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	315364	A. BUILDING ______ B. WING ______	03/25/2021

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F 000	INITIAL COMMENTS DATE: 3/25/21 CENSUS: 126 + 3 bedholds SAMPLE: 25 + 10 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are	F 584		4/9/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 04/07/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 584	Continued From page 1 in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to maintain a clean, comfortable, sanitary, homelike environment for 7 of 25 residents reviewed in the facility (Resident #47, #48, #63, #68, #71, #78 and #110) residing on 1 of 3 resident care units Executive Order 26, 4.b. The evidence was as follows: 1. On 03/16/21 at 11:29 AM, Surveyor #1 observed Resident #63 sitting on his/her bed in their room. The resident stated that the housekeepers who worked on the unit did not clean his/her room appropriately and only used a dry mop to clean the floors. The resident stated that he/she was unhappy with the cleanliness of his/her bathroom and showed the surveyor the shared bathroom belonging to Resident #47 and Resident #63's room. Surveyor #1 observed that the floor in the bathroom was whitish gray in color and had black and brown marks throughout that were in ingrained in the floor composition, a	F 584	1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice? Residents 63, 47, 68, 71, 63, 48, 78, and 110 All had their rooms and bathrooms wet mopped, as well as over bed tables, night stands, and televisions thoroughly cleaned by House Keeping Director. Residents #63 and #47 had the area identified in their bathroom wall cleaned. Resident #47 and #110 had their privacy curtains taken down and cleaned. Resident #68 had the area identified in their bathroom cleaned and repainted by House Keeping Director and Maintenance Director. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be	

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F 584	Continued From page 2 brownish black coating along the bathroom wall exterior where the edge of the tile floor touched the wall, and the white grout along the toilet was soiled and stained black in color and the painted yellow walls in the bathroom had grayish-black markings on them. The grayish black markings on the yellow walls were more dominantly observed closer to the floor in the resident's bathroom. On the next day on 03/17/21 at 11:26 AM, Surveyor #1 returned to the room of Resident #63 and observed the resident in bed. The resident pointed down to the floor by his/her bed to show the surveyor that the floor was soiled. Surveyor #1 observed brownish tan stains on the floor next to the resident's nightstand and a clear, sticky film on the top layer of the floor in front of the resident's nightstand. The resident stated that he/she thought the dry, caked on brownish tan stains were from Resident #47's tube feeding formula that had splashed. Surveyor #1 walked on the floor in front of the resident's bed where the floor was observed to be soiled and Surveyor #1's shoes stuck to the floor creating sounds heard while walking along the resident's bed frame. The resident stated, "See it's sticky. You can hear that it's sticky." The resident further stated that a housekeeping staff member was in the room about ten minutes prior and he/she had asked the housekeeper to clean the room and the housekeeper didn't. The surveyor re-entered Resident #47 and Resident #63's bathroom and observed the same soiled areas of the bathroom which was observed the day prior. On 03/17/21 at 11:41 AM, Surveyor #1 observed the Housekeeper #1 (HK#1) who was responsible for cleaning Resident #47 and Resident #63's	F 584	affected by this deficient practice. 3. What systematic changes will be put in place to ensure this deficient practice doesn t happen again? Housekeeping Director will re-in-service all House Keeping Staff on proper cleaning including: mopping, dusting, cleaning over bed tables, and washing privacy curtains for all resident rooms. Housekeeping Director will re-in-service all housekeeping staff on customer service which will included greeting all residents upon entry and asking if there would be anything else they need prior to leaving the room. House Keeping Director will re-in-service housekeeping staff to report to maintenance if any rooms are observed with peeling paint. House Keeping Director and/or Designee will audit 5 rooms weekly for three months, any unsatisfactory rooms will be addressed immediately by House Keeping Director and/or designee with re-education to any housekeeper that maybe affected. 4. How will the systematic corrective actions be monitored that the deficient practice is corrected and will not recur? Weekly audits will be presented on a monthly basis by House Keeping Director or Designee at Monthly Quality Assurance Meeting with any corrective actions needed or taken during the course of the Audit.	

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F 584	Continued From page 3 room in the hallway on the unit. Surveyor #1 asked the HK#1 if she had already cleaned Resident #47 and Resident #63's room. HK#1 stated, "yeah." The HK #1 did not elaborate on what she had cleaned. On 03/18/21 at 10:30 AM, Surveyor #1 observed Resident #63 in his/her room. The resident stated, "they" came into his/her room last night and tried to clean the floors with a scraper, but they didn't fully clean it and the floor was still sticky. Surveyor #1 observed the imprints from the bottom of someone's shoes on the floor where the stickiness was. Surveyor #1 stepped on the floor and Surveyor #1's shoes gripped to to the floor, and as the surveyor walked in the area it created audible sounds from walking in around the resident's bed-frame. The resident stated that he/she didn't spill soda on the floor and didn't know why the floor was still so sticky. At that time, Surveyor #1 observed the floor by Resident #47's bed and saw the same brownish-tan stains on the floor next to the resident's bed and underneath the resident's tube feeding formula. Resident #67 stated that "you would think they would be cleaning better with this COVID going around and at least use water to wash the floor." The resident further stated that he/she thought the room was "disgusting." On 03/18/21 at 12:36 PM, Surveyor #1 observed Resident #47 laying in bed. Surveyor #1 made the following observations of the resident's room: white stains on the resident's privacy curtain, brownish-tan liquid stained and splattered on the floor next to and underneath the resident's tube feeding pole, the bottom part of the resident's gray tube feeding pole had dried brownish-tan	F 584		

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F 584	Continued From page 4	F 584		

stains on it, and black and brownish colored stains were observed on the floor on the opposite side of the resident's bed where the resident's oxygen concentrator was located.

On 03/23/21 at 11:26 AM, Surveyor #1 observed Resident #47 lying in bed. Surveyor #1 made the following observations of the resident's room: there was a brownish-tan colored spillage underneath the resident's tube feeding pole, and the bottom part of the resident's gray tube feeding pole had dried brownish-tan stains on it.

2. On 3/16/21 at 11:12 AM, Surveyor #2 interviewed Resident #71 who was in his/her room. The resident stated that the rooms were not being cleaned properly. The resident added that this past Saturday he/she had called the manager on duty to have the housekeeper wet mop his/her room because the floor of the room had not been wet mopped for the past five days. The resident added that the housekeeper had only dry mopped the floor of the room. The resident added that his/her room was not cleaned every day.

At that time, Surveyor #2 also interviewed Resident #78, the roommate of Resident # 71, who stated that he/she agreed that the rooms were not being cleaned properly. Resident #78 stated that he/she had been transferred back to the room with Resident #71 that day and had been in another room prior. Resident #78 agreed that the floors of the room were not being wet mopped and was unsure if the rooms were cleaned every day.

On 3/16/21 at 11:45 AM, Surveyor #2 interviewed Resident #48 in his/her room. The resident stated

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F 584	Continued From page 5	F 584		

that the floors were a mess and were not mopped. The resident pointed out to Surveyor #2 several discolorations on the floor along with trash on the floor. Surveyor #2 observed several discolorations on the area of the floor near the side of the bed, in front of the bed, on the floor near the door to the room and near the bathroom door. In addition, the surveyor noted a stickiness when walking on the floor. The resident stated that he/she was not sure if a housekeeper had been in the room for the day and could not remember the last time a housekeeper came into the room to clean it.

At that time, Surveyor #2 and the resident observed the resident's overbed table was sticky and had reddish ring stains on it. The resident stated that the overbed table was where the food trays were placed, and the stains were probably from drinks and food The resident stated that no one cleans the overbed table. In addition, Surveyor #2 observed a stickiness when walking on the floor.

On 3/18/21 at 12:22 PM, Surveyor #2 observed Resident #48 in a different room. The resident stated that he/she had a room change. Surveyor #2 and the resident observed the resident's overbed table with similar reddish ring stains. The resident stated that their meals are served on the overbed table and that no one cleans it.

Upon leaving the resident's room, Surveyor #2 observed the Licensed Practical Nurse (LPN) preparing medications for administration at her medication cart which was near the resident's room. Surveyor #2 interviewed the LPN who stated that housekeeping usually cleans the overbed tables but that she would clean it while

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F 584	Continued From page 6	F 584		

she was in the resident's room. She acknowledged the surveyors findings.

3. On 3/16/21 at 12:23 PM, Surveyor #2 interviewed Resident #110 who was in his/her room. The resident stated that he/she was concerned with the cleanliness of the room and that the room was not being cleaned properly. The resident pointed out to Surveyor #2 that the floors were not wet mopped, his/her television was very dusty and the curtain in between the beds had white stains on it. The resident stated that the white stains on the curtain were probably from lotion and could not remember the last time the curtains had been changed/laundered.

At that time, Surveyor #2 also interviewed Resident #68, the roommate of Resident # 110, who stated that he/she agreed that the room was not cleaned properly and pointed out that his/her television was also dusty. Resident #68 then told Surveyor #2 to look in their bathroom on the wall adjacent to the sink at the bottom closer to the door of the bathroom.

On 3/16/21 at 12:39 PM, Surveyor #2 observed an area of the bathroom wall with layers of paint peeling off the wall. Surveyor #2 also observed both televisions had a layer of dust on the screens and tops of the televisions had fingerprints that were able to be seen in the dust. Surveyor #2 also observed the floor with discolorations and stain marks by the door of the bathroom and the door of the room.

At that time, Resident #68 stated that they had told the aides and the nurses about the bathroom and it had remained the same. In addition, Resident #110 agreed that the bathroom has had

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F 584	Continued From page 7 peeling paint for a while, staff were told about it and that it had not been fixed. Both residents also agreed that a housekeeper does not come in on a regular basis to clean their room. On 3/24/21 at 12:00 PM, Surveyor #2 interviewed Resident #68 and #110 who pointed out to the surveyor that the room had not yet been cleaned. Surveyor #2 corroborated the residents concerns and observed that the televisions remained dusty, the floors remained stained with discolorations and the bathroom wall remained with peeling paint. On 3/24/21 at 12:05 PM, Surveyor #2 with the LPN observed Resident #68 and 110's bathroom and floors. The LPN stated that she was unaware of the peeling paint on the bathroom wall and thought that the housekeeper had not gotten to the room yet. The LPN stated she would have to call maintenance to fix the bathroom wall. On 3/24/21 at 12:09 PM, Surveyor #2 interviewed the HK#2 who stated that he had not cleaned the room of Resident #68 and #110. On 3/24/21 at 12:10 PM, Surveyor #2 with the Director of Environmental Services (DES) observed Resident #68 and #110's room. The DES stated that a housekeeper would not take care of the peeling paint on the bathroom wall and that maintenance would have to be notified. The DES also stated that if a housekeeper had seen the bathroom wall, they could report that to himself or the nurses who would then notify maintenance. The DES also stated the housekeepers clean the bathroom every day and they would wet mop the floors every day and that the televisions should be dusted during their	F 584		

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F 584	Continued From page 8 routine cleaning. On 03/23/21 at 10:21 AM, Surveyor #1 and Surveyor #2 interviewed the DES who stated that the housekeepers were responsible for sweeping and wet moping every resident's room daily. The DES further stated that when a new hire was trained for the position, they were taught how to clean the resident's rooms appropriately and then observed to make sure that they were performing the task correctly. The DES stated that the housekeeping supervisor would randomly perform rounds on the unit to check for the cleanliness of the rooms for each working housekeeper. The housekeeping supervisor was unavailable for an interview at that time. A review of the undated Five Step Cleaning Process for bedrooms reflected that the housekeepers were responsible for emptying the trash, cleaning horizontal surfaces, spot cleaning walls, dust mopping the floors of the resident's bedrooms, and then damp mopping the floors of the resident's bedrooms. A review of the undated Seven Step Cleaning Process for the bathrooms reflected that the housekeepers were responsible for checking supplies, emptying trash, dust mopping the bathroom floor, cleaning and sanitizing the sink and the tub in the resident's bathroom, cleaning and sanitizing the commode, spot cleaning the walls in the bathroom, and damp mopping the bathroom floor. A review of the contracted Housekeeping aide Job Description included, "The Housekeeping Aide insures that the center is maintained in a clean and sanitary condition in a healthful	F 584		

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F 584	Continued From page 9 environment, In addition, he/she insures that good housekeeping services are performed in every department at the center and are planned in cooperation with the department head." A further review of the facility's Housekeeping aide Job Description indicated that the housekeeper followed specific cleaning instructions, provided a sanitary and orderly environment for the resident's, performed their duties as requested, and put customer service first; ensuring that the residents received the highest quality of services. Refer to F865 NJAC 8:39-31.4(a)(b)(c)(f)	F 584		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to perform reference checks in accordance with their Abuse Prohibition Policy and Procedure. The deficient practice was identified during an Abuse	F 607	1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice? Employee #1 that was identified was terminated.	4/9/21

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Prevention review for 1 of 5 newly hired employees in the last four months (a Contracted Housekeeper). The evidence was as follows:

On 3/24/21 at 9:00 AM, the surveyor reviewed the employee file for a contracted housekeeper, Employee #1 who was hired on [redacted]. A review of Employee #1's Reference Form for Applicant Information indicated to please provide up to two professional references if available. The Reference Form for Applicant Information indicated that Employee #1 provided only one close family member as a professional reference, a parent.

On 03/24/21 at 9:17 AM, the surveyor interviewed the contracted District Manager for the Housekeeping Company who stated that Employee #1 had only provided one close family member as a reference in their application for employment. The District Manger stated that the company he worked for considered an acceptable reference someone that the person who was applying for the job knew and only one reference check was performed because that was the only reference that Employee #1 provided. The surveyor asked if the District Manger knew of Employee #1's past work history which included retail. The District Manager stated that Employee #1 had worked in retail for about four to five years, but they did not check Employee #1's previous place of employment as a reference because Employee #1 did not include it as a reference, and there was no evidence of attempting any additional reference sources. The surveyor requested a copy of their Corporate policy for Reference Checks upon hire.

On 03/24/21 at 9:49 AM, the surveyor conducted

2. How the facility will identify other residents having the potential to be affected by the same deficient practice?
All resident have the potential to be affected by this deficient practice.

3. What systematic changes will be put in place to ensure this deficient practice doesn t happen again?
All new hire contractors which include housekeeping and dietary employees will provide two professional references prior to hire, copies of the two references will be provided to center Human Resources Manager to maintain on file and prior to the start of the new employee. House Keeping Director and Dietary Director will be re-in-serviced on the required process for new hires.

4. How will the systematic corrective actions be monitored that the deficient practice is corrected and will not recur?
Center Human Resources Manager/Designee will review and ensure any and all contract employee new hires have had two professional references before employment starts. This will be an ongoing process which will be shared at the Monthly Quality Assurance Meeting by Center Human Resources Manager/Designee.

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a follow up interview with the District Manager who stated that he called his corporate Human Resource Department who told him that they had no policy and procedure in place for reference checks upon hire. The District Manager further stated that a background check on Employee #1 was conducted and was the employee was cleared to work because no criminal record reports were found. He stated that reference checks were just an additional tool. He couldn't speak to the requirement for reference checks. The surveyor asked if they did not have a policy would they then use the Facility's policy for reference checks upon hire, and The District Manager suggested that they would not use the facility's policy for reference checks because the facility itself did not do the hiring. He acknowledged that the contracted housekeeper worked at the facility even though she was a contracted employee.

On 03/25/21 at 11:18 AM, the Licensed Nursing Home Administrator (LNHA) stated that the facility required two reference checks upon hire and the contracted housekeeping company only required 1-3 reference checks. He stated that having a parent provide a reference check was not ideal, but would be okay if there were no other references available. He confirmed that there was no evidence of any additional attempts to obtain another reference from another source.

