STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315268	A. BUILDING _____ B. WING _____	C 11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKHAVEN HEALTH CARE CENTER	**120 PARK END PLACE EAST ORANGE, NJ 07018**

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F 000	INITIAL COMMENTS Complaint #: NJ149514, NJ144485, NJ146745 Census: 117 Sample Size: 6 The facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities based on this complaint survey.	F 000		
F 800 SS=E	Provided Diet Meets Needs of Each Resident CFR(s): 483.60 §483.60 Food and nutrition services. The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. This REQUIREMENT is not met as evidenced by: Complaint Intake #NJ149514 Based on observation, interview, medical record review, and review of facility policies, the facility failed to ensure residents received the food on the meal ticket and adhered to resident preferences. This affected 3 out of 3 residents (Resident #6, Resident #1, and Resident #2) reviewed for food preferences and accuracy of meal tickets. Findings included: 1. Resident #6 was admitted to the facility on [redacted] with diagnoses that include [redacted] The quarterly Minimum Data Set	F 800	1. The following corrective actions have been accomplished for the identified deficiency: - Food preferences were updated to the meal tickets for identified residents #6, #1 and #2 to include only what is being provided to them during meal service and to reflect food preferences. The DDS immediately in-serviced the dietary staff on the importance of following the ticket including identifying portion size alterations. Menu choice / preference policy re in-serviced as well. 2. All residents that receive food from the kitchen have the potential to be affected by the deficient practice. 3. The following measures have been put into place to prevent the deficient practice	12/17/21

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

Electronically Signed | 12/06/2021

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F 800	Continued From page 1 (MDS), dated 09/10/2021, revealed a Brief Interview for Mental Status (BIMS) of [redacted] indicating the resident was [redacted]. Resident #6 was supervised to independent with all activities of daily living. Resident #6 had a care plan, dated [redacted], for overall dislike of the facility food and an obese BMI. Resident #6 would express an occasional desire for weight loss. Resident #6 was on a regular NAS (no added salt), double-portion diet. Resident #1 was admitted to the facility on [redacted] with diagnoses that included [redacted]. Resident #1's admission MDS, dated [redacted] revealed a BIMS score of [redacted], indicating the resident was [redacted]. Resident #1 needed extensive assistance of one person for all ADLs, except for eating. Resident #1 had a care plan, dated 08/20/2021, for being [redacted] and to adhere to food preference to facilitate weight gain. Resident #1 was on a regular, [redacted] Resident #2 was admitted to the facility on [redacted] with diagnoses that included [redacted]. The admission MDS, dated [redacted] revealed a BIMS of [redacted], indicating [redacted]. Resident #2 required extensive assistance of one for all ADLs except eating. Resident #2 had a care plan dated [redacted] that addressed the resident's need for being at risk [redacted]. Resident #2 was	F 800	from recurring: - All Dietary employees were in serviced on monitoring the meal tickets to ensure all items on the ticket are placed appropriately on the tray, including appropriate portion sizes and any substitutions are noted on the ticket or announced to the residents. 4. The Dietitian will audit for tray accuracy of 15 trays 3x a week during the tray line for 90 days and the findings will be reported to the QAPI committee on a quarterly basis for 3 months.	

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F 800	Continued From page 2 on a regular NAS, CCD [redacted].	F 800		

On 11/03/2021 at 12:55 PM, Resident #6 was interviewed. Resident #6 stated since the new contracted food service company was hired, about six months ago, it was rare that what was on the ticket was what arrived on the tray. The resident's lunch tray was still in the room. The ticket indicated green beans and there were no green beans provided on the lunch tray. The resident had requested ice cream and ginger ale and these items were not on the lunch tray.

On 11/03/2021 at 1:13 PM, Residents #1 and #2, who were roommates, were interviewed. They stated that they did not always get what was on their tray tickets, and when they asked for what was on the ticket, they would either get an excuse as to why it wasn't available, or no one would return with the item.

On 11/03/2021 at 5:17 PM, an observation was made of Resident #6's dinner tray. The tray ticket indicated the resident was supposed to receive baked chicken, and the resident received two pork sausages. The ticket also indicated no pork/ham.

On 11/03/2021 at 5:20 PM, an observation was made of the dinner trays of Residents #1 and #2. Both of their tray tickets indicated double portions and pepperoni pizza. Each tray had one slice of pizza and it was plain cheese pizza. Resident #1 had coffee on the ticket and there was no coffee on the tray.

