STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315492	A. BUILDING _____ B. WING _____	10/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOONTON CARE CENTER	**199 POWERVILLE ROAD BOONTON, NJ 07005**

(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: 10/29/2020 Census: 48 Sample: 15 A COVID-19 Focused Infection Control Survey was conducted by the New Jersey Department of Health. The facility was found to be not in compliance with 42 CFR §483.80 infection control regulations as it relates to the implementation of the CMS and Centers for Disease Control and Prevention (CDC) recommended practices for COVID-19.	F 000		
F 880 SS=F	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	F 880		11/11/20

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

Electronically Signed | 11/12/2020

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F 880	Continued From page 1 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, 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	F 880		

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F 880	Continued From page 2 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: Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure: a.) the identification of [redacted] residents who were exposed to COVID-19 by a positive Certified Nursing Aide, determine their exposure risk, and placing them on transmission-based precautions to prevent the spread of the virus, b.) nursing aides performed hand hygiene at the appropriate intervals and before and after donning/doffing personal protective equipment (PPE), c.) the designated PPE carts were used for the appropriate cohort zones to prevent cross contamination, d.) housekeeping equipment and supplies were designated to the positive COVID-19 unit, e.) a housekeeper replaced a mop head and water after cleaning a COVID-19 positive room, f.) staff wore the appropriate eye protection upon entering the rooms of persons under investigation for COVID-19, g.) a high temperature dish machine log was monitored for maintaining safe temperatures to preventing the spread of COVID-19, h.) nursing staff monitored a resident for changes in vital signs for two months prior to the resident testing positive for COVID-19 and i.) the facility outbreak plan was comprehensive to address elements for a COVID-19 outbreak. This deficient practice was identified during the COVID-19 Focus Infection Control survey conducted on 10/28/2020 and [redacted], affecting [redacted] nursing units [redacted] Unit and [redacted] Unit) and [redacted]	F 880	ELEMENT #1- Corrective action taken for affected resident Infection Prevention and Control Program a. Residents identified that had direct exposure with the COVID-19 Certified Nurse Aide were immediately relocated to the Yellow Zone□ per Transmission Based Protocols for observation. b. Temporary Nursing Aide was identified. Reeducation was provided to this Temporary Nurse Aide on Infection Control practices and proper Hand Hygiene with return demonstration. All necessary PPE such as gowns, gloves, masks and eye protection was available on all isolation carts. Facility staff immediately sanitized the identified contaminated yellow zone isolation cart. c. Temporary Nurse Aide was identified. In servicing was given on proper usage of PPE carts within the appropriate cohort zones to prevent cross contamination. d. Housekeeper was identified. In servicing was given on proper utilization of only Cohort Zone designated housekeeping equipment to avoid cross contamination between Red, Yellow, and Green Zones. One housekeeping cart was designated for the red zone and one for the yellow zone. Housekeeping Supervisor provided in servicing to the	

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F 880	Continued From page 3 residents reviewed (Resident [redacted]) for infection prevention and control. The evidence was as follows: According to the U.S. Centers for Disease Control and Prevention (CDC) guidelines, Responding to Coronavirus (COVID-19) in Nursing Homes updated 4/30/20 included, "Create a plan for managing new admissions and readmissions whose COVID-19 status is unknown...All recommended COVID-19 PPE [personal protective equipment] should be worn during care of residents under observation, which includes use of an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e. goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown. Testing residents upon admission could identify those who are infected but otherwise without symptoms and might help direct placement... However, a single negative test upon admission does not mean that the resident was not exposed or will not become infected in the future." 1. On [redacted] at [redacted], the surveyor interviewed the Assistant Administrator (AA) and the Chief Operating Officer (COO) in the presence of the survey team. The AA stated that the facility had [redacted] residents test [redacted] Executive Order 26, 4.b. and two staff members had tested Executive Order 26, 4.b. during weekly testing on [redacted]. The AA stated that 1 of the [redacted] staff members that tested [redacted] worked in the dietary department and had no resident contact, and the [redacted] staff member was a [redacted] who had a unit	F 880	specific housekeeper that performed this deficient practice. e. Housekeeper was identified. In servicing was given on proper infection control and cleaning practices within designated Cohort Zones to avoid cross contamination. f. Temporary Nurse Aide was identified. In servicing was given on proper use of eye protection upon entering resident rooms of persons under investigation of COVID-19 (yellow zone) and/or Positive of COVID-19 (Red zone). g. Food Service Director and Staff was identified. In servicing was given on policies and procedures outlining required temperature thresholds for a high temperature dishwasher machine(s) along with the policy in the event the temperatures are not within the required threshold. h. (I) Nursing staff was reeducated on proper monitoring and documentation of Vital Signs in medical record for persons under investigation and/or Covid-19 Positive residents. (II) COVID-19 Outbreak Plan has been reviewed and revised to include screening of staff, vendors, or visitors during a COVID-19 outbreak. Policy now includes instruction for routine monitoring of residents and staff to quickly identify signs of a communicable disease that could develop into an outbreak. ELEMENT #2- Identification of resident with the potential to be affected in the same manner and corrective actions	

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F 880	Continued From page 4 assignment and had no signs or symptoms of COVID-19. The AA provided the surveyor the facility's Resident and Staff Outbreak Line list for COVID-19. The AA stated Resident [redacted] and was subsequently moved to the [redacted] at the end of the [redacted]. The AA added that Resident [redacted] had a roommate (Residen [redacted] who was also placed in a private room on a separate unit on transmission-based precautions due to [redacted]. The AA added that there were an additional [redacted]) residents who were [redacted] and were on observation for persons under investigation (PUI) [redacted] (Resident [redacted] and Resident [redacted]). The AA confirmed there were a total of [redacted] residents identified as PUI at the facility and [redacted] resident who tested [redacted]. She acknowledged that the remaining [redacted] residents were [redacted] observation for COVID-19 or on transmission-based precautions. At [redacted], the COO and the Director of Nursing (DON) described the three cohort zones to the survey team. The COO stated the Red Zone was at the end of the U-shaped hallway of the [redacted] Unit and was designated as [redacted] The DON confirmed there was one resident in the Red Zone (Resident [redacted]). The DON stated that the Yellow Zone was designated for residents who had [redacted] but were PUI due to exposure to the virus or [redacted] in the last [redacted] days. The DON confirmed there were [redacted] residents currently in the Yellow Zone (Resident [redacted] and [redacted] and placed on transmission-based	F 880	a. All residents had the potential to be affected by this deficient practice. ELEMENT #3- Systemic changes made to prevent recurrence a. DON reviewed and updated the policies regarding Standard Precautions, Transmission-Based Precautions, COVID-19, Hand Hygiene, and Personal Protective Equipment. b. The Infection Control Preventionist provided additional support and guidance to frontline staff as well as maximize compliance to policies and procedures, i.e. in service. c. Housekeeping Services Director provided additional support and guidance to frontline housekeeping staff outlining changing of mop bucket solution and mop head upon cleaning each individual Covid-19 positive room (Red Zone). In addition housekeeping staff was reeducated on changing mop bucket solution and head every 100sq feet of corridor within the Covid-19 (red Zone). The mop head will be double bagged and appropriately transported to laundry department. d. Food Services Director provided additional support and guidance to frontline dietary staff outlining documentation of wash and rinse cycle temperatures on the high temperature dish machine. Re-servicing was provided to dietary staff on proper procedure in the event temperatures are not within the regulatory threshold. e. Direct Care and Non-Direct Care staff will be in-serviced on the policy and	

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F 880	Continued From page 5 precautions (strategy to prevent the transmission of COVID-19 in which staff wear an N-95 respirator mask, eye protection, a gown and gloves). The DON stated that the remainder of the [redacted] residents were in the Green Zone which meant that they were non-ill and non-exposed to COVID-19. The DON stated that there have been no deaths from COVID-19 for the current outbreak that began on [redacted]. The DON continued that [redacted] has been in contact the Local Health Department (LHD) regarding the outbreak in which [redacted] sends the line list of both residents and staff everyday and are in communication sometimes twice a day. At [redacted] the DON stated that the [redacted] worked the [redacted] and [redacted]. The DON stated that the [redacted] had no signs or symptoms of the virus and therefore had worked up until the results were posted on the morning of [redacted] The DON stated that the [redacted] had an assignment of residents that were in the Green Zone (non-ill, non-exposed to COVID-19), but because those residents had tested negative for COVID-19 on their last round of testing and none of them had signs or symptoms of COVID-19, then the residents were allowed to stay in their location in the Green Zone without adding transmission-based precautions. The surveyor asked for the list of resident names that the facility was tracking that had exposure to the [redacted] who had [redacted] days ago on [redacted]. The DON acknowledged [redacted] did not know the number or residents or their names on interview and that [redacted] would have to get back to to the surveyor on that. [redacted] also acknowledged that the residents	F 880	procedures comprising the Infection Prevention and Control Program. f. In servicing will concentrate on adherence to the policies and procedures and the application to daily infection control practices. g. Copy of the in service and attendance will be kept for reference & validation. ELEMENT #4- Quality Assurance Monitoring a. Direct Care and Non-Direct Care will be tested on competency of Hand Hygiene and PPE Donning/Doffing with return demonstration. b. (I) Observations of Hand Hygiene, PPE Donning/Doffing and Proper Transition between zones by direct care staff will be conducted by either Director of Nursing, Certified Infection Preventionist or designee weekly for one month, bi-weekly for one month and random checks for 1 month. (II) Observations of infection control practices, cleaning, disinfecting and disposal of soiled equipment used by direct care staff within each zone will be conducted by Director of Housekeeping weekly for one month, bi-weekly for one month and random checks for 1 month. (III) Observations of infection control practices, including monitoring of temperature log for high temp dish machine used by direct care staff will be conducted by Director of Food Services weekly for one month, bi-weekly for one month and random checks for 1 month. c. Negative findings will have corrective	

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F 880	Continued From page 6 were not marked on the Resident Outbreak Line List for COVID-19 as being exposed to the [redacted] who [redacted] At [redacted], the surveyor asked the DON how [redacted] determined which residents were placed in the Yellow Zone as PUI residents, and the DON stated that all [redacted] were temporarily placed in the Yellow Zone/PUI unit for 14 days for observation. [redacted] stated that residents that would have signs and symptoms of COVID-19 would also be placed in the Yellow Zone/PUI unit. The DON also added that the [redacted] of a [redacted] who [redacted] such as Resident [redacted] would be placed in the Yellow Zone/PUI unit for 14 days to ensure they did not develop signs and symptoms of the virus. She stated that all staff universally wear N-95 respirator masks throughout the facility due to the outbreak, and that when entering the room of a resident in the Yellow Zone/PUI unit, the staff would have to don a gown and gloves. The surveyor asked about eye protection and the DON stated that the eye protection was "by choice" of the staff. She stated "Some wear [eye protection], some do not." She added that if residents were not coughing or producing secretions, than the staff don't have to wear the eye protection. The surveyor continued to ask the DON in the presence of the survey team, the AA and COO, how residents are cohorted if they go to [redacted] or [redacted] treatment services outside of the facility, and the DON stated that they return to their original room, and that there was no need to routinely place a resident that goes to scheduled appointment on TBP even in the midst of a facility outbreak, "because the resident gets isolated at	F 880	actions and reviewed by the DON and/or designee. d. 1. DON has developed an audit tool to measure compliance. 2. Director of Housekeeping has developed an audit tool to measure compliance. 3. Director of Food Services has developed an audit tool to measure compliance. e. Audits will be presented to the Quality Assurance Committee quarterly. f. Compliance will be ongoing and ensured by designated department head.	

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F 880	Continued From page 7 their appointments." The DON stated that there were no residents that went to [redacted] and no residents who went to outside appointments in the last 14 days. The DON acknowledged that individuals can test positive for COVID-19 and have no signs or symptoms of the virus, but could not speak to why residents who were exposed to a [redacted] who had [redacted] were not placed in the Yellow Zone/PUI unit for 14 days for observation for COVID-19. The AA, DON and COO provided the survey team a copy of a floor plan in which they color-coded the Green Zone, Yellow Zone and Red Zone by room numbers. A comparative review of the cohort color-coded floor plan and the census Resident Listing Report with room numbers for [redacted] reflected that currently, there was [redacted] resident in the Red Zone/Positive COVID-19 unit, [redacted] residents in the Yellow Zone/PUI unit, and [redacted] residents in the Green Zone. At [redacted], the AA provided the surveyor a copy of a list of resident names that were on the [redacted] assignment from [redacted] through [redacted]. The surveyor requested that she provide the list of residents that had contact with the [redacted] who ha [redacted] and the AA stated that the DON was still working on that. At approximately [redacted], the AA provided the surveyor a copy of the list of resident names that were on [redacted] assignment from [redacted] ([redacted] had off on [redacted] and [redacted]). The surveyor asked which dates on [redacted] assignment list provided was the	F 880		

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F 880	Continued From page 8 facility was using as residents having had been exposed to [redacted]. The AA stated if the surveyor had any questions, the DON would be able to speak to the assignment list of names. The list was unclear whether the facility was tracking all residents from [redacted] or from any other date on the form. The surveyor reviewed the list of residents assigned to the [redacted] on [redacted] and [redacted] (the date in which [redacted]). The assignment sheet reflected there were [redacted] residents assigned to [redacted] (Resident [redacted] that were currently in the Green Zone/non-ill, non-exposed unit. During tour of the Green Zone/non-ill, non-exposed unit on [redacted] from [redacted], two surveyors observed the rooms of Resident [redacted]. There was no evidence the residents were on transmission-based precautions. At [redacted], the two surveyors interviewed the Licensed Practical Nurse (LPN) who acknowledged that there was a [redacted] who [redacted] but [redacted] could not speak to which residents were on the assignment of [redacted] and or which of them had possibly been [redacted] acknowledged there were no residents placed on TBP as a precaution otherwise [redacted] would have known and they would be placed on transmission-based precautions. [redacted] stated that the residents in the Green Zone get tested weekly for COVID-19 and had tested negative. At [redacted] the surveyor interviewed the DON in	F 880		

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F 880	Continued From page 9 the presence of the survey team who stated that they wouldn't put the residents on TBP unless they became symptomatic of COVID-19, otherwise "the whole side [of the unit] would be on precautions." The surveyor asked why that would be a problem to have a whole side of the unit on precautions, and the DON was unable to speak to why it would be a problem. [redacted] confirmed [redacted] had adequate personal protective equipment (PPE) in stock. On [redacted] at [redacted] the surveyor conducted a phone interview with the Local Health Department/Registered Nurse (LHD/RN) who confirmed the facility had a current COVID-19 outbreak that recently started on [redacted]. The LHD/RN stated that [redacted] had had regular contact with the DON sometimes twice a day and that [redacted] had been in contact with the DON again the evening of [redacted]. [redacted] stated that [redacted] was aware that [redacted] had [redacted] and that the facility identified the residents who were [redacted] and placed them in the Yellow Zone/PUI unit on TBP on the evening of [redacted] On [redacted] at [redacted], the survey team interviewed the Infection Preventionist/Registered Nurse (IP/RN) who stated that [redacted] had just started the role two weeks ago as the IP/RN. [redacted] stated that [redacted] was not involved in the contact tracing process or the communication with the LHD. [redacted] stated that the DON handled the communication with the LHD and that they would have discussed the contact tracing of the [redacted] [redacted] indicated that [redacted] provided COVID-19 education and competencies, COVID testing for residents and staff, immunizations and antibiotic stewardship.	F 880		

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F 880	Continued From page 10 At [redacted] the [redacted] stated that the [redacted] was wearing gloves and an N-95 respirator mask during her shift on [redacted] and [redacted] because the facility had been aware of the [redacted] resident (Resident [redacted]) on [redacted]. A review of the facility's Cohorting [to treat as a group] Policy reviewed 4/29/20 included that the Yellow Zone was for Admissions/Readmissions/PUI. It included that the resident may test negative from the hospital, however exposure was potential from the community therefore the resident would be placed on a 14-day quarantine. The policy did not include what constituted a "PUI" and what cohort zone a resident would go in, in the event they were exposed to COVID-19 by a positive resident or staff member. A review of the facility's COVID-19 policies and plan revised as late as 8/10/2020 did not address procedures for contract tracing and assessing exposure risk. 2. On [redacted] at [redacted], two surveyors observed a [redacted] providing care to [redacted] in the Green Zone. The surveyors observed [redacted] wearing wrist splints under a pair of gloves and an N-95 respirator mask. [redacted] assisted one unsampled resident who was sitting in a wheelchair by the window. [redacted] assisted the resident with repositioning him/her while touching a [redacted]. The surveyor then observed [redacted] immediately go to the roommate using the same gloves and without performing hand hygiene and assisted in	F 880		

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F 880	Continued From page 11 repositioning a pillow behind the roommates back touching the resident, his/her wheelchair and the positioning pillow. [redacted] then went back to resident he/she was initially assisting by the window and while wearing the same gloves and without performing hand hygiene assisted in applying leg rests to the wheelchair and applied heel booties to the resident's feet. [redacted] then removed [redacted] gloves and did not perform hand hygiene and while wearing [redacted] wrist splints and not reapplying new gloves, [redacted] began to adjust the linens on the bed and the pillow case on the bed. At [redacted], the surveyor interviewed [redacted] who stated that the facility does hand hygiene in-services all the time, including competencies. [redacted] stated that hand hygiene was supposed to be done when removing gloves and between care for residents. [redacted] stated that [redacted] uses soap and water and removes [redacted] wrist splints during hand hygiene. [redacted] stated that [redacted] always wears gloves and was supposed to wear a different pair of gloves between resident and resident contact. [redacted] could not speak to the breaches in infection prevention that occurred when assisting the [redacted] at [redacted] this morning. A review of a hand hygiene competency dated [redacted] reflected that [redacted] had met and passed the critical elements of hand washing including, "Verbalizing when handwashing should be completed." A review of the facility's Transmission Based Precautions policy reviewed 3/2020 included that "Handwashing is the single most important means of preventing the spread of infectious organisms to residents and others....gloves are	F 880		

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F 880	Continued From page 12 not a substitute for handwashing." A review of the Hand Hygiene policy reviewed 3/2020 included, "Decontaminate hands using an alcohol based hand rub OR wash hands with antimicrobial soap and water in the following clinical situations: Before any direct contact with resident; Before putting on gloves; ...After contact with inanimate objects in the immediate vicinity of the resident; After removing gloves." 3. On [redacted] at [redacted], two surveyors observed a Housekeeper exit the Red Zone/COVID-19 positive area into the Yellow Zone/PUI area with [redacted] housekeeping cart and mop/mop water. As [redacted] exited into the Yellow Zone through a large plastic barrier, the Housekeeper informed the Temporary Nurse Aide (TNA) that [redacted] had just finished cleaning the room of Resident [redacted], adding that [redacted] had cleaned the bathroom, emptied the garbage, and mopped the floor. The Housekeeper informed the TNA that [redacted] could now enter the room of Resident [redacted] if [redacted] needed. At that time upon exiting the Red Zone, the Housekeeper began to mop half-way up the hallway of the Yellow Zone using the same mop water and mop head as [redacted] had used in the Red Zone. At [redacted], the surveyor interviewed the TNA who acknowledged the Housekeeper had just exited the COVID-19 positive resident room and began to mop in the hallway of the Yellow Zone. At [redacted], the surveyor interviewed the Housekeeper who stated that [redacted] had just exited the room of Residen [redacted] in the Red Zone and that	F 880		

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F 880	Continued From page 13 [redacted] had mopped the room. [redacted] stated that uses a disinfecting product that kills COVID-19 diluted in the mop water. [redacted] stated that [redacted] changes the mop water and mop head every three resident rooms that did not have COVID-19 and that it would get changed after cleaning every COVID-19 positive rooms. [redacted] confirmed the Red Zone was designated as COVID-19 positive and that it was the last room to clean for the day. [redacted] further confirmed [redacted] had taken [redacted] housekeeping supplies out of the Red Zone into the Yellow Zone, acknowledging there was no designated housekeeping equipment for the Red Zone. The Housekeeper could not speak to why [redacted] had mopped the Yellow Zone hallway after exiting the Red Zone without changing the mop head or mop water. The Housekeeper showed the surveyor the locked Janitor's Closet which stored the chemicals and was a space for changing out mop water adjacent to the Red Zone. The disinfecting product used in the mop water was on the Environmental Protection Agency (EPA) List N and effective against COVID-19. At [redacted], the two surveyors entered the Red Zone and there was no evidence of designated housekeeping equipment stored within the area. At [redacted], the two surveyors interviewed the Unit Manager/Registered Nurse (UM/RN) who stated that the Red Zone should have designated housekeeping supplies or equipment to prevent cross contamination. The UM/RN could not speak to if there were designated housekeeping supplies or equipment in the Red Zone. On [redacted] at [redacted] the surveyor interviewed the Housekeeping Director who	F 880		

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F 880	Continued From page 14 acknowledged there was no designated housekeeping equipment in the Red Zone until surveyor inquiry. [redacted] acknowledged that even though the mop water had the appropriate disinfectant cleaner effective against COVID-19, the Housekeeper should not have cleaned the Yellow Zone hallway after cleaning the room of a resident who tested positive for COVID-19. [redacted] stated that the Housekeeper had been in-serviced that all mop water and mop heads are changed immediately after finishing cleaning a room of a resident who tested positive for COVID-19. [redacted] stated there was to be one mop head per room and that it gets placed in a clear plastic bag after use and immediately brought to the laundry room after use to be washed. A review of the in-service records dated [redacted] and [redacted] reflected that the Housekeeper attended an in-service for Daily Isolation Room Cleaning and copies of the in-service records were also provided in the [redacted] of the employee. A review of a Cleaning and Disinfecting Audit - COVID-19 Audit dated [redacted] reflected that the Housekeeper had met the criteria including COVID-19 positive resident room: "Housekeeping cart does not enter the resident room...Mop Head is laundered after each use." The competency Audit did not address using designated supplies/equipment to the Red Zone. A review of the facility's COVID-19 Isolation Room Cleaning policy (also used in the Housekeeping in-service training's) revised 5/2020, included that after finishing cleaning a room for a resident that tested positive for COVID-19, "Double bag all mops, sponges and cloths...delivered soiled mops, sponges, cloths to	F 880		

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F 880	Continued From page 15 laundry for laundering." According to the U.S. CDC guidelines, Responding to Coronavirus (COVID-19) in Nursing Homes updated 4/30/20, included "To the extent possible, restrict access of ancillary personnel (e.g., dietary) to the [COVID-19] unit. Assign environmental services [EVS] staff to work only on the unit. If there are not a sufficient number of EVS staff to dedicate to this unit despite efforts to mitigate staffing shortages, restrict their access to the unit. Also, assign HCP [Healthcare Personnel] dedicated to the COVID-19 care unit (e.g., NAs [Nursing Assistants) to perform cleaning and disinfection of high-touch surfaces and shared equipment when in the room for resident care activities. HCP should bring an Environmental Protection Agency (EPA)-registered disinfectant (e.g., wipe) from List N into the room and wipe down high touch surfaces (e.g., light switch, doorknob, bedside table) before leaving the room." 5. On [redacted] at [redacted], the two surveyors entered the Yellow Zone (person under investigation (PUI) area) located on the [redacted] Unit. The two surveyors observed the Temporary Nursing Assistant (TNA) preparing to distribute the lunch trays on a meal cart to the residents on the [redacted] unit. At [redacted], the two surveyors observed an individualized isolation Personal Protective Equipment (PPE) cart outside Residen [redacted] room. (PPE is a barrier used to protect an individual's skin, mouth, nose, or eyes.) The TNA wore an N95 mask and started to apply PPE which included, a blue disposable gown and	F 880		