A review of the facility's Abuse Prohibition Policy and Procedure indicated that as part of the facility's abuse prohibition program, screening of potential hires would be conducted. The Abuse Prohibition Policy and Procedure indicated, "The center will screen potential employees for a history of abuse, neglect, or mistreating patients,

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F 607	Continued From page 12 including attempting to obtain information from previous employers and/or current employers." NJAC 8:39-13.4 (c) 2i-2 vi	F 607		
F 849 SS=E	Hospice Services CFR(s): 483.70(o)(1)-(4) §483.70(o) Hospice services. §483.70(o)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(o)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified	F 849		4/9/21

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F 849	Continued From page 13 in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are	F 849		

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necessary for the care of the resident's terminal illness and related conditions.
(I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.
(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.
(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.

§483.70(o)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.
The designated interdisciplinary team member is responsible for the following:
(i) Collaborating with hospice representatives

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F 849	Continued From page 15 and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(o)(4) Each LTC facility providing hospice care under a written agreement must ensure that	F 849		

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each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to ensure: a.) a resident receiving hospice services had a specific individualized plan of care, and b.) subsequently ensure that plan of care was followed for the same resident receiving hospice services for end of life care. This deficient practice was identified for 1 of 2 residents reviewed for hospice services (Resident #120). The evidence was as follows:

On 3/16/21 10:49 AM, the surveyor observed Resident #120 lying in bed. The surveyor attempted to interview the resident, but the resident did not respond to the surveyor.

On 3/17/21 at 11:15 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) who stated that she was familiar with Resident NJAC 8:43E. The LPN stated that the resident was [redacted] and received [redacted] [redacted]. The LPN added that the resident had [redacted] but could make his/her needs known.

On 3/17/21 at 11:46 AM, the surveyor interviewed the Certified Nursing Aide (CNA) who stated that she had performed care for Resident [redacted]. The CNA stated that the resident was [redacted] and had [redacted] and was dependent on staff with all [redacted]. She added that

F 849

1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice?
For resident #120 we had the NJAC 8:43E-2.1 and Provider update the Goal of Care with specific services, goals, and interventions. It is kept in the Hospice binder for the resident. We informed Hospice Provider that they are expected to attend the Care Plan Meetings and update the care plans according to the changes and current needs of the resident. We re-confirmed with the Hospice Provider that November 2020 was the date we had informed all ancillary services to return to our building to provide services to our residents on-site.

2. How the facility will identify other residents having the potential to be affected by the same practice deficient practice?
All residents on Hospice have the potential to be affected by the same deficient practice.

3. What systemic changes will be put into place to ensure this deficient practice doesn t happen again?
All Nursing Staff, Social Services,

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F 849	Continued From page 17 the resident needed [redacted] as well. The CNA also stated that the resident was on [redacted] but there wasn't a [redacted] aide that came in on her shift. On 3/22/21 at 12:01 PM, the surveyor interviewed the Unit Manager/Registered Nurse (UM/RN) who stated that the [redacted] Registered Nurse [redacted] came to the facility once a month for Resident [redacted] and performed telehealth for other visits. The UM/RN stated that she thought telehealth was a phone call and was unsure if there was any visual observation made. The UM/RN added that the resident does not have a [redacted] Home Health Aide that comes to the facility. The UM/RN explained that she thought there was only limited visitation allowed because of the COVID-19 public health emergency and that this was the reason for the no [redacted] Home Health Aide and the [redacted] only making visits once a month. The UM/RN could not speak to whether the resident should have a [redacted] because she thought they weren't allowed. The UM/RN stated that the only notes kept in the [redacted] book were from the [redacted] on-site visits. The surveyor with the UM/RN reviewed the [redacted] book for Resident [redacted] which indicated on the [redacted] "Health group staff log" that a [redacted] visit was performed on [redacted] On 3/22/21 at 12:15 PM, the surveyor interviewed the LPN who stated that she had spoken with the [redacted] for telehealth on the phone. The LPN explained that telehealth meant that the nurse who cared for the resident reviewed the status of the resident with the [redacted] nurse on the phone and that there was no visual observation by the [redacted] nurse. The LPN added that she had seen the [redacted] in the facility	F 849	Activities, and Hospice Services Providers will be re-educated on Patient Specific Care Planning for our residents on Hospice. Hospice staff will also be expected to be here to provide the services they have agreed to according to the care plan and abide by the facility policy to ensure our residents and staff are safe. The Hospice Care Plans will be reviewed by the Director of Nursing/Unit Manager weekly x 3 months to ensure the Care Plan is resident specific and is being followed and updated according to the most recent needs of the resident. The Care Plan will be kept in the Hospice Binder. 4. How will the systemic corrective actions be monitored that the deficient practice is correct and will not recur? Weekly audits will be completed by the Director of Nursing/Unit Manger and presented at the Monthly Quality Assurance Meeting with any corrective actions needed or taken during the course of the Audit x 3 months.	