On 11/04/2021 at 10:17 AM, the Food and

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F 800	Continued From page 3 Beverage Director (FBD) was interviewed. He stated that there was a dietary aide at the beginning of the tray line who was calling out the order on the tray ticket, and then the last person on the line was supposed to be checking the ticket and tray for accuracy. He stated that he could not explain why the inaccuracy kept occurring, except he would need to work on the system. When asked about what made up a double portion, he explained, as an example, the pizza should have been 2 slices. He also stated that the pepperoni did not arrive on the delivery, so he changed the menu to cheese pizza, but never informed the residents of the change. The FSD did not know why Resident #6 received a pork sausage instead of chicken. He indicated he was not present in the kitchen during dinner tray line on 11/03/2021. On 11/04/2021 at 11:23 AM, the Registered Dietician (RD) was interviewed. She confirmed receiving complaints about the accuracy of the tray tickets, but stated her bigger concern was for those who needed a double portion and were not receiving the proper amount of food. The RD indicated she had been receiving fewer complaints about the tray accuracy, so she thought it was getting better. The Regional Registered Dietician (RRD), interviewed on 11/04/2021 at 11:26 AM, added the kitchen staff was fairly new, and the RRD knew the staff were working on accuracy. The facility policy titled, "Menu Choice/Preference Policy," dated 06/03/2013, indicated, "#7. Food Services employees carefully read meal tickets during meal service, to	F 800		

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F 800	Continued From page 4 ensure residents selected menu choices are honored." The facility policy titled, "Meal Tray Accuracy Audit Report Policy," dated 06/03/2013, indicated, "#1. Director of Dining Services or designee will complete meal tray accuracy audit form during tray line service at least 3 times per week and ensure coverage of all 3 meals per week." New Jersey Administrative Code: §8:39-17.4(e)	F 800		
F 880 SS=E	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, 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;	F 880		12/24/21

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F 880	Continued From page 5 §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 transport linens so as to prevent the spread of infection.	F 880		

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F 880	Continued From page 6 §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: Based on observation, interview, and facility policy review, the facility failed to ensure a certified nursing assistant (CNA) donned the proper personal protective equipment (PPE) prior to entering a resident room on the Person Under Investigation (PUI) unit. This had the potential to affect all residents and occurred during the COVID-19 pandemic. Findings included: 1. On 11/03/2021 at 4:15 PM, CNA #1 was observed walking in and out of two separate rooms on the PUI unit. The CNA was wearing a surgical mask below her chin and an N95 with a broken bottom strap. The broken bottom strap would compromise the integrity of the fit of the N95 mask. Additionally, the CNA did not have on gloves, a gown, or any eye protection (shield or goggles) and was not observed washing or sanitizing her hands prior to entering or exiting the room. On 11/03/2021 at 4:18 PM, CNA #1 was interviewed. CNA #1 stated the expectation was for her to wash her hands when she entered and exited a resident room on the PUI unit, since all residents were considered to be in quarantine. Each room on the PUI unit had signage for droplet precautions and a bin outside each room that contained gowns, gloves, eye protection, and hand sanitizer. CNA #1 stated she did not	F 880	1. The following corrective actions have been accomplished for the identified deficiency: - The employee identified as CNA #1 immediately re-educated on infection control standards including proper donning and doffing of personal protective equipment, the proper use of N95 facemask, gloves gown and face shield as well as handwashing protocols. Return demonstration completed by CNA #1 on proper donning and doffing of required PPE and handwashing. There was no negative outcome to any residents in regard to this deficient practice. 2. All residents have the potential to be affected by the deficient practice in regard to Infection Prevention & Control. 3. The following measures have been put into place to prevent the deficient practice from recurring: - Root Cause Analysis was conducted by the Infection Preventionist in conjunction with the QAPI committee and Governing Body. - All Topline staff and Infection Preventionist will receive education as per Directed Plan of Correction on Nursing Home Infection Preventionist Training Course Module 1- Infection Prevention & Control Program and Module 4 - Infection Surveillance.	

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F 880	Continued From page 7 touch any resident, so she did not wash her hands. She was just delivering supplies to the room. When asked if there was an expectation to wear PPE when entering and exiting the rooms, CNA #1 stated she was not sure, since none of the residents were positive for COVID-19 and the supervisor would have told her if anyone was positive. She understood that the residents on the PUI were on isolation since they were new residents and the requirement of the staff was to wear PPE, but she stated she didn't think she needed it since she was just delivering supplies. CNA #1 again mentioned that she didn't touch any residents. During the interview, she was asked what she would have done if a resident needed any care, but the CNA was not wearing her PPE. CNA #1 shrugged her shoulders as if to say, "I don't know." On 11/03/2021 at 4:20 PM, the Assistant Director of Nursing (ADON) was interviewed. The ADON was on the floor and observed CNA #1 entering the resident rooms on the PUI without wearing PPE. The ADON stated it was the expectation for all staff to wear full PPE (gown, gloves, proper N95, and face shield) when entering or exiting a resident room on the PUI unit. She stated this was the policy regardless of the resident's COVID-19 status because they were all new admissions, and the facility wanted to observe them for signs or symptoms of COVID-19. The ADON stated the facility did a lot of in-servicing, and she felt that after over a year of having a PUI unit, the staff would know the standards on the PUI unit. The ADON confirmed that CNA #1 had worked on the PUI unit before. On 11/04/2021 at 9:15 AM, the Director of	F 880	- All Staff including Topline Staff and Infection Preventionist will receive education as per Directed Plan of Correction on Prevention Messages for Front Line Staff Long Term Staff via YouTube training for Keep Covid-19 Out!, Clean Hands and Use PPE correctly for Covid-19. - All Staff including Topline Staff and Infection Preventionist will receive education as per Directed Plan of Correction on Nursing Home Infection Preventionist Training Course Module 11B-Environmental Cleaning & Disinfection, Module 7-Hand Hygiene, Module 6A- Principles of Standard Precautions and Module 6B- Principles of Transmission Based Precautions. -All staff will receive an infection control competency that will be validated by the Infection Preventionist or Director of Nursing. 4. The Infection Preventionist or Director of Nursing will audit / complete a competency on 5 employees a week to ensure proper measures of infection control measures are being taken to prevent and control the spread of infection for 90 days. The findings will be reported to the QAPI committee on a quarterly basis for 3 months.	

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F 880	Continued From page 8 Nursing (DON) reviewed the counseling and in-servicing that was completed with CNA #1 following the observations on 11/03/2021. The DON stated no matter how much training they did as a facility, she was frustrated that a staff member was not following the guidelines. The facility's policy titled, "Infection Control Policy," dated 03/24/2021 and revised 11/2021, revealed, "When entering a PUI room, staff must donn a new isolation down, a new pair of gloves. Staff may re-use eye protection by cleaning and disinfecting eye protection (according to manufacturer's recommendation) prior to entering the PUI room."	F 880		
F 921 SS=E	New Jersey Administrative Code: §8:39-19.4(n) Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Complaint Intake #NJ144485 Based on observations, interviews, record review, and facility policy review, the facility failed to ensure resident room bathrooms on the [redacted] floor were maintained as clean and sanitized. This affected eight (Rooms [redacted]) out of 22 rooms observed for cleanliness. Findings included:	F 921	1. The following corrective actions have been accomplished for the identified deficiency: - The identified bathrooms for rooms [redacted], were immediately cleaned. 2. All residents with have the potential to be affected by the deficient practice. 3. The following measures have been put into place to prevent the deficient practice from recurring: - Policy with protocols regarding cleaning	12/17/21

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F 921	Continued From page 9 1. On 11/03/2021 between 12:19 PM and 1:44 PM, observations were conducted on the [NJAC 8:43] [NJAC 8:43]. The following were the observations of the bathrooms: - Room [NJAC 8:43] at 12:55 PM had a buildup of grime around the base of the commode, and dried drip marks coming down the walls near the light switch, on either side of the sink, and behind the commode. The baseboards behind the sink and commode had a considerable amount of discoloration due to the amount of grime built up on the baseboards and the floor just beneath the baseboard. - Room [NJAC 8:43] at 1:13 PM had a buildup of grime around the base of the commode, and around the back of the commode. There was trash under the sink on the floor and an odor. There was brownish staining inside the bowl of the commode. The residents in this room did not use the bathroom. - Room [NJAC 8:43] at 1:20 PM had a brown, dried substance built up around the rim of the commode. - Room [NJAC 8:43] at 1:23 PM had dead bugs on the floor under the sink. The water in the sink could not be shut off. There was a buildup of grime around the baseboards of the entire bathroom, drip marks coming down the walls to the right of the sink, and a small trim piece about 18" up from the floor that had significant buildup of grime and was sticky. - Room [NJAC 8:43] at 1:25 PM had a bed pan on the railing that was not in a bag, a surgical mask tied	F 921	the bathrooms appropriately were initiated. - Housekeeping staff were re-educated regarding ensuring that proper protocols for room and bathroom cleaning / sanitizing were being followed as well as the necessity for rooms to be cleaned and sanitized upon the expectation of an admission into an empty room. 4. The Housekeeping Director or designee will audit 3 rooms per floor 2x a week for 90 days to ensure all rooms and bathrooms are maintained as clean and sanitized. The findings will be reported to the QAPI committee on a quarterly basis for 3 months.	

