STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315464	A. BUILDING _____ B. WING _____	02/17/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT EVESHAM	870 EAST ROUTE 70 MARLTON, NJ 08053

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Survey Date: 2/17/22 Census: 114 Sample: 24+3 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 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable	F 623		3/18/22

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

Electronically Signed | 03/11/2022

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F 623	Continued From page 1	F 623		

before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance

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F 623	Continued From page 2 and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview and review of the medical records and other facility documentation, it was determined that the facility failed to send the family representative a notification of transfer letter 1 of 2 residents reviewed for hospitalization transfers (Resident [redacted]). This deficient practice was evidenced by the following: A review of the facility Admission Record revealed	F 623	How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident [redacted] representatives were notified in writing of the specific reason for transfer, the date, and the location where the resident was transferred to. How the facility will identify other residents	

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F 623	Continued From page 3 Resident # was originally admitted to the facility on with diagnoses that included but were not limited to: [redacted] A review of the Quarterly Minimum Data Set (MDS), an assessment tool dated , revealed Resident scored a on the Brief Interview for Mental Status (BIMS), which indicated that the resident had cognitive . A review of Resident # s progress note dated at 05:33 PM, revealed the resident was transferred to the hospital for evaluation for or reaction. A review of Resident # 's progress note dated at 02:56 AM, revealed the resident was admitted to the hospital for . Further review of the progress note dated at 08:42 PM, revealed the resident was readmitted to the facility. A review of Resident # 's medical record did not include notification in writing to the family of the transfer to the hospital. During an interview with the surveyor on 02/14/2022 at 10:30 AM, the Director of Nursing (DON) stated that the facility did not send letters to the family or representative in writing of a discharge to the hospital, they notify the family by phone. During a meeting with the surveyor on 02/16/2022 at 01:10 PM, the Administrator was informed of the findings.	F 623	having the potential to be affected by the same deficient practice. Residents have the potential to be affected. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur. 1)The facility made a systemic change to process where the Administrator or Designee will notify Ombudsman and representative in writing of the Notice of Transfer to Acute Care Facility. 2)The facility reeducated and in-serviced on Transfer or Discharge Notice policy and procedure. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what QA program will be put into place to monitor the continued effectiveness of the systemic change. 1)The Administrator and designee will review the resident's transfer daily for one week, then 2X weekly for two weeks, and then weekly for two weeks. 2)Outcomes of the audit will be presented monthly to Quality Assurance Performance Improvement Committee for a period of three months. Changes to the plan will be implemented if needed upon review of the audits.	

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F 623	Continued From page 4 A review of the policy labeled "Transfer or Discharge Notice" with a revised date of March 2021, revealed the resident and representative are to be notified in writing of the specific reason for transfer, the date, and the location of where the resident was transferred to.	F 623		
F 812 SS=E	NJAC 8:39-4.1(a)(32) Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and review of documentation provided by the facility, it was determined that the facility failed to maintain proper kitchen sanitation practices and store, label, and date potentially hazardous foods to prevent the development of food borne illness.	F 812	How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. No residents were identified.	3/18/22

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F 812	Continued From page 5 This deficient practice was evidenced by the following: On 02/09/2022 at 09:21 am, during the initial tour of the kitchen in the presence of the Assistant Dietary Director (ADD), the surveyor observed the following: 1. The ADD was in the kitchen wearing a hair net. The hair net did not cover her hair to the hairline on the forehead and there were multiple long strands of hair that were not contained in the hair net. The ADD stated that she did not realize that all her hair was not contained in the hair net. The ADD stated that her hair should have been completely contained in the hair net to avoid hair from falling in the food. 2. There was a large stand-up mixer that had a clear plastic bag covering it. The ADD stated that the clear bag indicated that the mixer was clean and ready for use. The ADD removed the clear plastic bag in the presence of the surveyor. There was a dry white substance on the underside of the mixer above where the mixer blade would be attached. The ADD stated that the white substance should not have been there due to cross contamination. 3. In the reach-in refrigerator the following was observed: -A silver tray labeled "red gelatin" covered with clear plastic wrap with a use by date of 2/6/22 -A silver tray labeled "sliced deli turkey" covered with clear plastic wrap with a use by 2/5/22 -A sandwich wrapped in clear plastic labeled "jelly sandwich" with a use by date of 2/7/22 At that time, the ADD stated that the reason the items were dated was to make sure it was used	F 812	Employee implemented proper hair restraint procedure. Identified food service equipment were sanitized according to current guidelines and manufacturer's recommendation. Unlabeled foods were discarded. Expired items were discarded. Opened chicken bag was discarded. How the facility will identify other residents having the potential to be affected by the same deficient practice. Residents have the potential to be affected. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur. The food service director re-educated the staff on facility□s policy on Preventing Foodborne Illness- Employee Hygiene and Sanitary Practices. The education also included proper use of hair nets or caps and/or beard restraints, cleaning of equipment, utensils and linens according to manufacturer guidelines. The facility reeducated and re-in-serviced facility policy, Refrigerators and Freezer. Facility will ensure refrigerator and freezer maintenance, temperatures, and sanitation, and will observe food expiration guidelines. Food shall be dated to ensure proper rotation by expiration	

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F 812	Continued From page 6 by allotted time, so it doesn't go bad, 4. In the walk-in refrigerator: -An opened 1-gallon container of ranch dressing with a use by date of 1/16/22 -An opened 8-pound (lb) 10 ounce (oz) container of enchilada sauce with a use by date of 1/16/22 -An opened 1-gallon container of thousand island dressing with a use by date of 1/14/22 -An opened 5 lbs. container of teriyaki glaze with no open date -An opened 4 lb. 15 oz container of bourbon style sauce with no open date The ADD stated that it was everyone's responsibility check the dates to make sure the items were labeled and still good. At 09:45 AM, the Dietary Director (DD) joined the tour. 5. In the walk-in freezer, the DD identified the following: -An opened box of chicken cutlets that contained a bag of the chicken cutlets that was opened to air. The DD stated that they shouldn't be open to air due to cross contamination. -A clear bag of long white logs, there was no identifier label, received on label, or use by label. The DD identified them as French fries. -A clear bag of long oval brown logs, there was no identifier label, received on label, or use by label. The DD identified them as hot dogs. -A clear bag of brown circular patties, there was no identifier label, received on label, or use by label. The DD identified them as beef steak fritters. -A clear bag of tan circular nuggets, there was no identifier label, received on label, or use by label. The DD identified them as chicken nuggets.	F 812	dates. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what QA program will be put into place to monitor the continued effectiveness of the systemic change. The Food Service Director (FSD) has observed the dietary employees who handle, prepare, or serve food to ensure proper hair restraint policy. An audit will be conducted daily for one week, then twice weekly for two weeks, then monthly for two months. The Food Service Director will audit equipment, utensils and linen sanitation daily for one week, then twice weekly for two weeks, then monthly for two months. The FSD will audit food storage, labeling, and dating daily for one week, then twice weekly for two weeks, then monthly for two months. The Food Service Director will present the results of the audits to the Quality Assurance Performance Improvement Committee for review on a monthly basis for three months. The Committee will review and revise the plan if needed.	

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F 812	Continued From page 7	F 812		

-3 clear bags of white circular items, there was no identifier label, received on label, or use by label. The DD identified them as cookie dough.

At that time, the DD stated the purpose of labeling items was so that everyone knows what the item was and when to use it. He also stated that it was everyone's responsibility to label the items.

At 09:55 AM, the surveyor reviewed with the DD all the findings that were observed while touring with the ADD.

On 02/16/22 at 01:12 PM, the above findings were reviewed with the Administrator and the Director of Nursing.

Review of the facility's policy, "Preventing Foodborne Illness-Employee hygiene and Sanitary Practices" dated October 2017, Policy Interpretation and Implementation: 12. Hair nets or caps and/or beard restraints must be worn to keep hair from contacting exposed food, clean equipment, utensils and linens.

Review of the facility's policy, "Preventing Foodborne Illness-Food Handling" revised July 2014, Policy Interpretation and Implementation: 9. All food service equipment and utensils will be sanitized according to current guidelines and manufacturers' recommendation.

Review of the facility's policy, "Refrigerators and Freezer" revised December 2014, Policy Statement: This facility will ensure safe refrigerator and freezer maintenance, temperatures and sanitation, and will observe food expiration guidelines. Policy Interpretation and implementation: 7. All food shall be

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F 812	Continued From page 8 appropriately dated to ensure proper rotation by expiration dates ..."Use by " dates will be completed with expiration dates on all prepared food in refrigerators. Expiration dates on unopened food will be observed and "use by" dates indicated once food is opened. 8. Supervisors will be responsible for ensuring food items in pantry, refrigerators, and freezers are not expired or past perish dates.	F 812		
F 880 SS=F	NJAC 8:39-17.2(g) 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 procedures for the program, which must include,	F 880		3/18/22

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F 880	Continued From page 9 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 IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 880		

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F 880	Continued From page 10 Based on observation, interviews, review of medical records, and other facility documentation, it was determined that the facility failed to prevent the potential spread of infection and cross-contamination in accordance with current infection prevention standards and failed to: a) ensure that staff utilized proper serving utensils to scoop ice in a safe and hygienic manner during the meal pass b) follow appropriate infection control protocol for hand hygiene, ensure that medications were handled in a sanitary manner and that medical equipment was properly cleaned and disinfected between residents during the medication pass c) maintain the infection prevention protocol for a resident on transmission-based precautions and d) failed to ensure that dedicated medical supplies were stored in a safe and sanitary manner. This deficient practice was identified for 2 of 2 nursing units [redacted] Unit and [redacted] Unit) observed during meal pass, 2 of 2 nurses observed on 2 of 2 units during the medication pass which included 6 of 8 residents observed for medication administration (Residents #267, #75, #11, #23, #34 and an unsampled resident), 1 of 4 residents reviewed for Transmission-Based Precautions (Resident #46) and 1 of 3 residents reviewed for [redacted] (Resident #[redacted]). This deficient practice was evidenced by the following: 1. During a meal service observation on 02/09/22 at 12:05 PM, Surveyor #1 observed the beverage cart enter the [redacted] Unit. The beverage cart included an ice bucket filled with ice. Surveyor #1 observed staff use a ceramic coffee cup to dispense ice to the residents from an ice bucket.	F 880	How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. No residents were affected. An immediate in-service of C.N.A. and dietary aide who did not use an ice scoop to get ice for the residents beverages. An immediate re- education and Clinical Education Referral for two Licensed Practical Nurses who were observed during med pass and failed to follow the hand hygiene, sanitary handling of medication, and disinfection of medical equipment. An immediate re-education and Clinical Education Referral of a nurse who used her personal medical equipment instead of using the one provided by the facility. An immediate re-education and Clinical Education Referral for a Licensed Practical Nurse who forgot to don an isolation gown and gloves before entering the residents room who had an order of contact precaution due to [redacted]. An immediate in-service of nurses, C.N.A., receptionist, housekeeper, and maintenance staff who allowed the delivery of the patients [redacted] supplies to residents room and directly placed it on the floor. The supplies identified on the floor were moved and raised to ensure proper storage. A Root Cause Analysis (RCA) was	

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F 880	Continued From page 11 The following was observed: At 12:05 PM, Surveyor #1 observed a staff member use a ceramic coffee cup to scoop ice from an ice bucket and placed the cup on the counter of the beverage cart. At 12:10 PM, Surveyor #1 observed another staff member use a ceramic coffee cup to scoop ice from an ice bucket and placed the cup on the counter of the beverage cart. At 12:30 PM, Surveyor #1 observed another staff member use the ceramic coffee cup to scoop ice from the ice bucket and left the cup in the ice bucket. On 02/10/22 from 11:56 AM - 12:18 pm, Surveyor #1 observed meal delivery on the [redacted] Unit. Surveyor #1 observed each staff member use a plastic handleless drinking cup with their bare hands to dispense ice to the residents from an ice bucket. The following was observed: At 11:58 AM, Surveyor #1 observed a staff member use the cup to scoop ice and placed the cup back into the ice bucket. At 12:01 PM, Surveyor #1 observed a staff member use the same cup to scoop ice and then placed the cup on the counter of the refreshment cart. At 12:02 PM, Surveyor #1 observed another staff member use the cup to scoop ice then placed to cup into the ice bucket.	F 880	completed. A Root Cause Analysis (RCA) was done. The findings on why the staff did what they did was as follows: 1) Staff acknowledged they should have used an ice scoop but used another object because the ice scoop was not readily available. 2) The nurses involved in medication pass acknowledged that they should have used the proper hand hygiene. They did not use the proper hand hygiene because they were nervous. 3)The nurse acknowledged she should have not used her own medical equipment. She did so because it was easier for her to use her own equipment and liked it better. 4) The nurse acknowledged she was aware about the PPE needed for residents on isolation. She did not comply because she was nervous and trying to answer the call light as fast as possible. 5) The staff acknowledged that medical supplies in a resident's room need to be raised off the floor. The staff did not do so because the needed items to raise supplies off the floor was not readily available. The following in-services were conducted: 1)Module 1; Infection Prevention and Control Program. Completed by all Topline Staff 2)In-service titled, "Keep COVD-19 Out." Completed by all Frontline Staff including: Environmental and Housekeeping Department, Dietary Department, Rehabilitation Department, Administration	

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F 880	Continued From page 12 At 12:05 PM, Surveyor #1 observed another staff member use the cup to scoop ice and placed the cup in the bucket. At 12:07 PM, Surveyor #1 observed another staff member place the cup on a shelf under the cart and retrieved another plastic cup and scoop ice and placed the cup on top of the counter of the refreshment cart. At 12:18 PM, Surveyor #1 observed another staff member use the same cup to scoop ice and left the cup in the ice bucket. During an interview with Surveyor #1 on 02/10/22 at 12:45 PM, the Certified Nursing Assistant (CNA) stated the refreshment cart came to the unit daily with the ice bucket covered with plastic and the staff used a cup to retrieve the ice from the bucket. She stated that sometimes there was a scoop to use and stated she could not remember the last time she saw the scoop. During an interview with Surveyor #1 on 02/10/22 at 01:15 PM, the Licensed Practical Nurse (LPN) stated that she would use a new cup to retrieve the ice because reusing the cup, touching it, and placing it on the cart or in the ice bucket was not sanitary or a clean process. She stated they needed a scooper or tongs to retrieve ice. During a meal observation on 02/10/22 at 12:03 PM, Surveyor #2 observed a four-tiered rolling beverage cart positioned in the hallway on the [redacted] Unit. On the top shelf of the cart, a ceramic coffee mug was noted inside of an ice filled silver-colored metallic ice bucket. The surveyor observed a Hospitality Aide (HA) as she utilized the ceramic coffee cup to	F 880	Department, and Nursing Department. 3) In-service titled, "Sparkling Surfaces." Completed by all Frontline Staff including: Environmental and Housekeeping Department, Dietary Department, Rehabilitation Department, Administration Department, and Nursing Department. 4) In-service titled, "Clean Hands." Completed by all Frontline Staff including: Environmental and Housekeeping Department, Dietary Department, Rehabilitation Department, Administration Department, and Nursing Department. 5) In-service titled, "Closely Monitor Residents." Completed by all Frontline Staff including: Environmental and Housekeeping Department, Dietary Department, Rehabilitation Department, Administration Department, and Nursing Department. 6) In-service titled, "Use PPE Correctly for COVID-19." Completed by all Frontline Staff including: Environmental and Housekeeping Department, Dietary Department, Rehabilitation Department, Administration Department, and Nursing Department. 7) Module 5; Outbreaks. Completed by all Topline Staff and Infection Preventionist. 8)Module 11B; Environmental Cleaning and Disinfection. Completed by Topline staff, Infection Preventionist, and all Frontline Staff including: Environmental and Housekeeping Department, Dietary Department, Rehabilitation Department, Administration Department, and Nursing Department. 9)Module 4; Infection Surveillance. Completed by Topline Staff and Infection Preventionist.	

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F 880	Continued From page 13 scoop the ice out of the ice bucket and into a cup with her bare hands as she prepared a beverage for a resident. When interviewed, the HA stated that she just started working at the facility on Monday. At 12:05 PM, Surveyor #2 observed CNA #2 as she utilized the coffee mug to scoop out of the ice bucket and into a cup with her bare hands. When interviewed, CNA #2 stated that she utilized a coffee mug to scoop the ice instead of an ice scoop because it was just easier, as the handle of the ice scoop was too long. During an interview with Surveyor #2 at 12:10 PM, the Dietary Aide (DA) stated that staff was supposed to use an ice scooper when they scooped ice, not a coffee cup. She stated that the nurses should have had an ice scoop on the unit. At 12:11 PM, Surveyor #2 observed CNA #2 as she utilized the coffee mug to scoop ice into a cup a second time with her bare hands. At 12:12 PM, Surveyor #2 observed CNA #2 as she removed the coffee cup from the ice bucket with her bare hands and placed an ice scooper into the ice bucket. When interviewed, CNA #2 stated that there was no problem with using a coffee cup to scoop ice for the residents instead of an ice scooper because the coffee cup was clean. During an interview with Surveyor #2 at 12:15 PM, LPN #2 stated that she had never seen a staff utilize a coffee cup to scoop ice from the ice bucket before. She stated that nursing did not have an ice scoop on the unit. She stated that the ice scoop should have been sent to the unit on the beverage cart from the dietary department.	F 880	10)Module 7; Hand Hygiene. Completed by Topline staff, Infection Preventionist, and all Frontline Staff including: Environmental and Housekeeping Department, Dietary Department, Rehabilitation Department, Administration Department, and Nursing Department. 11) Module 6A; Principles of Standard Precautions. Completed by Topline staff, Infection Preventionist, and all Frontline Staff including: Environmental and Housekeeping Department, Dietary Department, Rehabilitation Department, Administration Department, and Nursing Department. 12) Module 6B; Principles of Transmission Based Precautions. Completed by Topline staff, Infection Preventionist, and all Frontline Staff including: Environmental and Housekeeping Department, Dietary Department, Rehabilitation Department, Administration Department, and Nursing Department. 13) Module 11A; Reprocessing Reusable Resident Care Equipment. Completed by Topline Staff and Infection Preventionist. LTC Self Assessment was completed by Administrator, Director of Nursing, Infection Preventionist, and Infectious Disease Doctor. Infection Preventionist completed Nursing Home Infection Preventionist Training Course through CDC and IP plan was complete. How the facility will identify other residents having the potential to be affected by the same deficient practice.	

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F 880	Continued From page 14 She further stated that the problem with using a coffee cup instead of an ice scoop was that there was a potential that the cup could chip and break off into the ice. During a later interview with Surveyor #2, at 12:18 PM, CNA #2, examined the inside of the ceramic coffee cup utilized to scoop ice and stated that the coffee cup was not chipped but was stained with a brown substance on the inside of the cup. During an interview with Surveyor #2 on 02/11/22 at 1:47 PM, the Registered Nurse/Infection Preventionist (RN/IP) stated that it was not appropriate for the DA or CNA #2 to use a coffee cup to scoop ice for the residents instead of an ice scoop. She stated that by not using a plastic ice scoop that went through the dishwasher and was sanitized prior to use, there was a break in protocol and was an infection control issue due to the risk of contamination. During an interview with the surveyor on 02/14/22 at 12:36 PM, the Food Service Director (FSD) stated that staff was required to utilize an ice scooper when they served beverages because if they used a ceramic coffee mug it may be subject to chipping. He stated that he did not know if there was a possibility of contamination if the cup was stained with a brown substance on the inside as it was used to serve beverages. He further stated that if staff forgot to stock the beverage cart with an ice scoop, then they should have known to come back to the kitchen to get an ice scoop and should not have used a coffee cup. During an interview with the surveyor on 02/16/22 at 12:06 PM, the Licensed Nursing Home Administrator (LNHA) stated that she thought that since the coffee cup was previously run through	F 880	Residents have the potential to be affected. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur. An immediate in-service, reinforcement and update sessions are conducted for facility staff by the Infection Preventionist, Facility Educator, DON, Unit Manager, Nursing Supervisor and/or designee to inform the staff that the beverage cart will no longer be utilized during meals effective 2/18/22. The residents/patients will be getting their pre-selected beverages with their regular meal tray delivery. The ice will be available for the residents/patients as requested. The Pharmacy Consultant, Facility Educator, DON, Unit Manager, Nursing Supervisor and/or designee will conduct an audit of nurses□ med pass in compliance with hand hygiene and disinfection of medical equipment. Four nurses will be completed monthly for three months and then 2 nurses quarterly for 6 months. The Infection Preventionist, Facility Educator, DON, Unit Manager, Nursing Supervisor and/or designee will conduct an audit of 5 staff for handwashing, donning and doffing of PPE weekly for four weeks, then observation and competency of 5 staff members monthly, and then quarterly for 5 staff members.	

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F 880	Continued From page 15 the dishwasher that it was sanitized. The Director of Nursing (DON) who was present during the interview, stated that the staff would tend to touch the ice when a coffee cup was utilized to scoop ice and there was a risk of contamination if the handle touched the ice. The LNHA stated that it was also possible for the cup to chip into the ice. The DON stated that the coffee cup should not have been left in the bucket. 2. On 2/11/22 at 8:25 AM, Surveyor #2 observed LPN #3 on the [redacted] Unit, as she performed the medication administration pass. LPN #3 reviewed the Electronic Health Record (EHR) of an unsampled resident and utilized both a mouse and keyboard to review the resident's medications on the computer screen. She then opened a drawer of the medication cart and stated that the resident's medications were not available and were required to be obtained from the back up medication storage room. LPN #3 entered the medication storage room and obtained the first medication from the automated medication dispensing system and then proceeded to remove a multi-dose bottle of [redacted] (used to [redacted] and [redacted]) [redacted] milligrams (mg) that was located on an opened shelf within the medication storage room. LPN #3 returned to the medication cart and opened the drawer of the medication cart without first performing hand hygiene. She stated that she previously overlooked a bottle of [redacted] mg that was in the top drawer of the cart and stated that she would use it instead of the bottle that she removed from the medication storage room. LPN #3 then placed the bottle of [redacted] in the right pocket of her uniform and stated that she would return it to the storage room after the medication pass. She placed both medications into a plastic medication cup.	F 880	Infection Preventionist and/or designee will in-service all the staff members that we will no longer accept the [redacted] delivered directly to the patients room. DON notified the [redacted] centers to send the [redacted] supplies during working hours for proper storage off the floor. Infection Preventionist and/or designee will educate family members that supplies are not to be directly brought to room. Family members will be educated that facility designee will be the ones to bring the supplies to room to ensure proper storage off the floor. Facility purchased additional [redacted] to ensure that the building has enough means of storage when there are multiple residents at the same time who require [redacted] supply storage. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what QA program will be put into place to monitor the continued effectiveness of the systemic change. The infection preventionist or designee will perform an audit on meals services, beverage preparation and refreshment cart delivery on each unit 3X weekly for two weeks, then two times weekly for two weeks, and weekly for one month. The pharmacy consultant will conduct a random observation and medication administration competency for one staff on each unit monthly for three months.	

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F 880	Continued From page 16 At 8:35 AM, LPN #3 entered the unsampled resident's room and stated that the resident's [redacted] was not properly positioned within the resident's [redacted] She donned (put on) a pair of gloves and adjusted the [redacted] accordingly and accidentally knocked the resident's television remote off of the table and onto the floor. LPN #3 picked up the remote control with her gloved hands and handed it to the resident without cleaning it first. The resident placed the television remote on the over-bed table. LPN #3 then doffed (removed) her gloves without performing hand hygiene. She then handed the resident a cup of water and medications that were contained within the plastic medication cup. LPN #3 proceeded to obtain the resident's [redacted] level (a probe is used to measure the amount of [redacted] in the [redacted] from [redacted]), and temperature with a portable automated [redacted], touchless [redacted] and [redacted] that she stated belonged to her and were not supplied by the facility. She placed the [redacted] on the resident's [redacted] and removed it after and placed it in the left pocket of her uniform without cleaning it first. At 8:44 AM, LPN #3 returned to the medication cart and rolled it down the hall, and positioned it in front of a resident room. She donned one glove on her left hand and cleaned her portable [redacted] with a disinfectant wipe that she obtained from a canister that was stored within a basket that was attached to a rolling automated [redacted], and [redacted] device that was positioned in the hallway. She did not perform hand hygiene after she doffed the single glove. She then returned her portable	F 880	IP and designee will continue the Environmental Rounds and add the peritoneal dialysis supply storage for audit weekly for 4 weeks and then monthly thereafter. The outcomes of the audits and observation will be presented to the monthly Quality Assurance Committee meeting for 3 months. The committee will review and revise plans as needed.	

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[redacted] to a storage case that she kept in the bottom drawer of the medication cart.

At 8:46 AM, LPN #3 picked up a plastic medication cup and placed it on top of the medication cart and the tip of her bare index finger touched the bottom of the inside of the medication cup as she laid it down on top of the med cart. She stated that she had to get Resident [redacted]'s [redacted] first and obtained the rolling automated [redacted] device from the hallway and applied the [redacted] to the resident's left wrist. She removed the [redacted] from the resident and then cleaned the [redacted] with a disinfectant wipe. She did not don gloves before she cleaned the [redacted] and failed to perform hand hygiene after she cleaned it. LPN #3 then utilized the mouse and computer keyboard as she reviewed the medications that she prepared to administer in the resident's EHR. She then prepared the resident's scheduled medications and placed them in the plastic medication cup that she had previously placed on the cart.

At 8:48 AM, LPN #3 entered Resident #[redacted]'s room and administered his/her medications. She removed a portable [redacted] from her left pocket and placed it on the resident's [redacted] r. After she removed the [redacted], she cleaned it with a disinfectant wipe with her bare hands and did not perform hand hygiene after.

At 8:57 AM, Surveyor #2 interviewed LPN #3 who stated that she should have returned the multi-dose bottle of [redacted] to the medication storage room when she realized that she was not going to administer it. She stated that she also should have washed her hands after

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F 880	Continued From page 18 she left the medications storage room before she prepared the unsampled resident's medications. She stated that she also should have washed off the television remote and washed her hands before she returned the remote and cup of water to the resident. She further stated that she should have washed her hands each time that she doffed her gloves during the medication pass to prevent the spread of infection. Surveyor #2 observed that LPN #3 did not perform hand hygiene before she reached into her pocket and obtained the bottle of [redacted] and returned the medication to the storage room. During an interview with Surveyor #2 on 02/11/22 at 12:30 PM, the LPN/UM (Unit Manager) of the [redacted] Unit stated that nursing was required to clean their hands before they entered a resident room to administer medications and clean their hands before they exited the room after medications were administered. She stated that she would have placed the multi-dose bottle of [redacted] in the drawer of the medication cart instead of in her pocket so that the bottle did not become contaminated. She stated that when the television remote control fell on the ground, LPN #3 should have donned gloves and wiped the remote with a disinfectant wipe and doffed the gloves, and performed hand hygiene after. She stated that by failing to clean the remote before she handed it to the resident, she now contaminated the table where the remote was placed. She stated that she also potentially contaminated the resident's cup that she handed to her after she touched the remote that had been on the floor. The LPN/UM stated that nursing staff were required to don gloves and clean all reusable equipment in between resident use and should have used equipment that was provided by the facility rather than their own for accuracy.	F 880		

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F 880	Continued From page 19 She stated when LPN #3 finished cleaning medical equipment, she should have doffed her gloves and performed hand hygiene. She stated that LPN #3 was also required to wash her hands after resident contact when she obtained a [redacted] to prevent contamination. She further stated that if LPN #3 returned a multi-dose vial of [redacted] to the medications storage room from her pocket without first performing hand hygiene or wiping the outside of the bottle with a disinfectant wipe it could potentially contaminate other medications that were stored on the shelf as both LPN #3's hands and pocket were contaminated. During an interview with Surveyor #2 on 02/11/22 at 12:50 PM, the RN/IP stated that LPN #3 could have immediately returned the multi-dose bottle of [redacted] to the medication storage room when she decided not to use it and failure to do so was an infection control issue. She stated that hand hygiene should have been performed before LPN #3 prepared the medications after she left the medication storage room. She stated that when LPN #3 dropped the television remote on the floor and picked it up and handed it to the resident there was a potential for the spread of infection. She stated that nursing was required to wear a pair of gloves when they sanitized equipment, not a single glove, and perform hand hygiene after gloves were doffed for infection control purposes. She stated that the nurse should have performed hand hygiene before and after she obtained vital signs and before and after medication administration. She stated that it was not appropriate for LPN #3 to touch the inside of a medication cup without first performing hand hygiene as it could have become contaminated. She further stated that the nurse should have performed hand hygiene after	F 880		

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medication administration and before she returned the multi-dose bottle of [redacted] to the medication storage room for infection control purposes.

On 2/14/22 at 7:39 AM, Surveyor #2 observed LPN #4 on the [redacted] Unit, during the medication pass. After LPN #4 used a [redacted] ([redacted]) is in the [redacted] for people with [redacted] and was obtained via a [redacted]) to obtain Resident [redacted] level she washed her hands, donned gloves and used a 75% alcohol wipe to disinfect the [redacted]. LPN #4 then doffed her gloves and did not perform hand hygiene after. LPN #4 then used the mouse and keyboard as she reviewed the resident's Electronic Health Record (EHR) in the computer and obtained the supplies from the medication cart that were required to obtain Resident #[redacted] (instrument used to pierce the [redacted]), [redacted], alcohol pad, [redacted], and adhesive bandage) without first performing hand hygiene.

At 7:41 AM, after LPN #4 obtained Resident #[redacted] she doffed her gloves and washed her hands before she donned a pair of gloves and cleaned a second glucose meter that she used alternatively with a 75% alcohol wipe. She doffed her gloves and did not perform hand hygiene after.

At 8:07 AM, LPN #4 washed her hands, donned gloves, and administered [redacted] to resident #[redacted] via an [redacted] a device that delivered [redacted]) into the resident's [redacted] doffed her gloves, and failed to perform hand hygiene before she removed the

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[redacted] tip and discarded it in the sharps container and returned the resident's [redacted] to the medication cart. She then accessed Resident [redacted]'s EHR in the computer and prepared the resident's medications without first performing hand hygiene.

At 8:22 AM, LPN #4 prepared Resident #[redacted]'s medications and carried the medications into the resident's bathroom and placed the plastic medication cup that contained the resident's medications on a paper towel on the edge of the sink, and washed her hands. She then handed the plastic medications cup to the resident and directed the resident to take the medications.

During an interview with Surveyor #2 at 8:52 AM, LPN #4 stated that she should have washed her hands after she cleaned the [redacted] and doffed her gloves and before she accessed the computer and medication cart as it posed an infection control issue. She stated that she should have washed her hands after she disposed of the [redacted] tip and related supplies in the sharps container before she resumed medication preparation as it posed an infection control issue. LPN #4 stated that she should not have placed Resident [redacted]'s medications on the edge of the sink while she washed her hands as there was a chance that she could have splashed water on them which was a potential infection control problem. She further stated that she thought that she was required to keep the medications within her sight and was not sure where to put the medications while she washed her hands.

During an interview with Surveyor #2 at 12:49 PM, the LPN/UM of the [redacted] Unit ([redacted]), stated that if LPN #4 failed to wash her hands when she doffed her gloves after she

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cleaned the [redacted] it posed a potential infection control issue. She stated that if medications were kept on the side of the sink while LPN #2 washed her hands, there was a potential for cross-contamination.

During an interview with Surveyor #2 on 02/15/22 at 12:21 PM, the RN/IP stated LPN #4 should have performed hand hygiene with hand sanitizer after she doffed her gloves when she finished cleaning the [redacted] because there could have been [redacted] on the meter when it was handled for the resident it was used for. She stated that there was a risk for contamination if medications were poured without hand hygiene after [redacted] contact. She further stated that the edge of the sink was not an appropriate place to store medications during hand hygiene and there was a risk of contamination. She further stated that LPN #4 posed a risk of contamination after she doffed her gloves and put the [redacted] in the medication cart and began to pour medications without first performing hand hygiene.

3. During the initial tour of the facility on 02/09/22 at 9:55 AM, Surveyor #2 observed a Personal Protective Equipment (PPE) (protective clothing, or equipment used to protect the wearer's body from injury or infection) caddy that was hung on the outside of Resident [redacted]s door. A Registered Nurse (RN) hung a sign on the wall above the resident's room number that cautioned: Stop, See Nurse. The RN stated that the resident had just came to the facility the prior night. Surveyor #2 donned a gown and gloves and entered the resident's room and observed the resident lying awake in bed. The resident stated that he/she had a history of [redacted]

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[redacted] related to a prior [redacted].

According to the Admission Record (an admission summary), Resident [redacted] was readmitted to the facility in [redacted] with diagnosis which included but were not limited to: [redacted] reaction due to [redacted] (an [redacted] that [redacted] which makes it hard to treat).

Review of Resident #46's Admission Minimum Data Set (MDS), an assessment tool dated [redacted], reflected that the resident had a Brief Interview for Mental Status (BIMS) of "[redacted]" which indicated that the resident was [redacted] Further review of the MDS revealed that the resident required extensive assistance of two persons for bed mobility and transfers.

A review of Resident [redacted]'s Care Plan revealed an entry dated [redacted], indicated that the resident had an infection of [redacted] and was maintained on isolation precautions as indicated.

Review of the Order Summary Report dated [redacted], revealed that an order was placed on [redacted] for Isolation and contact precautions ([redacted]) and on [redacted] an order was placed for Contact Isolation [redacted] in [redacted]

On 02/11/22 at 11:34 AM, as Surveyor #2 interviewed Resident [redacted] at his/her bedside, Licensed Practical Nurse (LPN) #3 entered the resident's room and did not don a gown or gloves prior to entry. LPN #3 held a glove in her left hand

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F 880	Continued From page 24 and a plastic medication cup in her right hand. She asked the resident about his/her air mattress function and pressed down on the mattress over top of the blankets that covered the foot of the bed with her bare hands. She stated that she would call Maintenance and inform them that there was a problem with the air mattress. LPN #3 left the resident's room with both the glove and plastic medication cup still in her hands without first performing hand hygiene. During an interview with Surveyor #2 at 11:47 AM, LPN #3 stated that she had not planned to administer medications to Resident [redacted] when she entered his/her room. She stated that both the plastic medication cup and the gloves that she held in her hands when she entered the resident's room were trash and she should have thrown them away before she entered the resident's room. She stated that she only wanted to look at the resident's bed and forgot to put a gown and gloves on before she entered the room. During an interview with Surveyor #2 at 12:30 PM, the LPN/UM of the SAR Unit stated that before LPN #3 entered Resident [redacted]'s room who was on transmission-based precautions (initiated when a resident develops signs and symptoms of a transmissible infection), she should have donned both a gown and gloves. She stated that by failing to do so she risked contamination when she touched the resident's bed linens. She further stated that the nurse should not have carried gloves or a medication cup into the resident's room and should have discarded them prior to entry and washed her hands before and after entry due to the risk of contamination. Review of LPN #3's Personal Protective Equipment (PPE) Competency Validation	F 880		

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Donning and Doffing Standard Precautions and Transmission Based Precautions dated 01/27/22 revealed the following: Perform hand hygiene, don gown ..., don gloves ..., doff PPE, remove gloves ..., remove gown ..., discard in waste container, perform hand hygiene.