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F 849	Continued From page 18 last week. The LPN stated she was unsure how often the nurse came in to see the resident and did not think any [redacted] aide came to the facility. The LPN added that a CNA from the facility provided all care for the resident throughout all the shifts. The surveyor reviewed the medical record for Resident [redacted]. A review of the [redacted] Record face sheet (an admission summary) indicated that the resident had a [redacted] date of [redacted] with diagnoses which included [redacted] A review of the annual Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted] NJAC 8:43E-2 reflected that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] indicating that the resident had [redacted] A review of the resident's current [redacted] care plan [redacted] revealed a focused area of [redacted] care due to [redacted] diagnosis of [redacted] with a [redacted] start date of [redacted] and an initiation date of [redacted]. In addition, there was an intervention of notifying [redacted] of significant changes, clinical complications needing a plan of care change. The [redacted] not address the telehealth visits, in-person visits, or frequency of visits from the [redacted] services. A physician progress noted dated [redacted] included that the resident was on [redacted] services without any new symptoms or status	F 849		

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change and that the resident was on [redacted] services since [redacted]

On 3/22/2021 at 1:25 PM, the surveyor interviewed the [redacted] on the phone. The [redacted] stated that she visited the resident one time a month and left a record with the nurses and every other week she performed telehealth. The [redacted] explained that telehealth was a phone conversation with the nurse caring for the resident and if she had any recommendations, she would drop off a recommendation form at the front desk of the facility. The [redacted] added that the resident had not received any other [redacted]-related services on-site. The [redacted] added that she was in contact with the [redacted] social worker and the legal guardian was notified via phone. The [redacted] stated that the schedule of limited visitations was decided between her company and the facility administration because of not being able to meet the need for COVID-19 testing results prior to entering the facility.

On 3/23/21 at 10:49 AM, the surveyor further interviewed the [redacted] on the phone. The [redacted] stated that she had faxed over the [redacted] plan of care [redacted] that morning to the facility. The [redacted] stated that she had the [redacted] at her office.

On 3/23/21 at 11:20 AM, the surveyor reviewed with the [redacted] with the UM/RN who acknowledged that she did not have a copy of the [redacted] prior to the surveyor inquiry. The UM/RN was unable to explain what [redacted] services were to be provided according to the [redacted]. The UM/RN verified that the [redacted] was dated 3/13/2020 and had no other [redacted]. The UM/RN stated that the [redacted] had faxed over the [redacted] but that she did not rely on the [redacted] to complete

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the [redacted] that she had created. The UM/RN was unable to speak to if the resident required visits from a [redacted] aide and weekly [redacted] visits. The UM/RN was unable to speak to what the specific services were to be provided by the [redacted] company.

On 3/24/21 at 03:06 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON). The LNHA stated that any outside vendor would be allowed in the facility if they took the rapid COVID-19 test at the facility with negative results or if they could provide proof of a COVID-19 negative test result within 48 hours. The LNHA further stated that he was unaware of any agreement regarding limiting the [redacted] visits. The DON stated that the [redacted] aides were not being allowed in the facility for a period of time, but that they should be allowed by now.

On 3/25/21 at 10:24 AM, the survey team met with the Administrative team. The LNHA stated that he had contacted the [redacted] and the [redacted] company administration and had requested on-site visitations from the [redacted] and the [redacted] Home Health Aide. The LNHA could not speak to why the [redacted] had only been providing once month on site visitations. Neither the LNHA nor the DON could speak to the resident's individualized [redacted] or interpret the [redacted] scanned to the facility. They confirmed that if there was no [redacted] on site, they had not way to verify that the [redacted] was being followed.

On 3/25/21 at 12:25 PM, the surveyor interviewed the front desk receptionist who stated that vendors have been allowed to enter the facility with screening and COVID-19 negative results

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F 849	Continued From page 21 since November 2020. On 3/25/21 at approximately 1:25 PM, the surveyor reviewed the findings with the LNHA and the DON who confirmed that November 2020 they should have allowed the [redacted] [redacted] back in the facility, and confirmed that they were not aware. A review of the facilities' [redacted] Program Agreement" dated 1/29/2021, provided by the LNHA included that [redacted] was responsible for developing a resident's plan of care, providing on-going care planning activities and scheduling care and services. Further review of the agreement included that the facility was responsible for providing nursing services in accordance with the [redacted] plan of care and allowing members of the [redacted] group and all other caregivers identified in the HPOC to visit and serve the [redacted] resident at the facility. NJAC 8:39-27.1 (a)	F 849		
F 865 SS=E	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee	F 865		4/9/21

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F 865	Continued From page 22 except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documentation it was identified that the facility failed to identify and implement interventions to address resident concerns regarding housekeeping services through their Quality Assurance and Performance Improvement program (QAPI). This deficient practice was identified on 1 of 3 resident care units ([redacted] and during a review of the resident council meeting minutes for the months of December 2020, January 2021, and February 2021. The evidence was as follows: From 3/16/21 through 3/25/21, two surveyors observed on the [redacted] Unit that several of the resident's rooms had soiled floors, bathrooms, curtains, a bedside table, and resident room floors that were sticky and had areas of peeling paint, and there was dust covering a resident's TV . Interviews with Residents who resided in those rooms revealed that housekeepers were not consistently coming into the room to clean. Interviews with the Housekeeper, Nurse, and the Director of Environmental Services confirmed the surveyors findings. A review of the facility's December 2020 Resident	F 865	1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice? All resident rooms identified on the [redacted] Unit were wet mopped, including bathrooms, over bed tables, beds side dresser, resident televisions, privacy curtain and bathrooms were thoroughly cleaned. An audit was initiated by House Keeping Director and District Manager for all of [redacted] Unit Rooms. Audit and corrective actions if any to be presented at March 31, 2021 Quality Assurance Meeting. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice? All resident have the potential to be affected by this deficient practice. 3. What systematic changes will be put in place to ensure this deficient practice doesn t happen again? Re-In-service to be provided to all Department Heads for each discipline that if a Concern Form is	