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F 921	Continued From page 10 to the handrail, and significant brown staining inside the bowl of the commode. - Room [NJAC 8:4] at 1:28 PM had garbage on the floor, including paper towels and a lid from a cup. The garbage can was full and overflowing. There was an unpleasant odor inside the bathroom. - Room [NJAC 8:4] at 1:32 PM had two bedpans on the floor behind the commode that were not bagged or labeled. The garbage was full and overflowing. There was an unpleasant odor inside the bathroom. - Room [NJAC 8:4] at 1:33 PM had used gloves and paper towels on the floor, and the garbage was overflowing. The water in the sink was continuously dripping and did not appear as though it could be shut off. The surveyor's shoes were sticking to the floor. On 11/03/2021 at 1:36 PM, Licensed Practical Nurse (LPN) #1 was interviewed. The LPN stated the bathrooms were never clean enough, and she felt the entire building was not clean. She thought there were three housekeepers assigned to the [NJAC 8:43E-2.1 and] floor, so she could not explain why the bathrooms were still dirty. Together, the surveyor and LPN #1 looked at Rooms [NJAC 8:43E-2.1 and], [NJAC 8:43E-2.1 and]. LPN #1 observed in Room [NJAC 8:43] at 1:39 PM the buildup of grime on the baseboards, stating, "This is what I'm talking about," while pointing to the baseboards. In Room [NJAC 8:4] at 1:42 PM, LPN #1 indicated the stains in the bowl of the commode were "filthy," and the bedpan did not belong on the railing and there was a "stench" in the bathroom. In Room [NJAC 8:4] at 1:44 PM, LPN #1 observed and pointed to the urinal	F 921		

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BROOKHAVEN HEALTH CARE CENTER	**120 PARK END PLACE EAST ORANGE, NJ 07018**

(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) COMPLETION DATE
F 921	Continued From page 11 on the handrail that had a dried and stained substance in the bottom, in addition to the dead bugs and grime built up along all of the baseboards. On 11/03/2021 at 4:20 PM, the Assistant Director of Nursing (ADON) was interviewed on the 2nd floor. Together, the surveyor and the ADON looked at Rooms [redacted] and [redacted]. In Room [redacted] at 4:33 PM, the ADON observed the bedpans on the floor and the unpleasant odor and overall lack of cleanliness. Her response to the bathroom was, "I haven't gotten anywhere with housekeeping." In Room [redacted] at 4:36 PM, the ADON observed and pointed out the significant brown staining in the bowl of the commode, the bed pan on the railing, and the surgical mask that was tied to the handrail. The ADON stated it was unacceptable for the bathroom to be so dirty. On 11/04/2021 at 9:16 AM, the Housekeeping Director (HD) was interviewed. He stated his expectation was everything needed to be clean. The HD stated he completed rounds at 10:30 AM, 12:00 PM, and 2:00 PM daily and went through at least two rooms per day with a check list indicating if a room was satisfactory or unsatisfactory. He indicated his focus had been the Person Under Investigation (PUI) unit. The HD revealed there had been occasions when the facility was expecting a new admission and the housekeeping staff did not have an opportunity to go to that particular room prior to the admission to clean it. On 11/04/2021 at 2:30 PM, the Nursing Home Administrator (NHA) was interviewed. He stated he had recently completed a performance	F 921		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315268	A. BUILDING _____ B. WING _____	C 11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKHAVEN HEALTH CARE CENTER	**120 PARK END PLACE EAST ORANGE, NJ 07018**

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F 921	Continued From page 12 improvement plan (PIP) with the HD due to concerns with the HD's job performance. The facility used a "5-step Daily Patient Room Cleaning" policy. The policy was not dated. The purpose statement of the policy indicated, "To show housekeeping employees the proper method to sanitize a patient room and bathroom or any area in the healthcare facility." The review of the 5-step policy did not include any information on how to clean a bathroom. New Jersey Administrative Code: §8:39-31.4(a-c) (f)	F 921		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
315268		1/3/2022

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BROOKHAVEN HEALTH CARE CENTER	120 PARK END PLACE EAST ORANGE, NJ 07018

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, 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 CMS-2567 (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 F0800 Reg. # 483.60 LSC	Correction Completed 12/17/2021	ID Prefix F0880 Reg. # 483.80(a)(1)(2)(4)(e)(f) LSC	Correction Completed 12/24/2021	ID Prefix F0921 Reg. # 483.90(i) LSC	Correction Completed 12/17/2021
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	
11/4/2021	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO