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FOUNTAINS AT CEDAR PARKE, THE	**114 HAYES MILL ROAD ATCO, NJ 08004**

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A 000	Initial Comments Initial Comments: Census: 87 A COVID-19 Focused Infection Control Survey was conducted by the State Agency on 2/26/21. The facility was found not to be in compliance with the New Jersey Administrative Code 8:36 infection control regulations standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19.	A 000		
A 310	8:36-3.4(a)(1) Administration (a) The administrator or designee shall be responsible for, but not limited to, the following: 1. Ensuring the development, implementation, and enforcement of all policies and procedures, including resident rights; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents on 2/25/21 and	A 310		

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

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2/26/21, it was determined that the Administrator failed to develop and implement a policy to ensure 1. new admissions and readmissions were placed on transmission-based precautions for observation for the appropriate length of time to observe for signs and symptoms of COVID-19, and failed to ensure 2. non-essential personnel were prohibited from entering the facility during an outbreak in accordance with Executive Directive No. 20-0261 , updated 1/6/21 and the New Jersey Department of Health (NJDOH) Guidelines dated 10/22/20. The facility was currently in an outbreak which began 9/22/20, and continued through the survey, with the facility experiencing a total of 14 COVID-19 related resident deaths, (1) in December 2020 and (13) in February 2021. This deficient practice was evidenced by the following:

Reference:

Executive Directive No. 20-0261 "Directive for the Resumption of Services in all Long-Term Care Facilities licensed pursuant to N.J.A.C. 8:43, N.J.A.C. 8:39, N.J.A.C. 8:36 and N.J.A.C. 8:37 revised date 1/6/21, Section IV. Required standards for services during each phase. 1. Phase 0 "iii. Entry of non-essential personnel is prohibited. Those providing elective consultations, personnel providing non-essential services (e.g., barber, hairstylist), and volunteers, are prohibited from entering the building.

Reference:

"Considerations for Cohorting COVID-19 Patients in Post-Acute Care Facilities (October 22, 2020):

d) Cohort 4 - New or Re-admissions:
This cohort consists of all persons from the

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community or other healthcare facilities who are newly or readmitted. This cohort serves as an observation area where persons remain for 14 days to monitor for symptoms that may be compatible with COVID-19. Testing at the end of this period could be considered to increase certainty that the person is not infected. COVID-19 positive persons who have not met the discontinuation of Transmission-Based Precautions should be placed in Cohort 1- COVID-19 Positive...."

"Regardless of cohort, all HCP [Healthcare Personnel] should adhere to Standard Precautions and any necessary Transmission-Based Precautions according to clinical presentation and diagnosis, when caring for any patients/residents. 1 Full Transmission-Based Precautions and all recommended COVID-19 PPE should be used for all patients/residents who are:

COVID-19 positive
Suspected of having COVID-19
New and re-admissions
Exposed to any COVID-19 positive person (e.g., HCP, visitor, roommate)
On a wing/unit (or facility wide), regardless of presence of symptoms, when transmission is suspected or identified2"

1. On 2/25/21 at 9:00 a.m. during the Entrance Conference, the Administrator (Adm) stated that the facility was in Phase 0 of a COVID-19 Outbreak. She stated that there were no residents at the facility that were considered Persons Under Investigation (PUI) to be monitored for signs and symptoms of COVID-19 after admission, readmission or who were symptomatic. She further stated that there were

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A 310	Continued From page 3 no active cases of COVID-19 at the facility. The Adm stated that residents that were admitted to the facility directly from home were maintained in quarantine on transmission-based precautions, (protective measures used to help stop the spread of germs that may be transmitted by touching the resident or items in the room, and/or may also be spread by coughing and sneezing), for seven days. She stated that new admissions, readmissions and residents that leave the facility to attend doctor's appointments were placed in quarantine on transmission-based precautions for 14-days, and are tested for COVID-19 weekly for 14 days before they are removed from quarantine. The Adm stated that staff were required to wear full Personal Protective Equipment (PPE), protective clothing, goggles, or other equipment designed to protect the wearer's body from infection, to enter the resident's room which included: a gown, gloves, goggles and an N95 (filtering facepiece respirator that filters at least 95% of airborne particles). The Adm stated that the rationale for seven day quarantine for new admissions that were admitted to the facility directly from home was that the residents were tested for COVID-19 prior to admission and upon admission and were required to have two negative tests within 72 hours. She further stated that residents would be sent out if they test positive. The Adm stated that she did not obtain guidance for this process from the Infection Preventionist the facility was contracted with or from the Local Health Department and that the facility did not have a policy to do so. The Adm stated that residents who were on	A 310		

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A 310	Continued From page 4 quarantine and transmission-based precautions had signage outside of their door to caution staff of the required PPE required to enter the room, which included, a gown, gloves, goggles and an N95. The Adm stated that all required PPE was stored in bins outside of the resident's door. At 10:22 a.m., during the tour of the facility, the surveyors observed that resident doors were maintained shut, to the extent possible, and there was no signage on the doors or PPE bins outside of resident rooms which indicated that any residents were maintained on quarantine with transmission-based precautions. At 11:00 a.m., the surveyor interviewed the Director of Nursing (DON) who stated that there were no new admissions/readmissions that he was aware of as the facility just opened to new admissions the week before. At 11:21 a.m., the surveyor interviewed a Certified Nursing Assistant (CNA) who stated that there were no new admissions or readmissions on her assignment. She further stated that when she performed direct care for a resident on quarantine, she wore an N95 mask, with a surgical mask over it, gloves, goggles and a gown. At 1:45 p.m., the surveyor interviewed the Adm who stated that she misspoke when she previously reported that there were no new admissions or readmissions at the facility. She stated that Resident Executive Order 26, 4.b. to the facility on Executive Order 26. from a Executive Order 26, 4.b. and was on Executive Order 26, 4.b. She stated that the resident was expected to remain in his/her room for Executive Order 26 and that the resident was tested for Executive Order 26, 4.b. and received a	A 310		

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rapid test upon admission at the facility.

The Adm stated that the resident would be tested again the following week at the facility using PCR Executive Order 26, 4.b.) testing. She further stated that all staff knew that the resident was on quarantine and were required to wear full PPE even though there was no signage on the resident's door or a bin with PPE located outside of the resident's room to alert staff that the resident was on transmission based precautions and quarantine for 14 days, as previously described by the Adm. The Adm stated that she wasn't sure why the signage and PPE wasn't present outside of the resident's door and stated that it must have been missed.

2. On 2/25/21 at 10:36 a.m., during a tour of the facility, the surveyor observed a sign posted on the wall outside of Resident Executive s room which revealed that the resident had a standing appointment with the hairdresser every Monday at 9:00 a.m. The surveyor interviewed the Licensed Practical Nurse (LPN) who stated that the hairdresser was opened on the Executive Order 26, 4.b. of the Independent Living, (a different type of facility that was located within the same building), and Assisted Living residents, who had appointments, were escorted to their appointments by facility staff. She further stated that all residents, who came out of their rooms for any reason, were required to wear a mask.

At 11:00 a.m., The surveyor interviewed the Director of Nursing (DON) who stated that the beauty salon reopened less than a month ago and was located on the Executive Order 26, 4.b. of the building on the Independent Living Unit within the same building. He stated that everyone who went to the hairdresser wore masks.

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A 310	Continued From page 6 The surveyor questioned why the hairdresser was reopened during Phase 0 of an active COVID-19 outbreak, the DON stated that he had no control over that. He stated that it was the resident's right to go to the hairdresser and that the hairdresser only worked at the facility and saw Assisted Living Residents on certain days. The DON stated that the CNAs were responsible to take the resident's to their appointments and they used the elevator to access the beauty parlor. At 12:36 p.m., during surveyor interview, the Adm stated that residents that went to the hairdresser were not required to isolate or be placed on quarantine when they returned from their hair appointments. The Adm also stated that the contracted Infection Preventionist was not aware that the facility resumed hair care services with the hairdresser. She further stated that the facility did not have a policy in place for residents who required hair care services during a COVID-19 Outbreak. On 3/2/21 at 1:36 p.m., during a post-survey phone interview, the Adm stated that the Local Health Department was unaware that the hairdresser reopened to residents of the Assisted Living Facility. She further stated that the decision to re-open the beauty parlor was based on the rationale that she thought that since the facility had not experienced a positive case of COVID-19 for two weeks, it was permissible to re-open. She further stated that she knew that she should have waited until the facility had not experienced a positive case of COVID-19 for 28 days and the outbreak was concluded. The Adm also stated that the facility remained at Phase 0 of an active outbreak.	A 310		

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A 310	Continued From page 7 According to the Executive Directive No. 20-0261, non-essential personnel were not permitted into the facility during Phase 0 of an active COVID-19 Outbreak. A Removal Plan was requested and received via e-mail on 2/26/21 at 10:30 a.m. The surveyors confirmed that the facility fully implemented the Removal Plan on 2/26/21, as required.	A 310		
A1271	8:36-18.1(a) Infection Prevention and Control Services (a) The facility shall develop and implement an infection prevention and control program. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of pertinent facility documents on [Executive Order 26] and [Executive Order 26], it was determined that the facility failed to follow appropriate infection control practices to prevent the spread of COVID-19 in accordance with Centers for Disease Control (CDC) guidelines. The facility failed to ensure 1. staff wore N95 masks without an exhalation valve for source control (used to reduce the likelihood of transmission of infection by preventing the spread of respiratory secretions), and failed to ensure 2. staff stored and limited reuse of N95 and KN95 masks appropriately, and failed to ensure 3. staff wore face masks appropriately over their mouth and nose, wore more than one mask in the appropriate order and were	A1271		

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A1271	Continued From page 8 appropriately socially distanced when not wearing masks, and failed to ensure 4. food items and items used to provide resident care were stored in a safe and sanitary manner. The facility was currently in an outbreak which began [Executive Order 26] and continued through the survey, with the facility experiencing a total of [Executive] COVID-19 related resident deaths, [Execut] in [Executive Order 26, 4.b.] and [Executive] in [Executive Order 26, 4.b.]. This deficient practice was evidenced by the following: Reference: CDC guideline titled, "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic", updated 2/23/21, which documented the following: "Implement Universal Source Control Measures" "Source control refers to use of well-fitting cloth masks, facemasks, or respirators to cover a person's mouth and nose to prevent spread of respiratory secretions when they are breathing, talking, sneezing, or coughing. In addition to providing source control, these devices also offer varying levels of protection for the wearer against exposure to infectious droplets and particles produced by infected people. Ensuring a proper fit is important to optimize both the source control and protection offered. Because of the potential for asymptomatic and pre-symptomatic transmission, source control measures are recommended for everyone in a healthcare facility, even if they do not have symptoms of COVID-19... HCP [Healthcare Personnel] should wear well-fitting source control at all times while they are in the healthcare facility, including in breakrooms or other spaces where they might encounter co-workers... For HCP, the potential for exposure to SARS-CoV-2 is not limited to	A1271		

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A1271	Continued From page 9 direct patient care interactions. Transmission can also occur through unprotected exposures to asymptomatic or pre-symptomatic co-workers in breakrooms or co-workers or visitors in other common areas...." Reference: CDC guideline titled, "Personal Protective Equipment: Questions and Answers", updated Aug. 8, 2020, included the following: "Respirators with exhalation valves protect the wearer from SARS-CoV-2, the virus that causes COVID-19, but may not prevent the virus spreading from the wearer to others (that is, they may not be effective for source control). Until data are available to describe how effective respirators with exhalation valves are in preventing the spread of SARS-CoV-2 from the wearer to others: Wear a respirator without an exhalation valve when both source control and respiratory protection are required. If only a respirator with an exhalation valve is available and source control is needed, cover the exhalation valve with a surgical mask, procedure mask, or a cloth face covering that does not interfere with the respirator fit." Reference: CDC guideline titled, "Clinical Questions about COVID-19: Questions and Answers" updated Feb. 22, 2021, that documented the following: Under "Using two masks at the same time ...to improve the fit of facemasks in healthcare settings: CDC has recommended several ways to improve the fit and filtration of masks...However, layering masks requires special care in healthcare settings ...Wearing a medical facemask or cloth mask under an N95 respirator is never recommended as it will interfere with the seal. In healthcare settings, medical facemasks	A1271		