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F 880	Continued From page 16 gloves in front of the resident's room. The TNA had on [redacted] eyeglasses but did not apply the appropriate eye protection PPE such as goggles or a face shield over [redacted] eyeglasses. The TNA entered the room of Resident [redacted] and placed the disposable lunch tray on the resident's bedside table and adjusted the table in front of the resident. The TNA exited Resident [redacted] room and removed [redacted] gown and gloves and did not perform hand hygiene. At [redacted], the two surveyors observed the TNA continue to push the meal cart down the hall and distribute the lunch meal in the Yellow Zone to the private rooms of Resident [redacted] Outside the rooms of Resident [redacted] were individualized isolation PPE carts. In each room the TNA placed the disposable meal trays on the bedside table and adjusted the resident's bedside tables. The TNA wore [redacted] N95 mask, applied a new disposable gown and gloves between each resident but did not wear appropriate eye protection. Also, the TNA did not perform hand hygiene before donning and after doffing the PPE during the lunch meal pass in the Yellow Zone (PUI area), between all three (3) residents in the Yellow Zone. At [redacted], the two surveyors interviewed the TNA. The TNA stated that in the PUI zone, the staff were only required to wear a single use gown and gloves, in addition to their N95 (which [redacted] stated was discarded at the end of their shift). The TNA further stated the only time the staff were required to wear a face shield and or goggles were when they entered the Red Zone (COVID-19 positive area). At [redacted], the TNA showed the two surveyors	F 880		

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F 880	Continued From page 17 the isolation PPE cart which included blue disposable gowns, gloves, goggles, face shields, surgical masks, N95 masks and disinfectant wipes. At [redacted], the two surveyors observed the TNA then apply new PPE including a disposable gown, gloves and face shield for the Red Zone without performing hand hygiene. The TNA used the individualized PPE cart located outside Resident [redacted] room, which was designated for the use in the Yellow Zone. The TNA then entered through the plastic barrier which separated the Yellow and Red Zones and proceeded through the opened room door of Residen [redacted] While inside the room of Resident [redacted] the TNA placed the lunch tray on the resident's bedside table. The TNA then [redacted] Resident [redacted]s [redacted] Executive Order 26, 4.b. [redacted], elevated the resident's head of the bed using the bed controls, adjusted the resident's bedside table and setup the resident's lunch in front of him/her. The TNA then leaned on the resident's footboard and talked to the resident while continuing to adjust the resident's sheets prior to exiting the room. Located at the door inside the room of Resident [redacted] was a red push lid trash bin. The TNA then removed [redacted] gloves and had to touch the lid of the red push lid trash bin and discarded the gloves. [redacted] then came outside the room, removed her gown and placed it in a red step trash bin located within the plastic barrier of the Red Zone. The TNA then left the Red Zone through the plastic barrier and went back to the individualized isolation PPE cart in front of Resident [redacted] room designate for the Yellow Zone. The TNA did not perform hand hygiene prior to doffing [redacted] PPE and prior to exiting the Red Zone or at the PPE cart in the Yellow Zone.	F 880		

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F 880	Continued From page 18 At [redacted] the two surveyors observed the TNA touch and open three (3) drawers on the individualized PPE cart for Resident [redacted] in the Yellow Zone. [redacted] then reapplied a new set of PPE without performing hand hygiene and returned to the Red Zone through the plastic barrier to assist Resident [redacted] who requested additional help. At [redacted], the two surveyors observed a designated individualized isolation PPE cart in the Red Zone, which the TNA did not use. At [redacted], the two surveyors observed the TNA remove the PPE inside the Red Zone plastic barrier and exit the Red Zone. The TNA then went back to the individualized isolation PPE cart in front of Resident [redacted] room in the Yellow Zone, disinfected [redacted] face shield and then performed hand hygiene with an Alcohol-Based Hand Rub (ABHR). [redacted] did not disinfect the PPE cart in the Yellow Zone. At [redacted], the two surveyors interviewed the UM/RN who confirmed if the TNA touched the PPE cart in the Yellow Zone prior to washing [redacted] hands, it should be disinfected with a disinfectant wipe to prevent cross contamination between the Red Zone and Yellow Zone. The UM/RN stated [redacted] would disinfect the PPE cart right away. A review of the facility's Transmission Based Precautions policy reviewed 3/2020 included to "See CDC Guidelines for Isolation Precautions for more information regarding the CDC's recommendations for isolation precautions." It further included that Respiratory protection is required when entering the room of a resident	F 880		

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with known or suspected respiratory infection." The policy did not address within the airborne precautions or droplet precautions that eye protection (a form of respiratory protection) was "optional" for staff upon entering a PUI resident room.

A review of the facility's Cohorting [to treat as a group] Policy reviewed 4/29/20 included that staff were to wear "Eye Protection (required for aerosol treatments)." This policy with an exception to use eye protection does not correspond with the US CDC guidelines for PPE use for upon entering the room of a PUI.

6. On [redacted] at [redacted], the Assistant Administrator stated that there was [redacted] resident (Resident [redacted]) in the facility who had [redacted]. The surveyor observed this resident on [redacted] at [redacted] in the resident's room, which was located in the Red Zone behind a plastic barrier. At that time, Residen[redacted] was awake, alert responding appropriately to the TNA. The resident was receiving Executive Order 26, 4.b. [redacted]

The surveyor reviewed the electronic medical record (eMR) for Resident [redacted], which revealed the following:

The resident's Face Sheet (an admission summary) included that the resident had Executive Order 26, 4.b. [redacted]

A review of the resident's weekly COVID-19

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F 880	Continued From page 20 laboratory report dated [redacted], revealed a [redacted] from a nasal pharyngeal specimen collected on [redacted]. The Physician's Order Summary Report for the month of [redacted] included the following orders: Oxygen via mask or nasal cannula to maintain SPO2 (oxygen saturation rate) above 90% with an order date of 6/13/2020. Weekly Vitals every evening shift every Wednesday for vitals monitoring with an order date of 2/29/2020 and a start date of 3/4/2020. (Vital signs that were monitored in this facility included resident's temperature, pulse, respiration, blood pressure and SPO2.) The resident's Treatment Administration Record (TAR) and Medication Administration Record (MAR) for the month of [redacted] not include documentation by the staff for the administration of supplemental oxygen. Review of the resident's Weights and Vitals Summary sheets since 7/1/2020 revealed the following: Temperatures were taken three times in July, once in September, and there was no documented evidence a temperature was documented again until [redacted], the day after Residen[redacted] was diagnosed [redacted] The resident's heart rate was monitored twice in July, but there was no further documentation that the resident's heart rate was monitored until [redacted]. Respirations (breaths per minute) were recorded	F 880		