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F 865	Continued From page 23 Council Precautionary Isolation Questionnaire (RCQ) indicated that nine residents who resided on the [redacted] Unit were individually interviewed on 12/2/2020 by a staff member from the activities department for the opportunity to voice their concerns. 6 out of the 9 residents interviewed on the [redacted] Unit had concerns regarding housekeeping services. The residents voiced concerns included statements such as, "When the men are working, doesn't clean. Please put things back when done cleaning. Needs improvement. Floors not always mopped, just swept. Rooms need [to be] cleaned better. Floors need cleaning." A review of the December 2020 Resident Council Meeting Minutes dated 12/2/2020 indicated that the resident's concerns and suggestions for Housekeeping were, "floors could be cleaned better." A review of the Grievance Complaint Form dated 1/7/21 indicated that the Director of Environmental Services (DES) was made aware of the residents concerns on 1/5/21 and documented that by 1/12/21 the residents concerns would be resolved. The action taken was documented as, "At this time floors cannot be stripped and waxed or buffed. But they can be mopped. Housekeeping will mop all floors daily." A review of the facility's [redacted: NJAC 8:43E-2.1 and Exec Order] Resident Council Precautionary Isolation Questionnaire (RCQ) indicated that seven residents who resided on the [redacted] Unit were individually interviewed by a staff member on 1/6/2021 from the activities department for the opportunity to voice their concerns. 6 out of the 7 residents	F 865	presented at monthly Resident Council it will be discussed at the next daily morning meeting with corrective actions that will take place. Activity Department will present any trends from Monthly Resident Council through the Resident Council Concern Form at monthly Quality Assurance meeting. Any concerns brought up at resident council will be discussed at monthly Quality Assurance meeting to determine what corrective action or Quality Assurance project will be needed. 4. How will the systematic corrective actions be monitored that the deficient practice is corrected and will not recur? Any Quality Assurance Project assigned from Resident Council Concern Forms will be reviewed monthly at center Quality Assurance Meeting.	

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interviewed on the [redacted] Unit continued to express concerns regarding housekeeping services.

The residents voiced concerns included statements such as, "My room is cleaned everyday except when male housekeepers are working. Room not cleaned as good. No one comes in on weekends. No one coming in on weekends to clean. They don't even come in my room. Rooms not being cleaned. No Tuesdays, no Fridays, and every other weekend. No Saturday. No Sunday. You call that enhanced cleaning...?"

A review of the [NJAC 8:43E-2.1 and Exec Order] Resident Council Meeting Minutes dated 1/6/21 indicated that the resident's concerns and suggestions for Housekeeping were summarized as: "Housekeepers are doing a good job but would like to see them on weekends."

A review of the Grievance Complaint Form dated 1/13/21 and 1/20/21 did not indicate that the Licensed Nursing Home Administrator (LNHA) and Director of Environmental Services (DES) were made aware of the resident's concerns on the [redacted] Unit. There was no documented evidence of follow up or resolution to the resident's housekeeping concerns.

A review of the facility's February 2021 Resident Council Precautionary Isolation Questionnaire (RCQ) indicated that 13 residents who resided on the [redacted] Unit were individually interviewed on [redacted] and on [redacted] by a staff member from the activities department for the opportunity to voice their concerns. 8 out of the 13 residents interviewed on the [redacted] Unit had concerns

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regarding housekeeping services.

The residents voiced concerns included statements such as: "They're not good. Could be better. Don't come in as often as they used to. Four days, no housekeeping. I see them once a week. Needs improvement. Haven't come in steady. Just OK. Haven't been in to clean. Don't do a good job."

A review of the February 2021 Resident Council Meeting Minutes dated 2/10/21 indicated that the resident's concerns and suggestions for Housekeeping was summarized as: "Not going into rooms as often."

A further review of the February 2021 Resident Council Meeting Minutes indicated that the resident's individual concerns on the [redacted] Unit were not addressed until 3/16/21, upon surveyor entrance to the facility, by the Housekeeping District Manager and the DES. This reflected over a month lapse in time in which the resident's concerns were acknowledged. The individual resident follow-up indicated, "that due to the Patient Specific Contact Plus Airborne Precautions rooms cannot be stripped or waxed at this time so the perception appears they are not cleaning as often." The residents were then assured by the EDS that the rooms would be checked for cleanliness daily. The resident's concerns that the housekeepers were not entering their rooms were not addressed by the administration.