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A1271	Continued From page 10 are used by healthcare personnel for two general purposes. First, as PPE to protect a healthcare worker's nose and mouth from exposure to splashes, sprays, splatter, and respiratory secretions, such as when treating patients on Droplet Precautions...Second, for source control to cover a healthcare worker's nose and mouth to prevent spread of respiratory secretions from the healthcare worker to other people. When used for source control, medical facemasks...may be used for the duration of a shift unless they become soiled, damaged, or hard to breathe through..." Reference: CDC guidelines titled, "Summary for Healthcare Facilities: Strategies for Optimizing the Supply of N95 Respirators during Shortages", updated 2/18/21, included the following: Under, "Contingency Capacity Strategies (during expected shortages)", "Extend the use of N95 respirators by wearing the same N95 for repeated close contact encounters with several different patients without removing the respirator..." Under, "Crisis Strategies (during known shortages)," "When N95 Supplies are Running Low...Implement limited re-use of N95 respirators and limit to no more than five uses (i.e., five donnings) per device by the same HCP, unless otherwise specified by the manufacturer..." Reference: CDC guideline titled, "Implementing Filtering Facepiece Respirator (FFR) Reuse, Including Reuse after Decontamination, When There Are Known Shortages of N95 Respirators", updated Oct. 19, 2020, that revealed the following: Under, "Limitations for Limited FFR reuse. Decrease in N95 FFR fit and filtration performance..." "CDC recommends limiting the	A1271		

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A1271	Continued From page 11 number of donnings for an N95 FFR to no more than five per device. It may be possible to don some models of FFRs more than five times [2]. One study reported that fit performance decreased over multiple, consecutive donnings and fit varied among the different models of FFRs examined [3]. If manufacturer guidance on how many times a particular FFR can be donned is not available, the CDC recommends limiting the number of uses to no more than five per device based on published data on changes in FFR fit from a limited number of FFR models over multiple donnings...A limited reuse strategy to reduce the risk of self-contamination. One strategy to reduce the risk of contact transfer of pathogens from the FFR to the wearer during FFR reuse is to issue five N95 FFRs to each healthcare staff member who care for patients with suspected or confirmed COVID-19. The healthcare staff member can wear one N95 FFR each day and store it in a breathable paper bag at the end of each shift with a minimum of five days between each N95 FFR use, rotating the use each day between N95 FFRs. This will provide some time for pathogens on it to "die off" during storage [8]. This strategy requires a minimum of five N95 FFRs per staff member, provided that healthcare personnel don, doff, and store them properly each day. As a caution, healthcare personnel should treat reused FFRs as though they are contaminated, while preventing FFR contamination prior to donning by following the precautions outlined in the reuse recommendations found here...If supplies are even more constrained, and five respirators are not available for each worker who needs them, N95 FFR limited reuse with FFR decontamination may be necessary...When to stop using crisis capacity strategies and return to normal operations. As soon as new supplies can meet	A1271		

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the projected demand, all reuse and decontamination of respirators should be discontinued. FFRs should only be reused when operating at crisis capacity due to the inability of FFR supplies to meet the burn rate."

1. On 2/25/21 at 9:50 a.m., during the entrance conference, the Surveyor #1 observed that the Director of Nursing (DON) was wearing an N95 mask with an exhalation valve. The DON did not wear an additional mask to cover the exhalation valve.

At 10:24 a.m., the surveyor observed a large plastic bin that contained labeled plastic bags that had either a N95 mask or KN95 mask in each plastic bag. Each plastic bag that had either a N95 mask or KN95 mask had a staff members name written in black marker on the plastic bag. The masks were not stored in a breathable paper bags.

At 10:27 a.m., the Administrator (Adm) took the surveyor to the storage room where the facility kept their stockpile of personal protective equipment (PPE). The surveyor asked the Adm what phase the facility was in. The Adm stated that the facility was in phase 0 and that they were still in an outbreak of COVID-19. The Adm showed the surveyor a large box which contained multiple boxes of N95 masks that did not have an exhalation valve and a large box that contained multiple boxes of N95 masks with an exhalation valve. The surveyor asked the Adm how it was decided which N95 mask the staff wore. The Adm stated that she gives out the N95 mask with the valve to staff because it's usually easier to breath in. The Adm then stated that the N95 masks or KN95 masks were kept in a plastic bag for the staff to reuse. She then stated that the

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FOUNTAINS AT CEDAR PARKE, THE	**114 HAYES MILL ROAD ATCO, NJ 08004**

(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) COMPLETE DATE
A1271	Continued From page 13 N95 masks or KN95 masks were changed weekly when the facility was in quarantine. She further stated that when the facility was not in quarantine, the N95 mask or KN95 masks were changed monthly, and the surgical masks were changed every four days. 2. At 10:43 a.m., the surveyor observed a Certified Medication Aide (CMA) wearing a surgical mask and then a KN95 mask over the surgical mask. At 10:50 a.m., the surveyor observed a Certified Nursing Assistant (CNA) #1 wearing two surgical masks and a KN95 mask over the surgical masks. During surveyor interview, CNA#1 could not give the surveyor a reason why she wore the masks the way she did. 3. At 12:12 p.m., the surveyor observed two housekeeping staff, Housekeeper (HK), HK #1 and HK #2 as they sat across from each other at a small table as they ate lunch in the staff break room. HK #1 and HK #2 were not socially distanced at least six feet apart while they ate lunch. During surveyor interview, HK #1 stated that she usually goes outside of the facility to eat lunch. HK #2 stated that she and HK #1 worked on the same unit and that the facility never said anything about keeping six feet apart in the breakroom. The surveyor then requested the Regional Director of Facilities (RDF) to measure the table where HK #1 and HK #2 were seated. The RDF measured the table and stated that the measurement was 30 inches (2 feet and 6 inches). At 12:48 p.m., during surveyor interview, the DON stated that the N95 masks and KN95 masks were changed weekly.	A1271		