4. During the initial tour of the facility on 02/09/22 at 12:06 PM, Surveyor #2 attempted to meet with Resident [redacted] and was instead greeted by his/her family member (FM) who stated that transport was at the facility to take the resident to the [redacted] center ([redacted]) and further stated that he/she did the resident's peritoneal (type of [redacted] which used the [redacted] treatments and the resident went to the center primarily for lab draws three times per week.

A review of the Admission Record revealed that Resident [redacted] was readmitted to the facility in [redacted] with diagnosis which included but were not limited to: [redacted] and [redacted].

Review of the admission MDS dated [redacted], revealed that Resident [redacted] had a BIMS Score of [redacted] which indicated that the resident was [redacted]. Further review of the MDS specified that the resident required extensive assistance of two persons for bed mobility and transfers.

On 02/11/22 at 12:14 PM, Surveyor #2 entered Resident [redacted]'s room and saw that there were

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F 880	Continued From page 26 multiple boxes of [redacted] supplies stored both directly on the resident's floor and three boxes were opened with their contents exposed and were placed on top of a thin, dark-colored piece of wood. There were seven boxes, stacked on top of one another stored directly on the floor and the top box was opened and contained supplies. There was another pile stacked on the floor that was two boxes high and had a plastic wash basin stored on top which contained additional sealed [redacted] supplies. The resident was asleep and unable to be interviewed at that time. The resident's FM, who was present, stated that he/she waited for a shipment of [redacted] supplies to be delivered to the facility and brought the supplies that were stored on the floor from home. The resident's FM further stated that he/she did not know who placed the piece of wood on the floor that held some of the opened boxes. During an interview with Surveyor #2 on 02/11/22 at 1:10 PM, the RN/IP stated that Resident [redacted] was hospitalized prior with peritonitis ([redacted], typically caused by [redacted] infection. She stated that the resident's [redacted] supplies were stored in the resident's private room and must be stored four inches from the floor on stacked pallets. She stated that it was an infection control issue if the boxes were stored directly on the floor. At 1:16 PM, Surveyor #2 and the RN/IP went to Resident [redacted]'s room and saw that there were boxes of [redacted] supplies stored directly on the floor, and some of the boxes were opened and laid on top of a thin piece of wood that was less than four inches thick. The RN/IP stated that the boxes should not have been stored directly on the floor and that was not	F 880		

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protocol due to a risk of contamination. She stated that she did not know what the thin, slab of wood was that was placed beneath some of the opened boxes. She stated that staff should have used pallets and the boxes were required to remain at least four inches off the floor for infection control purposes. She stated that there was no way that staff would not have seen that many boxes being delivered when they were going in and out of the room and should have noticed that the boxes were laid directly on the floor.

During an interview with Surveyor #2 on 02/14/22 at 11:22 AM, Resident [redacted]'s FM stated that last friday, their FM brought in boxes of [redacted] from home and used both a wheelchair and cart that were supplied by the front desk to bring them into the resident's room. She further stated that the wooden board was placed there previously and was supplied by the facility. The surveyor noted that the boxes were all now elevated off the floor on plastic pallets.

During an interview with Surveyor #2 on 02/14/22 at 11:33 AM, Licensed Practical Nurse/Charge Nurse (LPN/CN) ,who was assigned to Resident [redacted], stated that the resident's boxes of [redacted] supplies were required to be stored off the floor for infection control purposes and to keep them from getting wet. She stated that she did not recall what the boxes were stored on to ensure that they remained elevated off the floor.

During an interview with Surveyor #2 on 02/15/22 at 11:03 AM, the RN/IP stated that on friday, she notified Maintenance who then placed Resident [redacted] supplies on pallets as required. She stated that she was unsure of how the boxes were placed on the floor or where the

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thin piece of wood came from that was utilized to hold some of the boxes previously and stated that it was too thin.

During an interview with Surveyor #2 on 02/15/22 at 11:13 AM, the Director of Maintenance (DOM) stated that when [redacted] supplies were delivered to the facility, maintenance was responsible to transport them to the room on a dolly. He stated that the "problem" was that lately they delivered pallets of supplies and there was limited storage. He stated that when they stacked them, they had to be off the floor. He stated that they typically used a shelving base and in "dire conditions", a milk crate was used. He stated that the piece of wood appeared to have come off the side of a cabinet and was too thin to be utilized to hold the boxes and thought that maybe a porter placed it there after hours. He stated that it was an infection control issue if the boxes of peritoneal dialysis supplies were stored on the floor because of the risk of germs, disease and opened boxes may have served as a nest for varmints. He stated that all boxes in the facility were required to be elevated off the floor by four inches and stated that he was unable to provide the surveyor with a policy that detailed this specification.

During a later interview with Surveyor #2 on 02/15/22 at 12:08 PM, the RN/IP stated that she was unable to provide the surveyor with a policy though she knew that all boxes had to be either four or six inches off the floor for infection control purposes even though the inside of the box was sterile, and supplies were enclosed in plastic.

During an interview with Surveyor #2 on 02/16/22 at 11:43 AM, the LNHA stated that when a [redacted] delivery arrived at the loading

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docks, the shipment would be delivered to the resident's room and Maintenance would be notified to ensure that the supplies were elevated off the resident's floor. She stated that if the delivery occurred at night, and the supplies were left on the floor then "we need to raise it with what materials we have." She stated that if staff found the boxes on the floor, then they needed to get the boxes off the floor in the interim.