On 3/25/21 at 9:16 AM, the surveyor interviewed LNHA and the Director of Nursing (DON) regarding their QAPI program. The LNHA stated that the facility met monthly with all department

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F 865	Continued From page 26 heads including the DES. He stated that the last meeting was held on 2/24/21 and during those meetings they discuss the Resident Council Minutes as a key source for their improvement plans. The DON stated that the facility also used grievance logs as well as other data sources. The LNHA acknowledged that the residents complained in the resident council meeting interviews in December 2020, January 2021 and February 2021 regarding the housekeeping concerns. The LNHA also acknowledged that there was a competency evaluation for housekeeping done on 2/10/21 which reflected all the housekeepers that day had "unsatisfactory" audits. The surveyor asked if they had conducted a QAPI related to the complaints in housekeeping as well as the unsatisfactory audits conducted on 2/10/21, and the LNHA stated that they did not implement one. He stated that the DES did not bring it up. The surveyor asked if he prompted him to discuss results of any audits he was doing, and the LNHA simply stated that it just did not come up during the last meeting on 2/24/21. He acknowledged the surveyor's findings on the [redacted] Unit. He stated that they should have instituted a QAPI and set a measurable goal, and an effective evaluation of that goal to ensure that the rooms were cleaned to the level of satisfaction required during the pandemic and COVID-19 outbreak. At 11:19 AM, the surveyor interviewed the Regional Director of Housekeeping and the DES in the presence of the survey team who stated quality inspections are done daily and during an audit, it gets fixed immediately. The surveyor asked if they determined a root causes as to why the rooms were still not clean and they could not speak to it, other than it may have been the	F 865		

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F 865	Continued From page 27 resident's perception and may now know that the Housekeeper was in the room or didn't recognize that staff. They confirmed there was no data driven QAPI program for the issue with the sanitation of the rooms to ensure a clean, comfortable homelike environment. quality. The Regional Director discussed what their QAPI plan would be moving forward. A review of the facility's Quality Assessment and Performance Improvement Plan updated January 2021 included that individuals would meet "at least 10 times annually, preferably monthly, to monitor quality within the Center, identify issues, and develop and implement appropriate plans of action to correct identified quality issues...develop/implement an effective QAPI Program...Assess, evaluate, and identify potential improvement opportunities based on: ...Potential issues identified through Routine QAPI activities, such as, but not limited to family comments, resident requests, staff suggestions, grievances." Refer to F584 NJAC 8:39-33.1 (e); 33.2 (c)	F 865		
F 886 SS=E	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on	F 886		4/9/21

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F 886	Continued From page 28 parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19.	F 886		

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F 886	Continued From page 29 §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure 2 of 5 facility staff reviewed (a Certified Nursing Aide and a Contracted Dietary Aide) were tested for COVID-19 twice a week in accordance with the New Jersey Department of Health Executive Directive 20-026, nationally accepted guidelines for infection prevention and control, and the facility's testing schedules related to the high COVID-19 county positivity rate. The evidence was as follows: According to the U.S. Centers for Disease Control and Prevention (CDC) guidelines, Interim Guidance on Testing Healthcare Personnel [HCP] for SARS-CoV-2 [COVID-19] updated 2/21/21 included, "Currently, testing asymptomatic HCP without known or suspected exposure to SARS-CoV-2 is recommended for HCP working in nursing homes...Testing asymptomatic HCP without known or suspected exposure to SARS-CoV-2 is most valuable when it is repeated frequently, especially if testing is conducted with a test with a lower sensitivity. Testing less	F 886	1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice? The Certified Nursing Aide and the Contracted Dietary Aide were both tested on March 19, 2021, both are up to date with facility testing cadence. Infection Preventionist re-educated them both on the scheduled days of testing and instructed them if they were not able to make it on those days they must test on their next scheduled day to work prior to reporting to duty. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice? All residents and staff have the potential to be affected by this same deficient practice. 3. What systemic changes will be put in place to ensure this deficient practice doesn t happen again?	

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F 886	Continued From page 30 frequently than once per week increases the risk of missing HCP who are infected between scheduled tests..." According to the New Jersey Department of Health Executive Directive 20-026 updated 1/6/21 included, "Routine testing should be based on the extent of the virus in the community, therefore facilities should use the regional positivity rate reported in the COVID-19 Activity Level Index (CALI) Weekly report...in the prior week..." The order further specified that if the COVID-19 activity level index is high or very high, the facility should perform at a minimum COVID-19 testing twice a week for staff. According to the COVID-19 CALI weekly report ending in 1/30/21, 2/6/21, 2/13/21, 2/20/21, 2/27/21, 3/6/21, 3/13/21, and 3/20/21 reflected that the Monmouth County was consistently in a "high" index for COVID-19 activity. On 3/16/21 at 10:45 AM, the surveyor conducted an entrance conference with the Licensed Nursing Home Administrator (LNHA), the Director of Nursing (DON) and the facility's designated Infection Preventionist/Registered Nurse (IP). The IP stated that the facility was in a current COVID-19 outbreak that began on 9/1/2020 when three employees tested positive for COVID-19. The IP confirmed that a student in the Nurse Aide Training Program had just tested positive for COVID-19 this morning on [redacted] She stated there had been no residents that had tested positive for COVID-19 since [redacted]. The DON and IP confirmed that facility staff were tested twice a week on Tuesdays and Fridays for COVID-19 due to the elevated positivity rate in the county and because the facility was still in a	F 886	The Infection Preventionist/designee will ensure the Testing schedule is posted on the Human Resource door, on all units, given to all Department Heads and posted at the front desk. Infection Preventionist/designee will keep track of all staff that tested with an Index card file and line listing. Once completed the Infection Preventionist/Designee will review who was not tested and alert the Department Head with a list of their staff and they will be expected to contact them and have them come in for testing. If the staff does not come in they will need to come in prior to their scheduled day to work to get tested within the time frame of the facility s current cadence schedule. An audit will be completed weekly by the Infection Preventionist/Designee x 3 months and any staff member not tested will not be able to work until they are in compliance with the current cadence of the facility. 4. How will the systematic corrective actions be monitored that the deficient practice is corrected and will not recur? Weekly audits will be presented on a monthly basis by the Infection Prevention/Designee at the Monthly Quality Assurance Meeting with any corrective action needed or taken during the course of the audit.	