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A1271	Continued From page 14 At 12:49 p.m., during surveyor interview, the Adm stated that she was not sure what guidance she used for the storing of the N95 mask or KN95 masks in plastic bags. At 12:52 p.m., during continued surveyor interview, the Adm and the DON stated that they were not aware that the N95 masks with an exhalation valve was not good for source control. At 1:03 p.m., during surveyor interview, the Adm stated that the staff were supposed to remain six feet apart. At 1:05 p.m., during surveyor interview, the Adm stated that there would not be a proper seal if staff were wearing a surgical mask under the N95 or KN95 mask. Review of the facility provided document titled, "Infection Prevention Consultant Assessment" dated November 20, 2020 included the following: Under "COVID-19 Focused Survey for Long-term Care. Recommendations/Rationale: Place signage on the door of the staff break room limiting the number of people in the room at one time based on 6-foot social distancing..." Under "Conclusion. Recommendations include but are not limited to full enforcement of source control masking, proper use of PPE, social distancing..." 4. On 2/25/21 at 11:13 a.m., Surveyor #2 observed that the Assisted Living Coordinator/Certified Nursing Assistant (ALC/CNA) wore a cloth mask with the ear loops unsecured and they protruded from the sides of a KN95 Mask and caused the mask to bulge slightly away from her face. When interviewed, the ALC/CNA stated that she was permitted to	A1271		

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A1271	Continued From page 15 wear the cloth mask beneath the KN95 mask as the KN95 mask caused her face to break out so it served as a barrier for her skin. She stated that she always wore her mask like that unless she was required to care for a resident who had COVID-19. She further stated that if she cared for a resident with COVID-19, she wore an N95 mask, as required, without a cloth mask beneath it. At 11:39 a.m., Surveyor #2 observed that a CNA #2 wore a surgical mask beneath a KN95 mask. When interviewed, CNA #2 stated that she always wore her mask like that and was not instructed to wear it any other way. At 1:01 p.m., the surveyor interviewed the Adm who stated that she permitted the ALC/CNA to wear a cloth mask beneath her KN95 mask as the KN95 irritated her skin. The Adm stated that she was not aware that the CNA #2 wore a surgical mask beneath her KN95 mask. She further stated that if the CNA #2 wore a surgical mask beneath the KN95 mask it would not provide a proper seal to prevent the possible spread of infection. The Director of Nursing, who was present during the interview, stated that double masking was not implemented at the facility. 5. On 2/25/21 at 12:05 a.m., Surveyor #2 entered the laundry room and observed that the Laundry Supervisor (LS) and Laundry Attendant (LA) wore their masks beneath their chins as they stood within very close proximity of one another and folded laundry. When interviewed the LS stated that they did not leave the laundry area with their masks beneath their chins. She further stated that their masks did not cover their mouths and noses as it got too hot in the room to wear them	A1271		

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properly and added that she was fully vaccinated. The LA confirmed that she had not been vaccinated. The LS stated that they had received training related to social distancing and knew that they were supposed to wear their masks at all times and remain at least six feet apart.

6. On 2/25/21 at 12:08 p.m., the surveyors entered the staff lounge and observed two staff members seated across from one another eating lunch. When interviewed, HK #3 stated that she realized that they probably were not seated six feet apart as required. HK #4 stated that she was tested for COVID-19 weekly. She further stated that she knew that they were required to maintain six feet of distance from one another while they ate in the break room.

At 12:10 p.m., the Regional Director of Facilities (RDF) measured the square table where the Housekeepers sat in the break room and he stated that the staff were seated five feet part instead of six feet to maintain social distancing as required.

7. On 2/25/21 Surveyor #2 requested to utilize the restroom and was directed by the Adm to the staff restroom, which was located directly across from the Administrative Office. The surveyor entered the restroom and observed a three-tiered shelf that, within a walk-in shower, within the restroom. There were multiple boxes of resident care items stored directly on the floor in front of the shelving unit. The top shelf, on the front of the storage unit, had labels which identified where, "Big Towels" and "Bath Mats" were stored.

On the second shelf from the top, there were labels posted on the front of the storage unit that identified where, "Wash Cloths", "Full Fitted, Full

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A1271	Continued From page 17 Flat Set" and "Pillow Cases." The surveyor observed that there were multiple sheet sets stored on the shelf, four packages of individually wrapped cups of single-serve apple sauce, boxed gloves and individual boxes of tissues. There were multiple boxes stored on the floor in front of the shelving, which contained disposable drinking cups, bowls, and sealed packages of adult briefs. At 1:01 p.m., the surveyor interviewed the Adm who stated that she was not aware that there was apple sauce, linens and supplies intended for resident use stored in the restroom. She stated that they had no where else to put them and that the items would have to be removed and discarded for sanitary reasons. The Assistant Director of Nursing, who was present, stated that she had not seen the apple sauce in the restroom before. A Removal Plan was requested and received via e-mail on 2/26/21 at 10:30 a.m. The surveyors confirmed that the facility fully implemented the Removal Plan on 2/26/21, as required.	A1271		
A1297	8:36-18.3(a)(4) Infection Prevention and Control Services (a) Written policies and procedures shall be established and implemented regarding infection prevention and control, including, but not limited to, policies and procedures for the following: 4. Surveillance techniques to minimize sources and transmission of infection;	A1297		

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A1297	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of pertinent facility documents on 2/25/21 and 2/26/21, it was determined that the facility, in Phase 0 of reopening, failed to, 1. appropriately screen residents and failed to, 2. perform a risk assessment of COVID-19 positive staff in order to determine any potential exposures, infection control breaches, and to ensure the prevention of continued spread of COVID-19 in accordance with the requirements in the New Jersey Department of Health (NJDOH) Executive Directive No. 20-026[1] and the NJDOH Guidelines. The facility was currently in an outbreak which began 9/22/20, and continued through the survey, with the facility experiencing a total of 14 COVID-19 related resident deaths, (1) in December 2020 and (13) in February 2021. This deficient practice was evidenced by the following: Reference: NJDOH Executive Directive No. 20-026[1], updated 1/6/21, included the following: Under "Phases per this Directive: Phase 0: Any facility with an active outbreak of COVID-19, as defined by the Communicable Disease Service (CDS)..." Under "II. Required Core Practices for Infection Prevention and Control...5. A facility with a COVID-19 outbreak will remain in Phase 0 (maximum restrictions) until their outbreak of COVID-19 has concluded...iv. Outbreaks are considered concluded when there are no symptomatic/asymptomatic probable or confirmed COVID-19 cases among employees or residents after 28 days (two incubation periods) have passed since the last case's onset date or	A1297		

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specimen collection date (whichever is later) ...The determination of an outbreak's conclusion will be made by either NJDOH or local health officers, pursuant to N.J.A.C. 8:57-1.10..."

Under "section IV. Required standards for services during each phase. 1. Phase 0... iv. Facilities shall screen all residents, at minimum during every shift, with questions and observations for signs or symptoms of COVID-19 and by monitoring vital signs. Vital signs recorded shall include heart rate, blood pressure, temperature and pulse oximetry."

Reference: NJDOH guideline titled, "Testing in Response to a Newly Identified COVID-19 Case in Long-Term Care Facilities" dated 1/26/21, documented under "Identification of a COVID-19 case in LTCFs...Regardless of attribution of the case, all facilities should take the following steps when a new case of COVID-19 (e.g., residents, Health Care Providers (HCP), essential caregivers) is identified in their facility:

Perform a risk assessment to determine any potential exposures and/or infection control breaches at the facility.

Determine any possible exposures the new case of COVID-19 (e.g., resident, HCP, essential caregiver) may have had prior to diagnosis including contact with other known COVID-19 positive persons or those who later developed symptoms consistent with COVID-19.

Alert the local health department to the newly identified case.

Identify close contacts including 48 hours prior to symptom onset/date of specimen collection of

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A1297	Continued From page 20 associated case, if applicable. Close contact is identified as being within approximately 6 feet of a COVID-19 case for a prolonged period of time, a cumulative of 15 minutes or more over a 24-hour period starting from 2 days before illness onset (or, for asymptomatic residents, 2 days prior to test specimen collection) until the time the resident is isolated; or Having direct contact with infectious secretions from an individual with COVID-19... (e.g., being coughed or sneezed on). Quarantine all close contacts for 14 days from last exposure and provide care using all COVID-19 recommended personal protective equipment (PPE). Upon identification of a new COVID-19 case in HCP, and in addition to the steps outlined above the facility should: ...Conduct a risk assessment and perform contact tracing (an effective disease control strategy that involves identification of cases and their close contacts to interrupt disease transmission) to determine if the HCP may have exposed any residents or other HCP. Facilities should take into account the role of the HCP, level of resident contact, use of appropriate PPE, and use of sources control (e.g., facemask/face covering) when in the health care facility." 1. On 2/25/21 at approximately 9:10 a.m., during the entrance conference, the Administrator (Adm) stated that the facility was currently in an outbreak that began with a COVID-19 positive case on 9/22/20. She further stated that the facility was in Phase 0 since that date.	A1297		

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At 11:47 a.m., during surveyor interview, the Certified Medication Aide (CMA) stated that the residents in the REM unit (memory care unit) were being screened by taking their vital signs once a day and the vital signs included blood pressure (BP), temperature, heart rate (HR), respirations, pulse oximetry (measurement of oxygen level in the blood) and any signs or symptoms of COVID-19. The CMA then stated that the Nurse or CMA that worked the day shift would take the vital signs and write them on a form for that day and it was kept in a binder. She further stated that the Nurse or CMA that worked the evening shift would enter the vital signs, that were on the form in the binder, into the computer program the facility used for the residents' medical record.

At 12:30 p.m., the surveyor reviewed the daily log sheets for the month of February, provided by the CMA, and observed that each log sheet contained the names of the residents that resided on the REM unit. There was one log sheet for each day of the month. The log sheets contained all the residents name and their individual readings for "temp, BP, pulse, resp., 02%, pain Y/N, and symptoms Y/N". Each log sheet was preprinted with "REM DEPT" and "DAY SHIFT". The log sheets revealed that the residents on the REM unit were being screened by taking their vital signs and observing for signs and symptoms of COVID-19 one time a day on the day shift. There was no documented evidence that the facility screened the residents as required every shift (three times a day).

At 12:17 p.m., during surveyor interview, the Director of Nursing (DON) stated that the residents in the facility were being screened or had their vital signs taken one time a day.

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A1297	Continued From page 22 At 12:55 p.m., during surveyor interview, the Adm stated that the facility stopped taking vital signs every shift on 2/16/21 because they received 2 weeks of negative COVID-19 tests. The surveyor then asked the Adm if the facility was still in an outbreak period. The Adm stated that the facility was still in an outbreak period and that the facility should still be taking vital signs every shift because they haven't had 28 days since their last positive COVID-19 test result. The facility did not provide documented evidence that screening of residents was being done every shift at any time during the month of February. Review of the facility provided document titled, "Infection Prevention Consultant Assessment" dated November 20, 2020 included the following: Under "COVID-19 Focused Survey for Long-term Care; Recommendations/Rationale: Encouraged increasing frequency of vital signs within assisted living units." The surveyor reviewed the undated, facility provided policy titled, "Outbreak Response Plan," which included the following: "7. Policies to Conduct Routine Monitoring of Residents and Staff ...Residents will be assessed every shift (or as per current DOH requirements) for signs and symptoms of disease." The surveyor then reviewed the facility provided policy titled, "Resident Screening Policy," with a created date of 3/1/20, which included the following: "Residents are screened every day for Covid. A. VS [Vital Signs] B. S/Sx [Signs/Symptoms] of Covid."	A1297		

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A1297	Continued From page 23 2. On 2/26/21, during continued interview with the Adm, she stated that the last resident tested positive on 2/8/21 and the last staff member tested positive on 2/17/21 and remained out of work. She stated that she did not conduct an assessment, perform contact tracing, and did not attempt to identify close contacts that staff members may have had with both staff and residents through documented interview, in an attempt to determine the cause of the exposures and in an effort to decrease the chances of further exposure and spread of the virus. The Adm stated that she did not perform an assessment or conduct contact tracing for HCP who tested positive for COVID-19, as she was informed by an outside source that that she was not required to do so. The Adm stated that residents who tested positive for COVID-19, and that were symptomatic, were transferred to the hospital and residents who tested positive, and were asymptomatic, were transferred to a long-term care facility that had a COVID-19 unit for quarantine. She stated that staff who tested positive were immediately removed from the schedule and were out for 10 days, if asymptomatic, and they required physician clearance for them to return to work. The Adm stated that she was unsure how facility staff contracted COVID-19 as all staff were required to wear Personal Protective Equipment (PPE), (protective clothing, goggles or garments to protect the wearer's body from injury or infection), which included an N95 mask, (a filtering face-piece respirator that filters at least 95% of airborne particles), a KN95, or surgical masks and gloves to deliver resident care. The Adm maintained that none of the residents	A1297		

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A1297	Continued From page 24 went out of the building to attend appointments on a regular basis and they were required to wear a surgical mask if an appointment was scheduled. A Removal Plan was requested and received via e-mail on 2/26/21 at 10:30 a.m. The surveyors confirmed that the facility fully implemented the Removal Plan on 2/26/21 as required.	A1297		
A1299	8:36-18.3(a)(5) Infection Prevention and Control Services (a) Written policies and procedures shall be established and implemented regarding infection prevention and control, including, but not limited to, policies and procedures for the following: 5. Techniques to be used during each resident contact, including handwashing before and after caring for a resident; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation on 2/25/21 and 2/26/21, it was determined that the facility staff failed to consistently perform appropriate hand hygiene to prevent the spread of COVID-19 in accordance with Centers for Disease Control (CDC) guidelines and facility policy. The facility was currently in an outbreak which began 9/22/20, and continued through the survey, with the facility experiencing a total of 14 COVID-19 related resident deaths, (1) in December 2020	A1299		

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and (13) in February 2021. This deficient practice was evidenced by the following:

Reference: U.S. CDC guidelines titled, "Hand Hygiene Recommendations" "Guidance for Healthcare Providers for Hand Hygiene and COVID-19", updated 5/17/20, indicated the following:

"Hands should be washed with soap and water for at least 20 seconds when visibly soiled, before eating, and after using the restroom." Additionally, according to, "The CDC Guideline for Hand Hygiene in Healthcare Settings" "When cleaning your hands with soap and water, wet your hands first with water, apply the amount of product recommended by the manufacturer to your hands, and rub your hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. Rinse your hands with water and use disposable towels to dry. Use a towel to turn off the faucet. Avoid using hot water, to prevent drying of the skin. Other entities have recommended that cleaning your hands with soap and water should take around 20 seconds. Either time is acceptable. The focus should be on cleaning your hands at the right times."

1. On 2/25/21 at 10:34 a.m., the surveyor interviewed a Licensed Practical Nurse (LPN) who had already begun to wash her hands in the sink for an undetermined amount of time prior to the observation. The surveyor observed that the LPN, as she obtained a paper towel, dried her hands, and used the paper towel to turn off the faucet, she used the same paper towel to dry her hands off a second time before she discarded it.

When interviewed, the LPN stated that it was her

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(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) COMPLETE DATE
A1299	Continued From page 26	A1299		

practice to use the same paper towel that she dried her hands off with to turn off the faucet before she discarded it. She stated that she did not realize that she used the paper towel that she turned the faucet off a second time before she discarded it. She stated that if she utilized the same paper towel to dry her hand, turn off the faucet and dried her hands a second time, there was a possibility of contamination. The LPN further stated that she should wash her hands again to prevent the spread of infection. The surveyor observed the LPN as she exited the restroom and returned to her duties without washing her hands.

When interviewed the LPN stated that she should have rewashed her hands and forgot as she rushed to resume her duties.

At 10:57 a.m., the surveyor interviewed the Director of Nursing (DON) who stated that if staff utilized the same paper towel to dry their hands, turn off the faucet and dried their hands on the same paper towel a second time that there was a potential for contamination.

2. On 2/25/21 at 11:00 a.m., the surveyor observed a Certified Medication Aide (CMA) perform handwashing (HW). The CMA turned on the water and placed soap from the dispenser in her hands. She lathered her hands with the soap outside the flow of water for 8 seconds. The CMA then rinsed her hands inside the flow of water for 2 seconds. During surveyor interview, the CMA stated that the process for HW was 20 seconds. She further stated that she always counts every time she washes her hand.

At 1:02 p.m., during surveyor interview, the ED stated that the facility policy for HW was 20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15a007	A. BUILDING: ______ B. WING ______	C 02/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUNTAINS AT CEDAR PARKE, THE	**114 HAYES MILL ROAD ATCO, NJ 08004**

(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) COMPLETE DATE
A1299	Continued From page 27 seconds. The surveyor reviewed the undated facility provided policy titled, "Handwashing/Hand Hygiene", which indicated the following: Under "Procedure...Washing Hands 1. Vigorously lather hands with soap and rub them together, creating friction to all surfaces, for a minimum of 20 seconds (or longer) under a moderate stream of running water, at a comfortable temperature... 2. Rinse hands thoroughly under running water. Hold hands lower than wrists. Do not touch fingertips to inside of sink. 3. Dry hands thoroughly with paper towels and then turn off faucets with a clean, dry paper towel. 4. Discard towels into trash..." 3. On 2/25/21 at 11:53 a.m., the surveyor observed a Dietary Aide (DA) as she washed her hands for seven seconds. The DA attempted to remove a paper towel that protruded from the dispenser unsuccessfully. At 11:55 a.m., the surveyor observed the DA as she washed her hands a second time for five seconds under running water, dried her hands and donned gloves before she resumed plating food to be served to the residents. At 11:59 a.m., the surveyor observed the DA as she removed her gloves, touched the lid to the trash can and washed her hands for 14 seconds. The DA dried her hands and donned gloves before she resumed plating food to be served to the residents. At 12:25 p.m., in a later interview with the DA she stated that she knew that she washed her hands	A1299		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15a007	A. BUILDING: ______ B. WING ______	C 02/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUNTAINS AT CEDAR PARKE, THE	**114 HAYES MILL ROAD ATCO, NJ 08004**

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A1299	Continued From page 28 for less than 20 seconds, as required, when she was observed by the surveyor previously. She stated that she normally washed her hands under running water. She further stated that she may have transferred bacteria onto her hands when she touched the trash can lid and failed to wash her hands for 20 seconds before she donned gloves and plated food. On 2/26/21 at 9:11 a.m., the surveyor interviewed the Director of Dining Services (DDS) who stated that the DA should have removed her gloves, washed her hands out of the stream of running water for 20 seconds, rinsed, dried her hands, discarded paper towel, obtained a second paper towel to turn off the faucet and discarded it after in order to prevent the spread of infection. A Removal Plan was requested and received via e-mail on 2/26/21 at 10:30 a.m. The surveyors confirmed that the facility fully implemented the Removal Plan on 2/26/21 as required.	A1299		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT
15a007 Y1	Y2	5/6/2021 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUNTAINS AT CEDAR PARKE, THE	114 HAYES MILL ROAD ATCO, NJ 08004

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (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 A0310 Reg. # 8:36-3.4(a)(1) LSC	Correction Completed 03/15/2021	ID Prefix A1271 Reg. # 8:36-18.1(a) LSC	Correction Completed 03/15/2021	ID Prefix A1297 Reg. # 8:36-18.3(a)(4) LSC	Correction Completed 03/15/2021
ID Prefix A1299 Reg. # 8:36-18.3(a)(5) LSC	Correction Completed 03/10/2021	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
2/26/2021	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

 EVENT ID: SBN912

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15a007	A. BUILDING: ______ B. WING ______	C 02/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOUNTAINS AT CEDAR PARKE, THE	114 HAYES MILL ROAD ATCO, NJ 08004

(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) COMPLETE DATE
A 000	Initial Comments Initial Comments: Census: 87 A COVID-19 Focused Infection Control Survey was conducted by the State Agency on 2/26/21. The facility was found not to be in compliance with the New Jersey Administrative Code 8:36 infection control regulations standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19.	A 000		
A 310	8:36-3.4(a)(1) Administration (a) The administrator or designee shall be responsible for, but not limited to, the following: 1. Ensuring the development, implementation, and enforcement of all policies and procedures, including resident rights; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documents on 2/25/21 and	A 310		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] CALA
TITLE
(X6) DATE 3/18/21

The Fountains at Cedar Parke

114 Hayes Mill Rd Atco NJ 08004

856-809-7267

3/18/21

ID Prefix Tag A310

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

   #1 Develop policy for Admissions and Readmissions.

   #2 Develop policy for non-emergency personnel during an outbreak.

   #3 Develop a policy for transmission based precautions, and personal protective equipment for new and readmissions.

   #4 Resident #7 was placed in quarantine with proper transmission based precautions and personal protective equipment.

   #5 Resident#6, signage for beauty salon appointments removed from the door.

   #6 Develop policy for residents who require outside appointments during an outbreak.

   #7 Collaborate with the local health department for guidance.

2. How will the facility identify other residents having the potential to be affected by the same practice?

   All residents are vulnerable and were potentially affected by this deficiency. Upon review we did not find any other residents directly affected by this deficiency.

3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not reoccur?

The Fountains at Cedar Parke

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#1 Policy for new and readmissions during a pandemic was developed by the Director of Nursing. All new and readmissions are placed on a 14 day quarantine. Transmission based precautions and proper personal protective equipment is used.

#2 Policy for non essential personnel was developed by the Director of Nursing. Non essential personnel are not permitted during an outbreak. The beauty salon was closed to assisted living residents. All residents and family members were made aware.

#3 Policy for transmission based precautions and personal protective equipment was developed by the Director of Nursing, Proper transmission based signage will be posted on the entry door of the individual. This will include; stop sign on droplet precaution and contact precaution signage. Personal protective equipment will be placed in a bin outside the entry door. This bin will include; gloves, gown, goggles/face shield and N95 as well as surgical mask.

#4 Resident #7 was placed in quarantine with proper signage posted on the door for transmission based precautions. Isolation cart with proper personal protective equipment was placed outside the entry door. The administrator will ensure residents are placed quarantine with proper transmission based precautions and personal protective equipment.

#5 Active salon appointment signage was removed from Resident #6 doors. All residents and family members were made aware of non essential personnel being prohibited from Assisted Living during an outbreak by the Administrator. The administrator will ensure that all non essential personnel are prohibited from the Assisted Living residents.

#6 Policy was developed for residents who require outside appointments during an outbreak by the Director of Nursing. Residents will be placed on quarantine for 14 days and monitored every shift for signs and symptoms. Residents will continue to be tested while in quarantine. All residents will be provided with a surgical mask to wear to their appointments.

The Fountains at Cedar Parke

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#7 The Administrator will collaborate with the local health department for guidance during an outbreak.

4. How will the facility monitor its corrective actionings to ensure that the deficient practice is being corrected and will not reoccur?

   #1 and #4 The administrator will ensure that the policy is being upheld. New admits and readmits will be reviewed weekly during the level of care meeting. The policy will be reviewed quarterly and updated yearly unless new guidance requires updating the policy.

   #2 and #5 The administrator will ensure the policy is being upheld. The policy on non essential personnel will be reviewed quarterly and updated yearly unless new guidance requires updating the policy.

   #3 The administrator will ensure the policy and procedures are upheld. Personal protective equipment and transmission based precautions will be reviewed quarterly. The policy will be updated yearly unless new guidance requires updating the policy.

   #6 The administrator will ensure the policy and procedures for residents going out of the building for appointments are upheld. The policy will be updated yearly unless new guidance requires updating the policy.

   #7 The administrator will ask the local health department or the department of health for guidance during an outbreak. Questions and concerns will be discussed weekly at the level of care team meeting.

Completion Date

3/15/21

The Fountains at Cedar Parke

114 Hayes Mill Rd Atco NJ 08004

856-809-7267

ID Prefix Tag A1271

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

   #1 Develop infection and prevention control programs.

   #2 N95s with exhalation valves were removed.

   #3 N95s were stored properly.

   #4 Staff were inservice on proper mask wearing.

   #5 Staff were inservice on social distancing.

   # 6 All items were removed from the walk in shower in the bathroom.

2. How will the facility identify other residents having the potential to be affected by the same practice?

   All residents are vulnerable and were potentially affected by this deficiency. Upon review we did not find any other residents directly affected by this deficiency.

3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not reoccur?

   #1 Policy was developed for infection control and prevention by the Director of Nursing and the Administrator. This includes all elements of infection control and services as a guide for all staff.

   #2 All N95s with exhalation valves were removed from the personal protective equipment room by the administrator.

   #3 All N95s were placed into paper bags with employees' names. N95s will be changed out every 5 days to conserve equipment unless readily available. Surgical masks are available at the beginning of each shift and as needed.

#4 All nursing, laundry, and dietary staff were inserviced on proper mask wearing. There will be no further violations of mask wearing without disciplinary action.

#5 All nursing,dietary and laundry staff were inserviced on social distancing.

#6 Applesauce was discarded from the walk in shower. All linens were washed and moved to a storage area for linen only. All resident care products have been moved to the proper storage area for resident products.

4. How will the facility monitor its corrective actionings to ensure that the deficient practice is being corrected and will not reoccur?

   #1 The infection control policy will be reviewed quarterly and updated yearly unless new guidance requires updating the policy. The administrator will ensure the policy and procedures are upheld.

   #2 Personal protective equipment will be monitored when delivered to make sure no improper personal protective equipment is in use or circulation. The infection control personnel will monitor this monthly or when items arrive. The administrator will ensure only approved personal protective equipment is in use.

   #3 All N95s in plastic bags were discarded. Paper bags are used to store N95s. Ideally N95s would be discarded daily. During conservation of personal protective equipment ,N95s will be replaced weekly. Staff were inserviced by the Director of Nursing to cover the N95 with a surgical mask when entering an isolation room and to remove the surgical mask when exiting to conserve N95s. The administrator will ensure the N95s are stored properly weekly.

   #4 All nursing staff were inserviced by the Director of Nursing on proper mask wearing. No surgical mask under N95s. No cloth mask. No double masking. The administrator will ensure inservices are upheld and spot checks performed.

   #5 The Director of Nursing inservice nursing, dietary and laundry staff on social distancing. Staff are to wear their mask properly and distance six feet from each other in work areas. Spot checks will be performed by the Director of Nursing. The administrator will ensure inservicing is upheld.

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#6 Storage cabinet for linens was obtained. Storage for resident personal items was established in an appropriate area. Applesauce was replaced with new. The shelving unit was removed from the shower.

Completion date 3/15/21

ID Prefix Tag A1297

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

   #1 Develop policy and procedure for surveillance techniques.

   #2 Develop policy for resident monitoring during an outbreak.

   #3 Develop policy for persons under investigation.

2. How will the facility identify other residents having the potential to be affected by the same practice?

   All residents are vulnerable and were potentially affected by this deficiency. Upon review we did not find any other residents directly affected by this deficiency.

3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not reoccur?

   #1 Policy for surveillance was developed by the Director of nursing. Contact tracing for all staff and residents will be performed. Risk assessment will be done to identify any breaches of infection or exposure. Will identify anyone within 48 hours of close contact from a positive test collection date. All at risk residents will be placed on quarantine for 14 days. All at risk staff will be quarantined for 14 days.

   #2 Policy for resident monitoring during an outbreak was established by the Director of Nursing. During an outbreak residents are monitored/screened every shift for signs symptoms of Covid. Including vital signs.

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#3 Policy for persons under investigation was established by the Director of Nursing. Any resident who has been exposed to Covidand/or showing signs or symptoms will be placed on quarantine.

4. How will the facility monitor its corrective actionings to ensure that the deficient practice is being corrected and will not reoccur?

   #1 The administrator will ensure the policy and procedures for Surveillance are upheld. The policy will be reviewed quarterly and updated yearly unless new guidance requires updating the policy.

   #2 The administrator will ensure that the policy for resident monitoring is upheld. Spot checks are done by the Director of Nursing.

   #3 The Director of nursing will perform spot checks on residents under investigation for quarantine status based on the quarantine list placed in a binder on each unit. The administrator will ensure the policy is upheld.

Completion Date

3/15/21

ID Prefix Tag A1299

1. How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?

   #1 Develop a policy for techniques to be used with resident contact.

   #2 Inservice all staff on handwashing.

   #3 Update and correct handwashing Policy.

The Fountains at Cedar Parke

114 Hayes Mill Rd Atco NJ 08004

856-809-7267

2. How will the facility identify other residents having the potential to be affected by the same practice?

   All residents are vulnerable and were potentially affected by this deficiency. Upon review we did not find any other residents directly affected by this deficiency.

3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not reoccur?

   #1 Policy was developed for techniques for contact with a resident by the Director of Nursing. Inservices were done with all direct care staff on infection control in regards to handwashing. Focusing on the need to wash hands before and after care.

   #2 The director of nursing in-serviced all staff including nursing, caregivers, dietary and laundry on handwashing. Clocks were placed by all sinks for staff to use for adequate timing and signage.

   #3. The handwashing policy was updated with proper technique while hand washing. To include wetting hands first, apply soap, rub together vigorously for 20 seconds covering all surfaces, rinse with water and dry with a disposable towel. Then use another towel to turn off the water.

4. How will the facility monitor its corrective actionings to ensure that the deficient practice is being corrected and will not reoccur?

   #1 Spot checks will be performed by the Director of Nursing. The policy on resident contact techniques are updated yearly unless new guidance requires updating the policy. The administrator will ensure the policy is being upheld.

   #2 The director of nursing will do handwashing inservices quarterly and with any new employees upon hire. The Administrator will ensure in-services are being done.

   #3 The handwashing policy will be reviewed quarterly and updated yearly unless new guidance requires updating the policy. The new policy was distributed to all departments by the administrator.

The Fountains at Cedar Parke

114 Hayes Mill Rd Atco NJ 08004

856-809-7267

Completion Date

3/10/21