During an interview with Surveyor #2 on 02/17/22 at 11:15 AM, the RN/IP stated that she never reviewed a policy that specified how many inches of [redacted] supplies needed to be stored off the floor. The Director of Nursing (DON) who was present during the interview stated that she just knew that [redacted] supplies were required to be raised off the floor but "corporate" was not able to provide a policy that detailed a requirement.

Review of the facility policy titled, "Handwashing/Hand Hygiene" (Reviewed 02/28/2020) revealed the following:

This facility considers hand hygiene to be the primary means to prevent the spread of infections. Use an alcohol-based hand rub containing at least 62% alcohol; or alternatively, soap...and water for the following situations: Before and after coming on duty, before and after direct contact with residents, before preparing or handling medications, Before and after handling an invasive device, After contact with a resident's intact skin, after contact with objects (e.g., medical equipment) in the immediate vicinity of the resident, after removing gloves, Before and after entering isolation precaution settings. Hand hygiene is the final step after removing and disposing of personal protective equipment. The

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F 880	Continued From page 30 use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing health-care associated infections. Review of the facility policy titled, " Obtaining a Fingerstick [redacted]" Level III (Revised October 2011) revealed the following: Clean and disinfect reusable equipment between uses according to the manufacturer's instructions and current infection control standards of practice. Remove gloves and discard into designated container. Wash hands.... Review of the facility policy title, "Administering Medications" (Edited 05/21/19) revealed the following: Staff follows established facility infection control procedures (e.g., handwashing..., gloves, isolation precautions, etc.) for the administration of medications, as applicable. NJAC 8:39-19.4	F 880		

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S 000	Initial Comments THE FACILITY WAS NOT IN COMPLIANCE WITH THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE, CHAPTER 8:39, STANDARDS FOR LICENSURE OF LONG TERM CARE FACILITIES. THE FACILITY MUST SUBMIT A PLAN OF CORRECTION, INCLUDING A COMPLETION DATE, FOR EACH DEFICIENCY AND ENSURE THAT THE PLAN IS IMPLEMENTED. FAILURE TO CORRECT DEFICIENCIES MAY RESULT IN ENFORCEMENT ACTION IN ACCORDANCE WITH THE PROVISIONS OF THE NEW JERSEY ADMINISTRATIVE CODE, TITLE 8, CHAPTER 43E, ENFORCEMENT OF LICENSURE REGULATIONS.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff-to-shift ratios as mandated by the state of New Jersey for 11 of 14 day shifts and 1 of 14 evening shifts reviewed. This deficient practice was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 1/28/21, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey	S 560	How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. The leadership team has met on ongoing basis and continues to identify staffing challenges and areas of improvement for certified nursing assistant staffing needs. How the facility will identify other residents having the potential to be affected by the same deficient practice. Residents have the potential to be	3/18/22

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

Electronically Signed | 03/11/22

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S 560	Continued From page 1 Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 2/01/21: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. The surveyor requested staffing for weeks of 1/23/22 and 1/30/22. Review of the New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report revealed the facility was deficient in CNA staffing for residents on 11 of 14 day shifts and deficient in CNAs to total staff on 1 of 14 evening shifts as follows: 01/23/22 had 12 CNAs for 120 residents on the day shift, required 15 CNAs. 01/24/22 had 14 CNAs for 116 residents on the day shift, required 15 CNAs. 01/25/22 had 14 CNAs for 115 residents on the day shift, required 15 CNAs. 01/26/22 had 12 CNAs for 114 residents on the day shift, required 15 CNAs. 01/27/22 had 13 CNAs for 111 residents on the day shift, required 14 CNAs.	S 560	affected. What measures will be put into place or systemic changes will be made to ensure that the deficient practice will not recur. The center has implemented significant above market rate for nurses and certified nursing assistants. Incentives include tuition reimbursement, sign-on bonus program, employee referral program, and additional training if not certified. The center continues to conduct ongoing job fairs with immediate interviews, as well as walk-in applicants and has the ability to expedite contingency offers at the time of interview. Careone Evesham sponsored a job fair at a Restaurant on 10/19/21, and conducted on the spot interviews and hires. A text blast was sent out to all CNA's and nurses in the area. CareOne Evesham sponsored a car wash on 5/18/22 at a local business and conducted on the spot interviews. A text blast was sent out to all CNA's and nurses in the area. CareOne Evesham attended a job fair on 5/19/22. CareOne Evesham uses ICIMS (Internet Collaborative Information Management Systems) which is a human resources and recruiting software company. CareOne Evesham also uses Indeed to post job openings and for recruitment.	

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S 560	Continued From page 2 01/28/22 had 11 CNAs for 108 residents on the day shift, required 14 CNAs. 01/29/22 had 9 CNAs for 108 residents on the day shift, required 14 CNAs. 01/30/22 had 9 CNAs for 106 residents on the day shift, required 14 CNAs. 02/02/22 had 12 CNAs for 100 residents on the day shift, required 13 CNAs. 02/03/22 had 12 CNAs for 100 residents on the day shift, required 13 CNAs. 02/05/22 had 12 CNAs for 106 residents on the day shift, required 14 CNAs. 02/05/22 had 9 CNAs to 19 total staff on the evening shift, required 10 CNAs. During an interview with the surveyor on 2/14/22 at 10:40 AM, the staffing coordinator stated she was aware of the staffing ratio but it has been difficult to meet the ratios with the pandemic. During an interview with the surveyor on 02/16/22 at 10:08 AM, Director of Nursing stated that she was aware of the ratios, but call outs had made staffing a challenge.	S 560	The center continues to supplement with agency until staff is hired and has secured multiple contracts to assist with filling open shifts. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what QA program will be put into place to monitor the continued effectiveness of the systemic change. The Director of Nursing or designee will monitor the certified nursing aide. staffing ratios daily and document a weekly review of the daily staffing x 4 weeks then twice monthly for two months to monitor. The audits will be presented to the Administrator. The DON/Designee will present the results of the audits to the Quality Assurance Performance Improvement Committee for review on a monthly basis for three months. The Committee will review and revise the plan if needed.	