STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315217	A. BUILDING _____ B. WING _____	C 05/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT NORWOOD TERRACE	40 NORWOOD AVENUE PLAINFIELD, NJ 07060

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Covid-19 Infection Control Survey : Sample : 8 Census : 97 A COVID-19 Focused Infection Control Survey was conducted by the New Jersey Department of Health. The facility was found to be not in compliance with 42 CFR §483.80 infection control regulations as it relates to the implementation of the CMS and Centers for Disease Control and Prevention (CDC) recommended practices for COVID-19. C # : NJ00153883, NJ00154309 NJ00154327, NJ00154383 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 survey.	F 000		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: COMPLAINT: # NJ00153883 Based on interviews and record review, as well review of pertinent facility documents on 4/21/22 and 5/4/22, it was determined that the facility	F 760	Resident #2 and #5 did not have any adverse effects.Medication error form was completed with the nurses. All residents with a BP parameter are potentially affected	5/26/22

LABORATORY D RECTOR'S OR PROV DER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 05/25/2022

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315217	A. BUILDING _____ B. WING _____	C 05/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT NORWOOD TERRACE	40 NORWOOD AVENUE PLAINFIELD, NJ 07060

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 1 failed to administer medications according to physician's order and the facility policy on Administering Medications for 2 of 6 residents (Resident #2 and Resident # 5) reviewed for medication error. This deficient practice is evidenced by the following: 1. According to the "ADMISSION RECORD (AR)", Resident #2 was admitted to the facility on Ex.Order 26.4(b)(1) with diagnosis that included but was not limited to: Ex.Order 26.4(b)(1) The Minimum Data Set (MDS) an assessment tool dated 1/14/22, showed Resident #2's cognition was Ex.Order 26.4(b)(1) with Activities of Daily Living (ADL). The "Medication Review Report (MRR)" dated 10/15/21, showed an order for Ex.Order 26.4(b)(1) The "MEDICATION ADMINISTRATION RECORD (MAR)" showed the aforementioned order. The MAR further showed that the Ex.Order 26.4(b)(1) was administered to the Resident with the Ex.Order 26.4(b)(1) which was not according to the physician's order on the following dates and time: At 8:00 am on: Ex.Order 26.4(b)(1)	F 760	An audit of all residents currently on hypertensive medications was conducted. Reeducation on the importance of adhering to medication parameters to all nursing staff completed. Staff was educated on 5.23.22 on the updated procedure regarding medication errors and discipline. A weekly audit of Parameter medications will be conducted by DON/designee. Don/designee will coordinate the results of the weekly audit and review the findings with the Administrator/ QA Committee for 4 weeks then monthly for 2 more months. DON/designee will provide a report of findings to the QA committee for action as appropriate. Date of Compliance 5/26/22.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315217	A. BUILDING _____ B. WING _____	C 05/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT NORWOOD TERRACE	**40 NORWOOD AVENUE PLAINFIELD, NJ 07060**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 2 Ex.Order 26.4(b)(1)  Ex.Order 26.4(b)(1) At 6:00 pm on: Ex.Order 26.4(b)(1)  Ex.Order 26.4(b)(1) The medical record (MR) for Resident #2 showed	F 760		

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315217	A. BUILDING _____ B. WING _____	C 05/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT NORWOOD TERRACE	40 NORWOOD AVENUE PLAINFIELD, NJ 07060

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 3 that the Resident was Ex.Order 26.4(b)(1) on the aforementioned dates and time. The form "MEDICATION ERROR REPORT (MER)" from 11/2021 to 12/2021 showed a medication error occurred for Resident # 2. The MER showed that EX Order 26 § 4b1 to hold for Ex.Order 26.4(b)(1). However, the Ex.Order 26.4(b)(1) was not held for the Resident when Ex.Order 26.4(b)(1) . 2. According to the AR, Resident #5 was admitted to the facility on Ex.Order 26.4(b)(1 with diagnosis that included but was not limited to: EX Order 26 § 4b1 . The MDS dated 4/8/22, showed Resident #5's EX Order 26 § 4b1 was EX Order 26 § 4b1 . The "ORDER SUMMARY REPORT (OSR)" showed an order for EX Order 26 § 4b1 , give 1 tablet by mouth three times a day for Ex.Order 26.4(b)(1) hold for EX Order 26 § 4b1 Resident # 5's MAR for the month of 4/2022 and 5/2022 showed the aforementioned order and was administered to the Resident with the SBP below Ex.Order 2 which was not according to the physician's order on the following dates and time: EX Order 26 § 4b1 EX Order	F 760		

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315217	A. BUILDING _____ B. WING _____	C 05/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT NORWOOD TERRACE	**40 NORWOOD AVENUE PLAINFIELD, NJ 07060**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 4 EX Order 26 § 4b1 [redacted] [redacted] The MR for Resident #5 showed that the Resident was Ex.Order 26.4(b)(1) on the aforementioned dates and time. Review of the monthly "Custom Comments Report (CCR)", dated 4/7/22, reported by the Facility Pharmacist Consultant (PC) showed that	F 760		

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315217	A. BUILDING _____ B. WING _____	C 05/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT NORWOOD TERRACE	40 NORWOOD AVENUE PLAINFIELD, NJ 07060

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 5 the aforementioned medication was administered to Resident #5 when the EX Order 26 § 4b1 . The surveyor conducted an interview with the Director of Nursing (DON) on 5/4/22 from 10:00 to 4:19 pm, the DON stated that the medication error was identified and the nurses involved were educated. The surveyor attempted to conduct a telephone interview with the nurses involved on 5/5/22, however, the nurses were not available. The facility's policy titled "Administering Medications", undated, showed "...Medications shall be administered in a safe and timely manner, and as prescribed...Medications must be administered in accordance with the orders, including any required time frame..." NJAC 8:39-11.2(b) NJAC 8:39-27.1(b)	F 760		
F 837 SS=D	Governing Body CFR(s): 483.70(d)(1)(2) §483.70(d) Governing body. §483.70(d)(1) The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and §483.70(d)(2) The governing body appoints the administrator who is- (i) Licensed by the State, where licensing is required; (ii) Responsible for management of the facility; and	F 837		5/26/22

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315217	A. BUILDING _____ B. WING _____	C 05/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT NORWOOD TERRACE	40 NORWOOD AVENUE PLAINFIELD, NJ 07060

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 837	Continued From page 6 (iii) Reports to and is accountable to the governing body. This REQUIREMENT is not met as evidenced by: COMPLAINT: # NJ00153883 Based on interviews, record review, and review of other pertinent facility documents on 4/21/22 and 5/4/22 it was determined that the facility failed to ensure that their policy on "Investigations and Accidents" was implemented for 2 of 7 residents (Resident # 2 and Resident #5) reviewed for medication error. This deficient practice is evidenced by the following: 1. According to the "ADMISSION RECORD (AR)", Resident #2 was admitted to the facility on [redacted] with diagnosis that included but was not limited to: [redacted]. The "Medication Review Report (MRR)" dated 10/15/21, showed an order for [redacted] The "MEDICATION ADMINISTRATION RECORD (MAR)" showed the aforementioned order. The MAR further showed that the [redacted] was administered to the Resident with the [redacted] which was not according to the physician's order on the following dates and time: At 8:00 am on 11/2/21 to 11/5/21, 11/7/21 to 11/9/21, 11/17/21 to 11/22/21, 12/5/21 to 12/8/21, and 12/22/21 to 12/28/21.	F 837	Residents #2 and #5 did not have any adverse effects due to non-compliance. Other residents who have had a medication error form filled out are potentially affected by this practice Nursing administration/ designee will be performing an audit on the monthly medication errors confirming that responsible party and physicians are being notified. New process implemented for placement of medication error forms. Administrative Nursing Team (DON and IP) educated on the new process Medication Error Reporting policy updated and nursing educated on the new process A weekly audit of medication errors will be conducted. DON/designee will coordinate the results of the weekly audit and review the findings with the Administrator/ QA Committee for 4 weeks then monthly for 2 more months. DON/designee will provide a report of her findings to the QA committee for action as appropriate. Date of Compliance 5/26/22	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315217	A. BUILDING _____ B. WING _____	C 05/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT NORWOOD TERRACE	40 NORWOOD AVENUE PLAINFIELD, NJ 07060

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 837	Continued From page 7	F 837		

At 6:00 pm on 11/2/21 to 11/5/21, 11/11/21 to 11/12/21, and 11/14/21 to 11/16/21.

The form "MEDICATION ERROR REPORT (MER)" from 11/2021 to 12/2021 showed a medication error occurred for Resident # 2. The MER showed that EX Order 26 § 4b1 to hold for EX Order 26 § 4b1. However, the EX Order 26 § 4b1 was not held for the Resident when the EX Order was below EX Order 26 §.

Furthermore, Resident # 2's medical record (MR) showed no documented evidence that the Resident's Representative (RR) was notified of the medication error which was not according to their policy.

2. According to the AR, Resident #5 was admitted to the facility on Ex.Order 26.4(b)(with diagnosis that included but was not limited to: EX Order 26 § 4b1.

The Minimum Data Set (MDS) an assessment tool dated 4/8/22, showed Resident #5's EX Order 26 § 4b1

The "ORDER SUMMARY REPORT (OSR)" showed an order for EX Order 26 § 4b1, give 1 tablet by mouth three times a day for EX Order 26 § 4b1, EX Order 26 § 4b1

The MAR for the month of 4/2022 and 5/2022 showed the aforementioned order was administered to the Resident with the EX Order 26 § 4b1 which was not according to the physician's order on the following dates and time:

At 9:00 am, on 4/3/22, 4/9/22, 4/10/22, 4/15/22, 4/20/22, 4/28/22, and 5/1/22 to 5/3/21.

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315217	A. BUILDING _____ B. WING _____	C 05/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT NORWOOD TERRACE	40 NORWOOD AVENUE PLAINFIELD, NJ 07060

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 837	Continued From page 8 At 2:00 pm, on 4/3/22, 4/4/22, 4/9/22, 4/10/22, 4/15/22, 4/20/22, 4/21/22, and 5/1/22 to 5/3/22. At 9:00 pm, on 4/2/22 to 4/4/22, 4/6/22, 4/7/22, 4/9/22, 4/11/22, 4/13/22, 7/16/22, 4/22/22 to 4/25/22, and 5/1/22 to 5/2/21. Review of the monthly "Custom Comments Report (CCR)", dated 4/7/22, reported by the Facility Pharmacist Consultant (PC) showed that aforementioned medication was administered to Resident #5 when the EX Order 26 § 4b1 . The Progress notes (PN) for Resident #5 from 4/7/21 to 5/4/22 showed no documented evidence that the primary physician and the RR were notified of the medication error which was not according to their policy. The surveyor conducted an interview with the Director of Nursing (DON) and Administrator on 5/4/22 from 10:00 to 4:19 pm, they stated that the medication error was identified, and were educated. However, the DON and Administrator were unable to provide the EX Order 26 for Resident #5. The Job Description titled, "Director of Nursing Services", undated, showed "...is to plan, organize, develop and direct the overall operation of our Nursing Service Department in accordance with current federal, state, and local standards, guidelines, and regulations that govern our facility..to ensure that the highest degree of quality care is maintained at all times...implement, evaluate, and direct the nursing service department, as well as its program and activities, in accordance with current rules, regulations, and guidelines that govern the long-term care facility.	F 837		

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315217	A. BUILDING _____ B. WING _____	C 05/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT NORWOOD TERRACE	40 NORWOOD AVENUE PLAINFIELD, NJ 07060

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 837	Continued From page 9	F 837		

Make written and oral reports/recommendations to the Administrator, as necessary/required, concerning the operation of the nursing service department...ensure that all nursing service personnel are performing their work assignments in accordance with acceptable nursing standards...Monitor medication passes and treatment schedules to ensure that medications are being administered as ordered and that treatments are provided as scheduled.."

The facility's policy titled "Investigation", undated, showed "...the facility will investigate any form of resident abuse, neglect, abnormal occurrences...All occurrences...medication error will be reported investigated ..."

The facility's policy titled "Accidents and Incidents - Investigating and Reporting", undated, showed "...All accidents or incidents involving residents...occurring on our premises shall be investigated and reported to the Administrator...g. Notification of the accident/ incident person's Attending Physician h. The date/time the accident/ incident person's family was notified and by whom..."

