1's room and was helped into the [redacted] bed. Patient denied any distress and appeared to have liked "cuddling." No physical discomfort observed after the incident. [redacted]

Review of the progress notes for Resident #2 dated [redacted] at 6:18 p.m., revealed the

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following documentation by the [redacted] Advanced Registered Nurse Practitioner (ARNP): Staff reported that the Patient had a recent incident that involved wheeling self into a [redacted] resident's room. Staff found both residents in bed, [redacted] and "cuddling." Patient denied any distress and no physical discomfort was observed after the incident. [redacted]."

During an interview on 3/9/2021 at 11:36 a.m., the Licensed Practical Nurse (LPN #2) reported that she did not feel that Resident #1 or Resident #2 were able to consent [redacted]. "I don't believe (Resident #2's name) or (Resident #1's name) were able to consent. They are not alert enough to consent." LPN #2 also stated that Resident #2 is confused and only alert to self. Resident #1 "is not there all the time." Resident #1 is confused.

During an interview on 3/9/2021 at 12:07 p.m., the DON reported that there was a previous incident between Resident #1 and Resident #2 back in [redacted]. The evening nurse had observed Resident #1 and Resident #2 in Resident #1's room in bed together on [redacted] at 3:10 p.m., with their pants down and only a brief in place from the waist down. The nurse separated the 2 residents. Resident #1 was placed on [redacted] observation and a [redacted] consultation was ordered. Resident #1 was already being followed by the [redacted] for [redacted] behaviors. The DON also stated that she believed Resident #2 "went willingly," however, the DON stated "I'm not sure he/she (Resident #2) knew who he/she (Resident

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#1) was. I feel like he/she (Resident #2) was not alert enough to know what he/she (Resident #2) was doing."

Review of the staff assignments revealed [redacted] monitoring was in place from [redacted] to [redacted]

During an interview on 3/9/2021 at 2:23 p.m., the Director of Social Services (DSS) reported that she was aware that Resident #1 had [redacted] episodes of [redacted] with residents in the Facility. The DSS reported she felt Resident #1 was alert and oriented.

During an interview on 3/12/2021 at 9:44 a.m., the Certified Nursing Assistant (CNA#1), reported that the nurse informed her after the [redacted] incident that Resident #2 needed to be watched for safety reasons. Resident #1 would often try to get Resident #2 to go to his/her room by giving him/her "the eye" and telling Resident #2 "Let's go." Resident #1 would say "I can get anybody," when the staff would stop Resident #2 from going to Resident #1's room. We always watched him/her (Resident #2) to make sure he/she would not go down to his/her (Resident #1's) room. After the [redacted] incident we (CNAs) were told by the nurse to "keep them apart." The CNA further stated that she did not feel that Resident #2 was "cognitively with it" to have [redacted] with Resident #1.

During an interview on 3/12/2021 at 9:56 a.m., the DON reported that Resident #1 was discharged to another Facility on [redacted] secondary to his/her behaviors.

During an interview on 3/12/2021 at 10:10 a.m., CNA#2 reported that she was the regular CNA for

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Resident #2 and the resident was [redacted] and [redacted] on some days and other days the resident was confused. The CNA reported that she had often witnessed Resident #1 trying to get Resident #2 to his/her room by shaking his/her head then wheeling down towards the room, trying to get Resident #2 to follow. Resident #2 would try to follow Resident #1, however, the staff would stop them. The nurse had informed the CNA's to keep them apart for safety.

CNA #2 also reported that at times Resident #1 would "brag" and stated, "That was old stuff (referring to Resident #2). I can get anybody else." Resident #1 had stated this after the CNA had stopped Resident #2 from going to Resident #1's room.

During an interview on 3/12/2021 at 11:30 p.m., the DON reported that when the Social Worker (SW) interviewed both residents. Resident #2 stated the following, '[redacted] However, the DON was not sure if Resident #2 thought Resident #1 was his/her [redacted] due to his/her [redacted]

The DON also stated that she felt Resident #2 was cognitively intact enough to decide to have intimate relations with Resident #1. The DON further verified that she was aware that Resident #2 had a BIMS score of [redacted] on [redacted], which indicated [redacted].

During an interview on 3/12/2021 at 12:09 p.m., the RDON reported that she was notified the next day by the Supervisor on [redacted], of the incident between Resident #1 and Resident #2 on [redacted], and she did not report it to the Police since interviews had to be completed first. The RDON stated, that she was able to look up both

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F 600	Continued From page 12	F 600		

resident's BIMS at home and Resident #1's BIMS was [redacted] and Resident #2's BIMS was [redacted] which indicated [redacted] for Resident #1 and [redacted] for Resident #2.