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F 880	Continued From page 21 twice in July and then monitored by staff again beginning on [redacted]. Blood pressure was checked twice in July and not recorded again until [redacted] Oxygen saturation rates were recorded twice in July (on room air) and not recorded again until [redacted]. The Physician's progress note, dated [redacted] at [redacted], included the following information: "Spoke to RN. Routine [redacted]. Was [redacted] No fever, no symptoms...O2 [oxygen saturation rates] 97%. Will be isolated. Watch for symptoms." Once the facility staff resumed recording vital signs for Resident [redacted] on [redacted], they continued to monitor every shift in either the Progress Notes or the Weights and Vitals Summary report, but there was no evidence of routine monitoring for COVID-19 through the means of assessing and documenting the resident's complete set of vital signs since August 2020. A review of the Nurses Progress Note dated [redacted] at [redacted], revealed that the resident's temperature (T) had risen to 99.2 degrees Fahrenheit (F). The resident's SPO2 was 90-92% on room air. "Tylenol given for low grade fever and mild body aches with good effect - T97.4. O2 Sat increased to 94% / 95% on O2 @ 2 l/m [2 liters/minute] via NC [nasal cannula]. Noted with periodic non productive cough. Increased hydration given." The Weights and Vitals Summary for [redacted] revealed that Resident [redacted] had a temperature of 99.1 degree F on [redacted]. The	F 880		

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F 880	Continued From page 22 O2 saturation summary indicated that Resident [redacted] was receiving [redacted] every day since [redacted]. Prior to that date, there was no recorded evidence that Resident [redacted] required [redacted] On [redacted] at [redacted], the Chief Operating Officer (COO) stated that the resident's vital signs were not done for the period between [redacted] and [redacted]. On [redacted] at [redacted], the Director of Nursing (DON) stated that the order for vital signs was placed on [redacted] and it never made it to the MAR clarifying that "If it's not added, it's not done." [redacted] further stated that the nursing staff does monthly recaps if the order is on the physician's order sheet (POS). The DON stated, "The nurses look at the POS and compare it to the MAR, but the order never made it to the MAR during the recapitalization process. According to the New Jersey Department of Health Required Outbreak Response Plan memorandum dated 3/6/2020, specified that the Outbreak Response Plan shall cover ..."protocols for assessing whether facility visitors are ill, protocols to require ill staff to not present at the facility for work duties, and processes for implementing evidenced based outbreak response measures...Policies to conduct routine monitoring of residents and staff to quickly identify signs of a communicable disease that could develop into an outbreak." A review of the Facility Outbreak Plan revised8/10/20 did not address screening of staff, vendors, or visitors during a COVID-19 outbreak and the Plan did not address routine monitoring	F 880		

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F 880	Continued From page 23 of residents and staff to quickly identify signs of a communicable disease that could develop into an outbreak. 7. During the entrance conference on [redacted] at [redacted], the COO stated that the dish machine used by the facility was a high temperature machine. This type of dish machine kills germs and contaminants with hot water temperatures. It can be safely used to sanitize dishes and utensils, etc. for residents with any type of communicable disease. During the entrance conference the DON stated that residents on the Yellow Zone (PUI unit) and Red Zone (COVID-19 positive unit) were provided with disposable meal trays. [redacted] stated that the residents on the Green Zone/non-ill non-exposed unit were given regular meal trays that would be washed after use. At [redacted], the surveyor reviewed the Dish Machine temperature log for the month of [redacted], which was provided by the Assistant Administrator. According to the log, the minimum temperature for the rinse cycle to sanitize food service utensils and other equipment was 180 degrees Fahrenheit (F). The log revealed 21 instances out of 82 opportunities that the rinse cycle temperature was below 180 degrees F. On [redacted] at [redacted] the surveyor observed the operation of the dish machine in the presence of the Food Service Director (FSD). At that time, the rinse cycle was 190 degrees F. The FSD stated that [redacted] had never had a problem with the dish machine in two years. [redacted] also stated that	F 880		

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F 880	Continued From page 24	F 880		

[redacted] had chlorine available to use as a sanitizer if the rinse cycle did not reach the proper temperature.

The surveyor then inquired about all the low temperatures that were recorded on the dish machine log. The FSD was unaware of the unacceptable rinse temperatures documented. [redacted] stated that the one employee who had filled out the form in those instances may not have known how to read the dials on the machine. The employee did not [redacted]. [redacted] stated that the employee had been working in the kitchen for one year. The FSD concluded that [redacted] would sit down with the Food Service Worker (FSW) and try to explain how to record the temperatures.

On [redacted] at [redacted], the FSD stated that he was responsible for reviewing the dish machine temperature logs. [redacted] stated that [redacted] usually checked to see that the boxes were filled in, but didn't examine the actual numbers. [redacted] stated that [redacted] checked the operation of the machine daily and had never seen a problem. [redacted] stated that [redacted] told the staff that, if there was ever a problem with the machine, to stop washing dishes and tell [redacted]. The FSD stated that the "soap company" had been at the facility about two months ago for general maintenance, and they had checked the dish machine gauges at that time. [redacted] stated that the company representative found no problem with the machine.