The facility's policy titled "Administering Medications", undated, showed "...Medications shall be administered in a safe and timely manner, and as prescribed...Medications must be administered in accordance with the orders, including any required time frame..."

The facility's policy titled "Charting and Documentation" revised on 1/2021, showed "...All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315217	A. BUILDING _____ B. WING _____	C 05/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT NORWOOD TERRACE	40 NORWOOD AVENUE PLAINFIELD, NJ 07060

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 837	Continued From page 10 psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care...Documentation of procedures and treatment will include care-specific details, including...Notification of family, physician or other staff..." NJAC 8:39-11.2(b) NJAC 8:39-27.1(b)	F 837		
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, 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	F 880		6/3/22

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315217	A. BUILDING _____ B. WING _____	C 05/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT NORWOOD TERRACE	**40 NORWOOD AVENUE PLAINFIELD, NJ 07060**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 11	F 880		

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.

§483.80(f) Annual review.
The facility will conduct an annual review of its

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315217	A. BUILDING _____ B. WING _____	C 05/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT NORWOOD TERRACE	40 NORWOOD AVENUE PLAINFIELD, NJ 07060

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 12 IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: C #: NJ00154309 and 00154383 Based on observation, interviews, and record review on 4/21/22 and 5/4/22, it was determined the facility failed to implement the use of Personal Protective Equipments (PPEs) according to their "Outbreak Plan" policy and acceptable standards of infection control practice according to the Centers for Disease Control and Prevention (CDC). This deficient practice was identified for 1 of 2 Licensed Practical Nurses (LPN #1) observed for Infection Control. This deficient practice was evidenced by the following: Reference: Centers for Disease Control and Prevention (CDC) COVID-19 Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, updated 2/2/22, "Personal Protective Equipment HCP [Health Care Provided] who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions...gown, gloves..." Review of the facility line listing (LL) provided by the facility on 5/2/22, showed that the Covid-19 outbreak started on 4/15/22 involving a staff who was fully vaccinated and the last tested positive for COVID 19 was on 5/2/22 involving a fully vaccinated resident. The LL further showed that the Covid 19 outbreak started on the second (2nd) floor. According to Admission Record, Resident #6 was	F 880	Resident #6 did not have any adverse effects as resident had 3 negative covid swabs prior to this date due to non-donning of full PPE that had signage for PUI. Had final negative COVID test the day prior. All residents who have signage for PUI would be potentially affected. LPN #1 was disciplined and reeducated on the importance of wearing appropriate proper PPE as per the current policy as well as removing visible indicators of PUI when indicated All staff will be educated on the importance of wearing appropriate PPE as per the current policy All staff educated on the importance of removal of observation signage upon completion of observation status. Staff were trained on the following topics: A. Nursing Home Infection Preventionist Training Course Module 1 □ Top Line and IP B. CDC COVID-19 Prevention □ Keep COVId-19 Out! □ Front Line Staff C. CDC COVID-19 Prevention □ Sparkling Surfaces □Frontline Staff D. Nursing Home Infection Preventionist Training Course Module 5 □ Outbreaks □ Top Line and IP	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315217	A. BUILDING _____ B. WING _____	C 05/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT NORWOOD TERRACE	**40 NORWOOD AVENUE PLAINFIELD, NJ 07060**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 13 admitted to the facility on Ex.Order 26.4(b)(with diagnoses that included but was not limited to: EX Order 26 § 4b1 . The Minimum Data Set (MDS) an assessment tool dated 3/7/22, showed that Resident #6 had EX Order 26 § 4b1 On 5/4/22 at 8:55 am, the surveyor toured the 2nd floor unit with the Unit Manager (UM #1). UM #1 stated that the 2nd floor had 10 residents who were tested positive for Covid 19 and 5 residents who were under observation for signs and symptoms of COVID 19. The UM stated that Resident #6 was under EX Order 26 § 4b1 due to an EX Order 26 § 4b1 During the tour of the 2nd floor on 5/4/22 at 9:35 am, the surveyor observed a signage to "STOP" and don PPEs which included but were not limited to gloves and gown prior to entering Resident #6's room. The surveyor observed LPN #1 entered Resident #6's room wearing N95 mask and face shield, without donning gown and Ex.Order 26.4(b)(1) . Then she removed her gloves, performed hand hygiene and stepped out of the room. LPN #1 proceeded to prepare the Resident's medication, returned to the Resident's room without donning gown and gloves and administered Resident #6's medications. The surveyor observed the LPN's uniform touched the Resident's bed and linens. On 5/4/22 from 10:55 am to 2:14 pm, the surveyor conducted an interview with UM #1 and Infection Control Preventionist (ICP), they stated that Resident #6 was being monitored for signs and symptoms of EX Order 26 § 4b1 . They	F 880	E. Nursing Home Infection Preventionist Training Course Module 4 □ Infection Surveillance □ IP and Top Line F. Nursing Home Infection Preventionist Training Course Module 7 □ Hand Hygiene - All staff G. Nursing Home Infection Preventionist Training Course Module 6A □ All staff The IP Nurse/designee will audit 5 staff members PPE usage in accordance with signage on a weekly basis for 4 weeks; then monthly x 3 and reviewed by our next quarterly until compliance attained and maintained. Results of the audits will be forwarded to the Quality Assessment and Performance Improvement Committee for review and action as appropriate. The QAPI committee meets quarterly. The Committee will determine the need for further audits and or action plans.	