The RDON was asked if she felt a resident with [redacted] could consent to have [redacted] with other residents, she responded, [redacted]." When asked if [redacted] had to occur for [redacted] abuse, the RDON responded, "No." The RDON also stated that she was not aware that Resident #1 had prior [redacted] incidents in the facility.

During an interview on 3/12/2021 at 2:22 p.m., the Administrator reported that "what we did was because we felt both residents were able to make their own decisions. We did not feel it was abuse so the police were not called. We just now called the Police to see if they will investigate for abuse. They (Resident #1 and Resident #2) developed a friendship with each other. They needed human touch. Everyone is missing their families at this time."

According to the facility policy titled "Abuse Policy," dated 3/2016, revised date of 10/2017, under Policy; the Facility prohibits the mistreatment, neglect, and abuse of residents/patient and misappropriation of resident/patient property by anyone including staff, family, friends, etc. The facility has designed and implemented processes which strive to ensure the prevention and reporting of suspected or alleged resident/patient abuse, neglect, mistreatment, and/or misappropriation of property.

Under "Reporting," Notify the local law

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F 600	Continued From page 13 enforcement and appropriate State agency(s) immediately by fax or telephone after identification of alleged/suspected incident. Initiate process according to the Elder Justice Act and State specific regulations. The IJ was identified on 3/12/2021 at 2:27 p.m., when the Administrator and the Director of Nursing were notified of the IJ situation and were provided with the IJ template. The IJ ran from 2/20/2021 to 3/5/2021 when Resident #1 was discharged from the facility and the staff were in-serviced. The facility provided an acceptable Removal Plan which included in-servicing of the staff on Abuse, and Reporting of Abuse which removed the Immediacy. The IJ was Past Non-Compliance on 3/12/2021.	F 600		
F 609 SS=D	N.J.A.C. 8:39-4.1(a)5 Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other	F 609		3/15/21

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F 609	Continued From page 14 officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: COMPLAINT #NJ 143459 Based on interviews, Medical Record (MR) review, and other pertinent facility documentation on 3/9/2021 and 3/12/2021, it was determined that the facility staff failed to report an allegation of abuse timely to the New Jersey Department of Health (NJDOH), as well as follow their own policy titled "Abuse Policy," for 1 of 5 sampled Residents (Resident #1). This deficient practice is evidenced by the following: 1. According to Resident's #1 MR, the Resident was admitted to the facility on [redacted], with diagnoses which included but was not limited to: [redacted] According to the Minimum Data Set (MDS), an assessment tool dated [redacted], Resident #1 had a Brief Interview of Mental Status (BIMS)	F 609	1a. Facility informed Police Department on 3-12-2021 who stated there was no abuse noted and would not be opening a case. The Root Cause Analysis was done to identify breakdowns in the processes and systems that contributed to the events and how to prevent future events. The Facility conducted an RCA with QAPI committee which includes but not limited to, Medical Director, Director of Nursing, Director of Social Services, Infection Preventionist, Assistant Director of Nursing, Staff Educator, Directors of Recreation, Housekeeping, Maintenance, Rehab, and Administrator. The Root Cause Analysis revealed that lack of timeless of knowledge of incident to Director of Nursing (DON) or Administrator and lack of timeliness of Administrator or DON to Report incident to NJDOH within 2 hours of suspected or actual abuse all contributed to the main	

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F 609	Continued From page 15 score of [redacted], which indicated the resident had [redacted]. The MDS also indicated Resident #1 needed assistance with Activities of Daily Living (ADL)s. Review of Resident # 1's Progress Notes dated [redacted] at 4:53 p.m. (late Entry), revealed the following: Resident noted on [redacted], while staff was doing rounds with [redacted] peer in [redacted] bed in [redacted] room. Staff called for assistance from the nurse. Both residents were noted laying next to each other in bed. Room light not on. Staff members noted both residents [redacted]. Both residents appeared to be sleeping when staff entered room. Resident #1 noted with shirt on, but no pants. Resident #2 noted with shirt on but with pants down above the knee. Both Residents stated when asked what happened that they were cuddling and lying down. Peer stated she self ambulated her wheel chair (W/C) to resident's room and the resident assisted her to his bed from the W/C.... Review of the facility Reported Event Record (FRE) dated [redacted], revealed on [redacted] at approximately 11:30 p.m., Resident #2 was found in another residents bed. Both have a diagnosis of [redacted] Resident #2 had propelled themselves in their W/C to the room of Resident #1. According to the facility's investigation conclusion no name/unsigned revealed "it is in my professional opinion that no neglect, abuse or mistreatment has occurred." During an interview with the Regional Director of Nursing (RDON) on 3/1/2021 at 12:09 p.m., explained if you find out about it you need to report it within 2 hours. Per the RDON, the local police were not notified, only the administrator.	F 609	problem: What Happened? 1. The apparent cause of this was due to non-deliberate lack of by Nursing Management staff to report suspected or actual abuse to NJDOH in a timely manner (2 hours) was determined to be the Root Cause of this systemic failure. How it Happened? Facility failed to follow facility Policy Abuse Corrective Action " Staff/Administrative Staff was educated immediately on [redacted] and following days " Additional In-services for Abuse Prevention and Peggy□s law provided 3/09/21, 3/12 3/13, 3/14, 3/15, 3/16 " Facility gives Abuse In-service to all new hires " Facility educated line workers and Administrative staff on Abuse, Sexual Behavior and Accidents " In-services for accidents and incidents provided to staff 3/13, 317 " In-services for staff on sexual behavior 3/09/21, 3/12, 3/13, 3/14, 3/16 3/17 " In addition, In order to ensure staff has knowledge of facility Abuse Policy policy will be presented at weekly staff education meetings x 3 months Abuse policy and Grievance policy will be reviewed at QAPI committee monthly, X 3 months. -All staff will continue to receive on-going education on Abuse. Responsible Individual Staff Educator will be responsible for	

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F 609	Continued From page 16 The RDON further explained I could have called it in. We did not feel it was abuse at the time. If abuse is suspected we would report it to the police within 2 hours. Review of the facility's policy titled "Abuse Policy" dated 10/2017, revealed the following: Under "Policy": The facility prohibits the mistreatment, neglect, and abuse of residents/patients, and misappropriation of resident/patient property by anyone including staff, families, friends, etc. The facility has designed and implemented processes, which strive to ensure the prevention and reporting of suspected or alleged resident/patient abuse, neglect, mistreatment, and/or misappropriation of property. Under "Protocol": The Administrator and Director of Nursing are responsible for investigation and reporting. They are also ultimately responsible for the following as they relate to abuse, neglect and/or misappropriation of property standards and procedures. Implementation, ongoing monitoring, reporting, investigation, tracking and trending. Under "Investigation": The Administrator and Director of Nursing are responsible for investigation and reporting. Under "Reporting": Notify the local law enforcement and appropriate State agency'(s) immediately by fax or telephone after identification of alleged/suspected incident. Initiate process according to the Elder Justice Act and State specific regulations, Report. If a crime is suspected, the Elder Justice Hotline must be notified. The Administrator, Director of Nursing or designee shall notify the Department of Health,	F 609	maintaining education for staff on Abuse 2b. Resident #1 [redacted] was discharged from facility on [redacted] Resident after incident was immediately placed on [redacted]. behavior monitoring on a locked unit until discharge from facility on [redacted] Resident #2 [redacted] was immediately placed on [redacted]. behavior monitoring and transferred to another unit (no other resident was affected). 2. Others having the potential to be affected by the deficient practice: a. All residents on the unit to have the potential to be affected by this deficient practice were interview immediately after incident on [redacted]. No other resident was affected. b. The Staff Educator will provide in-service to staff on Abuse. The facility will continue with Abuse education for all new hires and on an ongoing basis 3. Facility will educate all new hires on Abuse and policy will be presented at weekly staff education meetings x 3 months. " in-service training to staff will be validated by attendance sheets signed and maintained by Staff Educator System Changes The facility will educate all New Hires on	

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F 609	Continued From page 17 via the Event Reporting System electronically, or by telephone in the event of the electronic system being unavailable within (2) hours of knowledge of the alleged incident. The Administrator or designee will notify Adult Protective Services Area Agency on Aging, and the ombudsman that an abuse investigation is being conducted within 24 hours of knowledge of alleged incident. The ombudsman will be invited to participate in the investigation. N.J.A.C: 9.4(f)	F 609	Abuse and policy will be presented at weekly staff education meetings x 3 months. Monitoring The Staff Educator will continue to give in-service on Abuse to hew hires and ongoing basis. Any Facility failure to adhere to facility Abuse Policy will be reviewed, and presented to monthly QAPI committee x 3 months. The facility will be in compliance with regard to this deficiency, and the corrective actions and competencies mentioned above by 3-15-2021 to ensure the deficient F609 SS=D practices will not reoccur.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents,	F 880		5/11/21

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staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and

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F 880	Continued From page 19 transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: COMPLAINT #: 143459 Based on observations, interviews, and review of pertinent facility documents on 3/9/2021 and 3/12/2021, it was determined that the Facility failed to following acceptable standards of Infection Control (IC) practices to safely transport and deliver Personal Protective Equipment (PPE), gowns, to prevent the spread of infection, as well as, failed to follow their Policy's titled "Covid-19 Infection Control:" and "Laundry Operations Manual.." This deficient practice was evidenced by the following: 1. On 3/9/2021, the surveyor observed an Environmental Services Department (ESD) employee, in the hallway delivering clean, cloth isolation gowns to the unit and placing them in the isolation carts outside of the resident rooms # [redacted], and [redacted] The linen cart was observed with a label on the outside of the cart "Soiled Linens." The inside of the linen cart contained a single bag of white cloth isolation gowns, which was observed ripped open on the top. The linen cart was observed to have dirt throughout the	F 880	1a. After Surveyor informed Director of Nursing (DON) and the Regional Director of Nursing they immediately: • removed the employee from the unit and asked employee to clock out; employee was suspended pending termination • removed the gowns from the isolation carts and disinfected the carts The Root Cause Analysis was done to identify breakdowns in the processes and systems that contributed to the events and how to prevent future events. The Facility conducted an RCA with Regional Nurse, Administrator, Executive Director and CEO and QAPI committee which includes but not limited to, Medical Director, Director of Nursing, Infection Preventionist, Director of Social Services, Assistant Director of Nursing, Staff Educator, Directors of Recreation, Housekeeping, Maintenance, Rehab and Administrator. The Root Cause Analysis revealed that the facility failed to follow acceptable standards of Infection Control practices to safely transport and deliver Personal Protective Equipment (PPE), gown, to prevent the spread of infection, as well as, Failure to follow facility policy “Covid-19	

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F 880	Continued From page 20 inside of the cart. The isolation gowns were not individually wrapped. The ESD employee was observed removing the gowns one at a time from the cart, rolling the gowns, without gloves in place then he placed the gowns into the isolation carts outside of the resident's rooms. During the observation of the employee it was noted that the gowns were touching the inside of the linen cart while he was rolling them. During an interview on 3/9/2021 at 3:05 p.m., the ESD employee reported that he was delivering clean linens to the unit. He stated that the reason he was using the "soiled linens" cart, was because "no other bins were available." He reported that he had already stocked several isolation carts, and pointed to the isolations carts outside of rooms [redacted], and [redacted]. When the employee was asked if this was an infection control issue, the ESD employee failed to respond. The surveyor immediately reported the Infection Control situation was to the Director of Nursing (DON) and the Regional Director of Nursing (RDON), who removed the employee from the unit and removed the gowns from the isolation carts and disinfected the carts. During an interview on 3/9/2021 at 3:35 p.m., the Infection Control Nurse (ICN), reported that she was made aware of the IC issue involving the ESD employee delivering linens and she (ICN) had just finished in-servicing the ESD employees on "Linen handling." The surveyor was given a copy of the in-servicing which verified the in-service was completed on 3/9/2021. During an interview on 3/9/2021 at 3:42 p.m., the Director of Environmental Services (DES),	F 880	Infection Control" and "Laundry Operations Manual" which all contributed to the main problem: What Happened? 1. The apparent cause of this was due staff member lack of concern that he was using a "Soiled Linen" cart to deliver "Clean Linen" to units for isolation bins was determined to be the Root Cause of this systemic failure. How it Happened? One facility staff member failed to follow facility Policy, "Covid-19 Infection Control" and "Laundry Operations Manual" after being educated numerous times. Corrective Action • The ESD employee that was noted in violation of Infection Control Practice by surveyor and CEO was terminated • ESD employees in facility was immediately in-serviced by the Infection Control Preventionist on 3-9-2021 and surveyors given a copy • In order to ensure ESD employees have knowledge of facility policy, ESD facility staff will be re-in-serviced on Infection Control and Transportation of Linen weekly/monthly X 3 Months -Findings will be reviewed, and presented to monthly QAPI committee x 3 months -ESD employees will continue to receive on-going education on Transportation of linen and Infection Control Responsible Individual Staff Educator and Director of Environmental Services will be responsible for maintaining education for staff on Transportation of Linen and	

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F 880	Continued From page 21 reported that the employee was immediately removed from the unit and asked to clock out and was suspended and pending termination. Review of the ESD employee record revealed a document titled "Cleaning of Face Shield/ Goggles," dated [redacted], which listed the "Mode of Presentation," as: Direct lecture with Policy on Infection Control/Transmission Based Precaution and the "Mode of Evaluation." listed: Observation of staff work practices throughout shifts monitoring of Infection Control Practices, which was signed by the employee on [redacted] According to the Facility Policy titled "Covid-19 Infection Control," with a revised date of 1/20/2021, revealed Under Policy: The facility has established appropriate guidelines pursuant to recommendations from the Local Public Health, State department of Health, CMS and the Federal Centers for Disease Control (CDC). The policy addresses resident, staff and visitor behavior and responsibilities to try to prevent the transmission of communicable disease, such as undiagnosed respiratory illness and Covid-19. According to the Facility Policy titled "Laundry Operations Manual" with a revised date of 3/2020, under "Delivering Clean Linen:" When delivering clean linen all employees should follow safety precautions and proper procedures. Section 1. Stock "clean linen cart" or bin with the appropriate amounts of required linens. NJAC 8:39-21.1(d,e)	F 880	Infection Control 2b. ESD employee was terminated (no other resident resident was affected). 2. Others having the potential to be affected by the deficient practice: a. All residents have the potential to be affected by this deficient practice After Surveyor informed Director of Nursing (DON) and the Regional Director of Nursing immediately: a. removed the employee from the unit and asked to clock out and was suspended pending termination b. removed the gowns from the isolation carts and disinfected the carts no resident was affected by this deficient practice c. The Staff Educator and Director of Environmental Services will provide in-service to staff on Infection Control and Transportation of Linen. 3. The Staff Educator and Director of Environmental Services will continue to give in-service on infection Control and Transportation of Linen weekly/monthly and on an ongoing basis x 3 months. • in-service training to staff will be validated by attendance sheets signed and maintained by Staff Educator and Director of Environmental Services • Daily rounds will be conducted by Director of Environmental Services along with Department heads and Infection Control Preventionist to ensure that	

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F 880	Continued From page 22	F 880	Infection Control Practices are adhered to: On site in-service given if noted not following that could lead to termination • Facility will not tolerate any staff member failing to follow Proper Infection Control Guidelines by NJ DOH, State/Federal/CMS 4. As per the Directed Plan Of Correction received from the NJ Department Of Health, The following in-service training was completed, with staff competency validated by Director of Nursing or Infection Preventionist. I. Nursing Home Infection Preventionist Training Course – Module 1 – Infection Prevention and Control Program [redacted] This was completed by Topline staff, including but not limited to; Executive Director, Administrator. Director of Nursing, Director of Social Services, Admissions Director, Assistant Director of Nursing, Staff Educator, Directors of Recreation, Housekeeping, Maintenance, Rehab, Dietary, Business office manager, HR director, Central Supply. In-service training was also completed by frontline staff which includes but not limited to; Dietary Aides, Cooks, Rehab techs, Therapists, Receptionists, CNA's, LPN's, RN's, Housekeepers and floor techs, Recreation aides and ancillary employees. Infection Preventionist has also completed this module. II. CDC COVID-19 Prevention messages for front line long term care staff: Keep COVID out!	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315183	A. BUILDING _____ B. WING _____	C 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 23	F 880	[redacted] This was completed by Topline staff (See above) as well as Frontline staff (See above) III. Nursing Home Infection Preventionist Training Course – Module 11d – Linen Management [redacted] In-service provided to Topline staff (See above) as well as Frontline staff (See above) Infection Preventionist has completed these as well. System Changes The Staff Educator and Director of Environmental Services will continue to give in-service on infection Control and Transportation of Linen weekly/monthly x 3 months and on an ongoing basis. Monitoring The Staff Educator and Director of Environmental Services will continue to give in-service on infection Control and Transportation of Linen weekly/monthly x 3 months and on an ongoing basis. Any Facility failure to adhere to facility Policy on Infection Control and Transportation of Linen will be reviewed, and presented to monthly QAPI committee x 3 months Recommendations will be based upon outcomes. The facility will be in compliance with regard to this deficiency and the corrective	

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F 880	Continued From page 24	F 880	actions and competencies mentioned above by 5-11-2021 to ensure the deficient F880 SS=D practices will not reoccur.	