On [redacted] at [redacted], the surveyor again checked the dish machine. The rinse temperature was 190 degrees F. Using a T-stick thermometer, the surveyor was able to verify the machine's rinse temperature. The dish machine

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	315492	A. BUILDING _____ B. WING _____	10/29/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BOONTON CARE CENTER	**199 POWERVILLE ROAD BOONTON, NJ 07005**

(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 880	Continued From page 25 was operating as it should. In a follow-up interview on [redacted] at [redacted], the FSD stated that [redacted] met with the FSW who had written the low temperatures on the log. [redacted] stated that the FSW was checking the rinse gauge when [redacted] first filled the machine, when the rinse temperature was still low. The FSW would then quickly fill out the log with the low rinse reading. At that point, the FSD explained that the machine was not completely filled with water and it would not be possible to wash dishes. The FSD then demonstrated that anyone working the dish machine would have to lift the front panel and lower it again to completely fill the machine with water. At that point, the water heating booster was engaged and the rinse temperature rose to 190 degrees F. Then the temperature log could be accurately completed and it would be possible to safely wash and sanitize the dishes. The FSD stated that [redacted] in-serviced the FSW about when to record the rinse temperatures in the presence of an [redacted] on [redacted] Both the FSW and the [redacted] signed the in-service sheet. On [redacted] at [redacted] the FSD provided a Dish Machine Usage Policy which was reviewed and revised on 5/21/19. The policy included the procedures mentioned by the FSD, although some lacked details, i.e. how to properly monitor and record the rinse temperature. The policy also included the statement that the Wash Temperature should be 160 degrees F. The manufacturer's recommended wash temperature that the surveyor observed on the front of the dish machine was actually 150 degrees F. The FSD revised the wash temperature on the policy on [redacted] to reflect the manufacturer's	F 880		

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F 880	Continued From page 26 recommendation. NJAC 8:39-19.1, 19.2; 19.4; 19.5; 12.1	F 880		
F 886 SS=D	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests;	F 886		11/11/20

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F 886	Continued From page 27 §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of pertinent facility documents, it was determined that the facility failed to develop and implement a procedure for residents who refused testing for COVID-19 in accordance with nationally accepted guidelines for infection prevention and control of COVID-19. This deficient practice was identified for 2 of [redacted] residents who refused testing for [redacted] (Resident [redacted] and Resident [redacted]), and was	F 886	Resident [redacted] - Corrective action taken for affected resident [redacted] A. Director of Nursing (DON) conducted a full investigation in the cases of the resident(s) [redacted] who refused testing for COVID-19 were immediately relocated to the Yellow Zone as Person Under Investigation (PUI). B. Resident [redacted] - Educational counseling	

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F 886	Continued From page 28 evidenced by the following: According to the U.S. Centers for Disease Control and Prevention (CDC) guidelines, Preparing for COVID-19 in Nursing Homes updated 6/25/2020 included guidelines to "Create a Plan for Testing Residents and Healthcare Personnel [HCP] for SARS-CoV-2 [COVID-19]" It specified that, "Testing for SARS-CoV-2, the virus that causes COVID-19, in respiratory specimens can detect current infections (referred to here as viral testing or test) among residents...in nursing homes. The plan should align with state and federal requirements for testing residents...for SARS-CoV-2 and address: Triggers for performing testing (e.g., a resident...with symptoms consistent with COVID-19, response to a resident or HCP with COVID-19 in the facility, routine surveillance); ...A procedure for addressing residents or HCP who decline or are unable to be tested (e.g., maintaining Transmission-Based Precautions until symptom-based criteria are met for a symptomatic resident who refuses testing). According to the U.S. CDC's "Clinical Questions About COVID-19" updated 10/5/20 included that "If a resident is asymptomatic [without signs and symptoms of COVID-19] and declines testing at the time of facility-wide testing, decisions on placing the resident on Transmission-Based Precautions for COVID-19 or providing usual care should be based on whether the facility has evidence suggesting SARS-CoV-2 transmission (i.e., confirmed infection in HCP [Health Care Personnel] or nursing-home onset infection in a resident)." On [redacted] at [redacted], the surveyor	F 886	was given on policy and procedure that resident would remain in the PUI zone indefinitely or until resident resumed COVID-19 testing with negative results. C. Resident [redacted]- Responsible Party educational counseling given on policy and procedure that resident would remain in the PUI zone indefinitely or until resident resumed COVID-19 testing with negative results. ELEMENT #2- Identification of resident with the potential to be affected in the same manner and corrective actions A. All residents had the potential to be affected by this deficient practice. B. List was utilized by nurses to ensure all residents with transmission-based precautions have the proper transmission-based precaution. C. Documentation of Refusal of Testing will be reviewed and documentation in medical record. ELEMENT #3- Systemic changes made to prevent recurrence A. Director of Nursing reviewed and revised the policy and procedure of Transmission Based Precautions and Surveillance to include Residents Who Refuse COVID-19 Testing. B. All Nurses have been in-serviced on the policy and procedure of Transmission Based Precautions and Surveillance with focus on Residents Refusing COVID-19 Testing. C. In service will concentrate on the following: (I) Identification of residents with infections or potential for infections.	

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F 886	Continued From page 29 interviewed the Assistant Administrator (AA) and the Chief Operating Officer (COO) in the presence of the survey team. The AA stated that the facility had a current COVID-19 outbreak in which 1 of [redacted] residents tested [redacted] on [redacted], and [redacted] staff members had [redacted] during weekly testing on [redacted]. At [redacted], the COO and the Director of Nursing (DON) described the three cohort zones to the survey team. The COO stated the Red Zone was at the end of the U-shaped hallway of the [redacted] Unit and was designated as COVID-19 positive. The DON stated that the Yellow Zone was designated for residents who had tested negative for COVID-19 but were PUI due to exposure to the virus or [redacted] in the last [redacted] days. The DON confirmed there were three residents currently in the Yellow Zone and placed on transmission-based precautions (strategy to prevent the transmission of COVID-19 in which staff wear an N-95 respirator mask, eye protection, a gown and gloves). The DON stated that the remainder of the [redacted] residents were in the Green Zone which meant that they were non-ill and non-exposed to COVID-19. At [redacted], the surveyor continued to ask the DON if any residents had refused testing for COVID-19. The DON stated that there were [redacted] residents that refused testing for COVID-19 (Residen [redacted] and that Resident [redacted] was in a [redacted] room in the Green Zone/non-ill, non-exposed unit. Resident [redacted] [redacted] room [redacted] (Resident [redacted]) in the Green Zone. The DON confirmed that the two residents were not placed on transmission-based	F 886	(II) Identification of residents with transmission-based precautions and the interventions associated with maintaining transmission-based precautions. (III) Plan of care review and revision as per Attending Physician evaluation and consultation recommendations. (i.e. Infectious Disease Consult) D. Copy of the in service and attendance will be kept for reference & validation. ELEMENT #4- Quality Assurance Monitoring A. Director of Nursing or designee will develop an audit tool that tracks residents with transmission-based precautions. B. Director of Nursing, Certified Infection Preventionist or designee will monitor audit tool outlining progress and ensure residents with transmission based precautions are identified to include residents who refuse covid-19 testing weekly for one month, bi-weekly for one month and random checks for 1 month. C. Audits with negative findings will have corrective actions and reviewed by the Director of Nursing or designee. D. Audit will be presented to the Quality Assurance Committee quarterly. E. Compliance will be ongoing and ensured by Director of Nursing.	