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COVID-19 outbreak.

The surveyor selected five facility employees for COVID-19 testing. The surveyor identified that 2 of the 5 facility staff did not have evidence of twice a week COVID-19 testing in accordance with the Executive Directive 20-026 and the facility's outbreak response plan for COVID-19 testing of staff. The following was revealed:

A review of a Contracted Dietary Aide (DA) COVID-19 rapid antigen COVID-19 test result reflected that the DA was tested for COVID-19 on 3/5/21, 3/9/21, but was not tested again until 3/19/21. All rapid antigen tests were negative for COVID-19.

A review of the DA's Time Card Report reflected that the DA worked six (6) shifts over a period of seven (7) days on Friday 3/12/21, 3/13/21, 3/14/21, 3/15/21, 3/17/21 and 3/18/21 without evidence of COVID-19 testing. The Time Card reflected that the DA did not work on the scheduled Tuesday 3/16/21 COVID-19 testing date, but no subsequent testing was done upon return to work on 3/17/21 and 3/18/21.

A review of a per-diem Certified Nursing Aide (CNA) hired on [redacted] reflected that the CNA was tested for COVID-19 one time in the last three weeks, Friday 3/19/21. The rapid antigen test was negative for COVID-19.

According to the CNA's Time Card Report reflected that the CNA had worked at the facility 12 days over a period of 27 days without documented evidence of twice a week COVID-19 testing. The CNA worked on 2/20/21, 2/22/21, 2/24/21, 2/27/2, 3/3/21, 3/5/21, 3/7/21, 3/12/21,

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3/13/21, 3/14/21, 3/16/21, and 3/18/21.

On 3/24/21 at 9:14 AM, the surveyor interviewed the DON who acknowledged a second time that the facility performed COVID-19 testing for all staff twice a week on Tuesdays and Fridays. The surveyor requested for any additional COVID-19 testing results for the DA and CNA.

At 2:06 PM, the DON stated that she had no other evidence of COVID-19 testing for the CNA and the DA. She stated that the IP had a system for tracking the results and would be able to speak to why there was no evidence of twice a week testing on Tuesdays and Fridays for the DA and CNA.

On 3/25/21 at 10:21 AM, the surveyor interviewed the IP in the presence of the DON, LNHA and the survey team. The IP stated that the facility conducts between 400-500 COVID-19 tests on residents, staff, compassionate care visitors, and vendors. The IP acknowledged that for the DA, there were only three (3) COVID-19 tests conducted out of an opportunity to conduct six (6.) She stated that five (5) out of six (6) days the DA was here when COVID-19 testing was being conducted or could have been conducted to accommodate. The IP stated that we post the dates and times of the COVID-19 testing so staff should know. She stated that it was always Tuesdays and Fridays, but we still test anytime if its needed. The IP stated that the system the facility uses to track COVID-19 included that they had index cards for all the employees and when tested for COVID-19, "we pull the index card at end of testing day and what is left in the box is who has not been tested that day." She stated that the method was "not 100% fool-proof." The

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IP stated that it wasn't necessarily up to the staff to remember they needed to be tested because they may forget, She acknowledged that the facility's system for tracking COVID-19 testing had to improve.

The IP continued that the CNA only worked per-diem and often worked the night shift. The IP stated that the CNA worked at another facility and that they got tested for COVID-19 at that other facility. The IP acknowledged that facility did not keep copies of COVID-19 testing done at the other facility or document that results taken on a specific date were reviewed to ensure the facility was meeting the requirements. The IP stated that they start testing at 6:30 AM on designated shifts so that they can capture the night shift and day shift both, but also stated that the Registered Nurse Supervisors on the evening and night shifts had been trained on how to do COVID-19 testing as well. She stated that the facility had tried to reach out to the CNA for the COVID-19 test results, but that they were unable to obtain evidence that the CNA had been tested from 2/20/21 until 3/19/21. No additional documentation was provided. The IP, LNHA and DON acknowledged the surveyors findings.

A review of the facility's undated Outbreak Response Plan, included, "The early detection of the Facility staff and resident/patient infection with COVID-19 is also essential to preventing the spread of COVID-19 to our residents staff and to the community...The Facility has tested, and will continue to test, the Facility's staff and residents for COVID-19 in accordance with all Governmental Guidelines and Directives..."

NJAC 8:39-5.1 (a)

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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)
315364		5/7/2021

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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 F0584 Reg. # 483.10(i)(1)-(7) LSC	Correction Completed 04/09/2021	ID Prefix F0607 Reg. # 483.12(b)(1)-(3) LSC	Correction Completed 04/09/2021	ID Prefix F0849 Reg. # 483.70(o)(1)-(4) LSC	Correction Completed 04/09/2021
ID Prefix F0865 Reg. # 483.75(a)(2)(h)(i) LSC	Correction Completed 04/09/2021	ID Prefix F0886 Reg. # 483.80 (h)(1)-(6) LSC	Correction Completed 04/09/2021	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	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	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO
3/25/2021	