STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	55a003	A. BUILDING: _____ B. WING _____	11/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWS AT HOLMDEL, THE	713 N BEERS STREET HOLMDEL, NJ 07733

(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: 68 A COVID-19 Focused Infection Control Survey was conducted by the State Agency on 11/14/2020. 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. 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 provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations.	A 000		
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	A1299		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	55a003	A. BUILDING: _____ B. WING _____	11/14/2020

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A1299	Continued From page 1 by: Based on observation, interview, and facility policy review, the facility failed to ensure one (Resident #1) of six residents on transmission-based precautions was served a meal on disposable dishware with disposable utensils. Resident #1 Executive Order 26, 4.b. [redacted] The facility identified [redacted] residents that were Executive Order 26, 4.b. [redacted] This deficient practice occurred during the COVID-19 pandemic. Findings included: 1. Resident #1 Executive Order 26, 4.b. [redacted] The resident was on Executive Order 26, 4.b. [redacted] with Executive Order 26, 4.b. [redacted]. An observation of Resident #1 on 11/14/2020 at 11:55 AM, revealed Resident Assistant #1 assisting the resident with the meal. The tray, plates, cup, and utensils were reusable. During an interview on 11/14/2020 at 12:45 PM, the Wellness Director/Infection Preventionist (WD/IP) stated residents were considered a PUI for COVID-19 if the resident had been out of facility. The WD/IP confirmed residents were a PUI until 14 days without signs and symptoms of COVID-19. The WD/IP was unaware that a PUI resident was getting reusable dishware. During an interview on 11/14/2020 at 3:20 PM, the WD/IP confirmed the meal ware for the PUI resident should be discarded and not returned to the kitchen.	A1299		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	55a003	A. BUILDING: _____ B. WING _____	11/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWS AT HOLMDEL, THE	713 N BEERS STREET HOLMDEL, NJ 07733

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A1299	Continued From page 2 Review of the facility policy titled, "Managing Outbreaks," last revised 03/2020, directed, "Procedure: 8. Institute control measures, 6. Use disposable meal trays."	A1299		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
55a003 Y1	A. Building B. Wing Y2	12/30/2020 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOWS AT HOLMDEL, THE	713 N BEERS STREET HOLMDEL, NJ 07733

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 A1299 Reg. # 8:36-18.3(a)(5) LSC	Correction Completed 11/21/2020	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 11/14/2020	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			