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F 886	Continued From page 30 precautions (TBP), because the residents were not displaying signs or symptoms of COVID-19. At [redacted], two surveyors toured the Green Zone and observed Resident [redacted] sitting in a [redacted] in the doorway of his/her private room. The resident was wearing a surgical mask but it was positioned under the nose, exposing the resident's nares. There was no evidence of a cart of personal protective equipment (PPE) outside the resident's room or a sign indicating the resident was on transmission based precautions (TBP) during the current COVID-19 outbreak. The surveyor attempted to interview the resident but the resident was unable to communicate [redacted]. At [redacted], the two surveyors observed Resident [redacted] sitting in a [redacted] in a [redacted] room. The [redacted] of Resident [redacted] was in bed with eyes closed. There was no sign or PPE cart to indicate that Resident [redacted] was on transmission based precautions during the current COVID-19 outbreak due to refusing testing for COVID-19. At [redacted], the two surveyors interviewed the Certified Nursing Aide (CNA) assigned to care for Resident [redacted]. The CNA stated that [redacted] works full time and was familiar with the residents. [redacted] stated that residents and staff get tested for COVID-19 weekly. The surveyor asked if any residents on [redacted] assignment had refused weekly testing for COVID-19 and the CNA stated "No" adding that all residents had accepted testing. The surveyor asked what would happen if a resident did refuse testing for COVID-19 and the CNA stated, "I am not sure." The CNA stated that none of the residents on [redacted] assignment the	F 886		

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F 886	Continued From page 31	F 886		

Green Zone were having signs or symptoms consistent with COVID-19, including Resident [redacted], and no residents on his assignment were on transmission-based precautions.

At [redacted], the surveyor observed an Activities Aide with the roommate of Resident [redacted] in the [redacted] room. The Activities Aide was wearing an N-95 mask and eye glasses.

The surveyor reviewed the facility provided documents.

The surveyor reviewed the facility's floor plan in which the administration color-coded the three cohort groups, Green Zone, Yellow Zone and Red Zone by room numbers.

A comparative review of the cohort color-coded floor plan and the census Resident Listing Report with room numbers for [redacted] reflected that there was [redacted] resident in the Red Zone/Positive COVID-19 unit, [redacted] in the Yellow Zone/PUI unit, and [redacted] residents in the Green Zone including Resident [redacted] who refused testing for COVID-19.

A review of the last COVID-19 specimen report for Resident [redacted] reflected that on [redacted] the resident tested [redacted]

A review of the last COVID-19 specimen report for Resident [redacted] reflected that on [redacted], the resident [redacted].

On [redacted] at [redacted], the surveyor conducted a phone interview with the Local Health Department/Registered Nurse (LHD/RN)

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F 886	Continued From page 32 who confirmed the facility had a current COVID-19 outbreak that recently started on [redacted]. The LHD/RN stated that [redacted] had had regular contact with the DON sometimes twice a day but was not aware that any residents had refused weekly testing at the facility. [redacted] added that had [redacted] known [redacted] would recommend that the residents who refused testing to be placed on transmission-based precautions / airborne precautions during the duration of the outbreak. On [redacted] at [redacted], the survey team interviewed the Infection Preventionist/Registered Nurse (IP/RN) who stated that [redacted] had just started the role two weeks ago as the IP/RN, but that the [redacted] residents who refused to be tested for COVID-19 were recorded on the Resident Line List that they refused testing. [redacted] confirmed the facility had an active COVID-19 outbreak and stated that [redacted] of the residents who refused was in a [redacted], and the other resident had [redacted]. [redacted] stated that Resident [redacted] was moved into the Yellow Zone/PUI unit yesterday on [redacted] upon surveyor inquiry because he/she had a roommate, but Resident [redacted] remained in a [redacted] room in the Green Zone and was not on TBP. [redacted] stated that she didn't think the resident needed TBP because he/she was in a private room. At [redacted], two surveyors observed Resident [redacted] sitting in a [redacted] wearing a surgical mask below his/her nose in the Green Zone. The resident was in a common area without staff present. At [redacted], the Director of Nursing (DON) confirmed that the dates of [redacted] and [redacted] were the most recent testing dates of Resident	F 886		

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F 886	Continued From page 33 [redacted], respectively. [redacted] stated that both residents declined testing when the outbreak began on [redacted] but have no clinical signs or symptoms of COVID-19. A review of the facility's COVID-19 Plan for Testing Residents and Staff in Compliance with Executive Directive #20-013 implemented 5/14/2020 included, "If a resident refuses to be tested in the facility, notification is made to any authorized family members or legal representatives of this decision, and continue to check temperature on the resident daily. Onset of temperature or other symptoms consistent with COVID-19, resident will be treated as Persons Under Investigation and require immediate cohorting in accordance with the Plan. At any time, the resident may rescind their decision not to be tested." The plan did not differentiate a procedure for residents that refuse testing during an active in-facility transmission of COVID-19, or if no transmission was occurring within the facility. The procedure did not address placing asymptomatic residents who refuse testing on Transmission Based Precautions during an active facility outbreak of COVID-19 in accordance with U.S. CDC guidelines. NJAC 8:39-27.1 (a)	F 886		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315492 (Y1)	A. Building B. Wing (Y2)	11/18/2020 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BOONTON CARE CENTER	199 POWERVILLE ROAD BOONTON, NJ 07005

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0880 Reg. # 483.80(a)(1)(2)(4)(e)(f) LSC	Correction Completed 11/18/2020	ID Prefix F0886 Reg. # 483.80 (h)(1)-(6) LSC	Correction Completed 11/18/2020	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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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 10/29/2020	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			