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315217	A. BUILDING _____ B. WING _____	C 05/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT NORWOOD TERRACE	40 NORWOOD AVENUE PLAINFIELD, NJ 07060

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 14	F 880		

explained that Resident #6 was under observation/investigation because the Resident was not EX Order 26 § 4b1 to her/his roommate on EX Order 26 § 4b and will be monitored for EX Orde days until EX Order 26 §. The ICP stated that the staff should wear full PPE when entering the Resident's room.

The surveyor conducted an interview with LPN #1 (who was fully vaccinated) on 5/4/22 at 11:05 am, LPN #1 stated that it was required to don full PPE prior to entering Resident #6' room because the Resident was under observation for signs and symptoms of COVID 19. LPN #1 further stated that she forgot to don the full PPEs. She explained that donning PPEs as required decreased the risk of transmission of infection from residents to staff.

A review of the form "SUMMARY REPORT OF MEETING/IN-SERVICE", dated 4/18/22, showed that LPN #1 was provided education to apply appropriate PPE prior to entering resident's room who was on isolation and under investigation.

The facility's policy titled "Outbreak Plan" revised on 4/28/22, showed "Policy Statement: Outbreaks of Communicable diseases within the facility will be promptly identified and responded appropriately to decrease the risk of transmission to residents and staff which has a potential to pose a significant public health threat and danger of infection to the residents, resident representatives, and staff of the facility...Cohort 3 (YELLOW ZONE) - Asymptomatic patients/residents who are NOT up to date with all recommended COVID-19 vaccine doses, have a viral test that is negative for SARS-C0V-2, and have had close contact with someone with

STATEMENT OF DEFIC ENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT FICATION NUMBER:	(X2) MULT PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315217	A. BUILDING _____ B. WING _____	C 05/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT NORWOOD TERRACE	**40 NORWOOD AVENUE PLAINFIELD, NJ 07060**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 15 SARS-CoV-2...These patients/residents should be placed in quarantine after their exposure and cared for using full PPE. (gowns, gloves, eye protection, and NIOSH approved N95 or equivalent or higher-level respirator)..." NJAC 8:39-27.1 (a) NJAC 8:39-19.4 (1)(a)	F 880		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315217	A. Building B. Wing	6/27/2022

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT NORWOOD TERRACE	40 NORWOOD AVENUE PLAINFIELD, NJ 07060

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 F0760 Reg. # 483.45(f)(2) LSC	Correction Completed 05/26/2022	ID Prefix F0837 Reg. # 483.70(d)(1)(2) LSC	Correction Completed 05/26/2022	ID Prefix F0880 Reg. # 483.80(a)(1)(2)(4)(e)(f) LSC	Correction Completed 06/03/2022
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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	
5/4/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO