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	315195	A. BUILDING _____ B. WING _____	11/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT BERKELEY HEIGHTS	35 COTTAGE STREET BERKELEY HEIGHTS, NJ 07922

(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: 11/10/2020 Census: 64 Sample: 6 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=E	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		11/26/20

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

Electronically Signed | 11/25/2020

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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 documentation, it was determined that the facility failed to a.) ensure staff implemented infection control practices for performing hand hygiene appropriately and donning (putting on) Personal Protective Equipment (PPE) before entering a COVID-19 isolation unit, and b.) put adequate interventions in place to address a [redacted] resident that [redacted] on the [redacted] unit. This deficient practice was identified on [redacted] of [redacted] units, and for [redacted] of [redacted] residents reviewed (Resident #1) during a focused COVID-19 infection control survey and was evidenced by the following: 1. On 11/10/2020 at 10:25 AM, the surveyor observed a Recreation Aide (RA) on the A-Unit perform handwashing. The surveyor observed the RA turn on the faucet, wet her hands then apply soap to her hands. The surveyor then observed the RA lather both hands with soap and water, outside of the stream of running water, for a total of nine seconds. Upon interview, at the time of the observation, the RA stated she would wash her hands for thirty seconds total and would lather her hands first and then put them under the running water. The RA further stated that she would lather her hands	F 880	CORRECTIVE ACTION: RA (Recreation Ade), RN and CNA #1, were re-in serviced by the Infection Control Preventionist on the deficient practice of Handwashing, donning/Doffing PPE and the appropriate PEE for different categories of isolation with return demonstration per facility policy and procedure and the CDC guideline. Resident #1 medical record reviewed by the Director of Nursing for the deficient practice on putting adequate interventions in place to address a [redacted] resident that [redacted] unit. Resident #1 was placed [redacted]. All the newly admitted residents on the [redacted] unit were assessed for COVID symptoms. IDENTIFICATION OF AT RISK RESIDENTS: All Resident may potentially be at risk for this deficient practice. These residents can be identified by reviewing the physician orders, medication administration record and the residents medical records. SYSTEMIC CHANGES: All staff re- in-serviced on handwashing, donning/doffing PPE, Appropriate PPE for different categories of isolation i.e.	

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F 880	Continued From page 3 with soap and water outside of the running water for at least ten seconds. At 10:34 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) #1 who stated that hands should be washed with soap and water outside of running water for 20 to 30 seconds. The LPN #1 stated that if you were to keep your hands under the running water, it would wash the soap off. 2. At 11:46 AM, the surveyor observed a Registered Nurse (RN) who was assigned to the COVID-19 unit don gloves without first performing hand hygiene. The RN then proceeded into a resident's room on the COVID-19 unit. At 12:00 PM, the surveyor continued observations on the COVID-19 unit and observed a Certified Nurse Aide (CNA) #1, enter through the plastic barrier and into the COVID-19 unit. CNA #1 was observed wearing scrubs, a mask and was not wearing eye protection or a gown over the scrubs. CNA #1 entered an open room on the unit and donned a gown, face shield and then donned gloves without first performing hand hygiene. She then proceeded to enter a resident's room. At 12:10 PM, the surveyor interviewed the RN who stated the process was to don the required PPE prior to entering through the plastic barrier and entering into the COVID-19 unit. At 1:26 PM, the surveyor, in the presence of another surveyor, interviewed the ADON/IP. The ADON/IP stated that prior to entering a room on the COVID-19 unit, the nurse must wash hands or utilize an alcohol based hand rub (ABHR). The ADON/IP stated the staff should have donned all	F 880	(Contact, Droplet and Airborne isolation). Infection Control Preventionist or designee will perform random audits of 10 staff members per week on handwashing, donning/doffing PPE, and appropriate PPE for the different categories of transmission based precautions i.e. (Contact, Droplet and Airborne isolation precautions) with return demonstration and competency test to ensure compliance. Staff in serviced to implement [redacted] supervision on [redacted] and develop a care plan to address the behavior. QUALITY ASSURANCE: A random weekly audit of 10 staff members will be done By Infection Control Preventionist or designee on Hand washing, donning /doffing PPE, Appropriate PPE for the different transmission based categories for six months, then biweekly for three months then monthly for one year. Any issues identified will be immediately addressed and findings will be reported to the Administrator as well as the Quality Assurance Committee/QAPI Quarterly for a year. The Director of Nursing/ Assistant Director of Nursing or designee will do a daily rounding on the [redacted] unit and review medical records of [redacted] Any issue identified, will be addressed immediately and finding will be reported to the Administrator as well as the quality	

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F 880	Continued From page 4 appropriate PPE, which included a gown, gloves, mask, face shield or goggles, prior to entering through the plastic threshold and entering into the COVID-19 unit. 3. On 11/10/20 at 12:18 PM, two surveyors observed Resident #1 walk into an occupied resident's room on the [redacted] unit. The resident was not observed wearing a mask. The surveyor further observed signage posted outside of the door that indicated the resident was on transmission-based-precautions and specific PPE needed to be applied prior to entering the resident's room. The sign indicated to stop before entering the room because the resident was on droplet precautions and in addition to standard precautions everyone must clean hands when entering and leaving the room, wear a mask, wear eye protection, wear a gown, and wear gloves. Pictures of hands utilizing ABHR (alcohol based hand rub), a person wearing a mask, goggles, a gown, and gloves were also displayed on the signage. Outside of the resident's room the surveyors observed a plastic bin stocked with PPE which included disposable gowns, washable gowns, K95 masks, face shields, and gloves. At 12:21 PM, the surveyors observed Resident #1 walk into another occupied resident's room on the [redacted] unit. The room the resident walked into did not have signage posted. At that time, the surveyors observed LPN #2 approach Resident #1 and then redirect the resident to sit in front of the nursing station. A 12:23 PM, the surveyors interviewed LPN #2 who stated that the resident had behaviors of [redacted] on the unit	F 880	Assurance Committee/QAPI quarterly.	

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and would not [redacted]. LPN #2 stated that the resident needed to be constantly redirected all day from going into other residents' rooms on the unit and was not on special supervision.

At 1:30 PM, the surveyors interviewed the ADON/IP in the presence of the DON. The ADON/IP stated that Resident #1 was [redacted] admitted into the facility and because he/she was a [redacted], the resident fit into the criteria for requiring additional PPE when the staff was interacting and providing care to the resident. The ADON/IP stated that the resident was [redacted] and had [redacted] throughout the unit which required the resident to be supervised by staff. The surveyors asked the ADON/IP what supervision meant. The ADON/IP stated that supervision meant keeping an eye on the resident and making sure the resident did not fall.

At 1:34 PM, the surveyors interviewed the DON in the presence of the ADON/IP and asked what the concern would be if the resident was [redacted] who was not on droplet precautions? The DON stated that the concern would be the potential spread of the virus to another resident.

At 1:51 PM, the surveyor interviewed the resident's CNA #2 who stated that it was her second time taking care of the resident. CNA #2 stated that the resident was [redacted], came out of his/her room during the day, and [redacted]. CNA #2 stated that the resident liked to walk around the hallway and occasionally would [redacted]

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F 880	Continued From page 6 At 1:56 PM, the surveyor interviewed LPN #3 who stated that she was one of two nurses who were working on the [redacted] unit and that Resident #1 had resided at the facility for less than 14 days. LPN #3 stated that during the night time, the resident would sleep in his/her room, but during the day the resident would walk throughout the unit. LPN #3 stated that when she saw the resident during the day, the resident would usually sit in front of the nurse's station or another staff member would be walking with the resident down the hallway. LPN #3 stated that she had never observed the resident [redacted] on the unit. LPN #3 stated that all residents that were new admissions to the facility were under a 14-day quarantine and observation to monitor and prevent the spread of COVID-19. LPN #3 stated that full PPE needed to be worn when entering the rooms of resident's that were on a 14-day observation and quarantine. LPN #3 acknowledged that the resident was unreceptive to wearing a mask and stated that not wearing a mask put the resident, staff, and other resident's at risk for the potential spread of the virus. The surveyor reviewed the medical record for Resident #1. Review of the resident's Admission Record reflected that the resident had diagnoses which included, but were not limited to, [redacted]	F 880		

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F 880	Continued From page 7 Review of the resident's admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, reflected that the MDS assessment was still in progress as the resident had been admitted to the facility for less than 14 days. Review of the resident's November 2020 Medication Review Report indicated that the resident had a physician's order dated [redacted] that the resident was on droplet precautions for COVID-19 prophylaxis every shift for prevention for 14 days. Review of the resident's laboratory results indicated that the resident [redacted] Review of the resident's Progress Notes (PN) from [redacted] reflected that the resident was monitored for signs and symptoms of COVID-19 twice daily and did not present with signs and symptoms of the virus. A further review of the PN did not reflect documentation that the resident had [redacted]. Review of the resident's Care Plan (CP), initiated on [redacted] reflected a focus area that the resident was on droplet precautions. The goal of the CP was to prevent the transmission of infectious agents to other residents and the environment within the next review date. Interventions for the resident's droplet precautions CP included staff would adhere to hand hygiene policy, resident to be placed in a private room, and staff to wear protective gear as needed and ordered by the physician. A complete review of the resident's CP did not reflect a focus	F 880		

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F 880	Continued From page 8 area for the resident's [redacted] and interventions for care related to the resident's [redacted] Review of the facility's outbreak response plan reviewed and updated on 07/29/2020 indicated in their Monitoring New and Re-Admissions for Possible COVID-19 Policy and Procedure that, "Our facility will protect our current residents and staff from the spread of COVID-19. Once the 14 days are complete, and there are no signs and symptoms of COVID-19, they can be transferred to a room/unit and intermingle with the general facility population." Review of the Handwashing/Hand Hygiene policy, updated March 2020, revealed the use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections. The policy further revealed the procedure for washing hands was to wet hands first with water, then apply an amount of product recommended by the manufacturer to hands. Rub hands together vigorously for at least 20 seconds, covering all surfaces of the hands and fingers. Rinse hands with water and dry thoroughly with a disposable towel. Use towel to turn off the faucet. Review of the Centers for Disease Control and Prevention's (CDC) Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, updated Nov. 4, 2020, revealed the PPE recommended when caring for a patient with suspected or confirmed COVID-19 included the following: Respirator or Facemask (Cloth masks are NOT PPE and should not be	F 880		

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worn for the care of patients with suspected or confirmed COVID-19 or other situations where use of a respirator or facemask is recommended.)

The CDC Recommendations further revealed under Hand Hygiene: HCP (Healthcare Personnel) should perform hand hygiene before and after all patient contact, contact with potentially infectious material, and before putting on and after removing PPE, including gloves. Hand hygiene after removing PPE is particularly important to remove any pathogens that might have been transferred to bare hands during the removal process. HCP should perform hand hygiene by using ABHS (Alcohol Based Hand Sanitizer) with 60-95% alcohol or washing hands with soap and water for at least 20 seconds. If hands are visibly soiled, use soap and water before returning to ABHS.

Put on eye protection (i.e., goggles or a face shield that covers the front and sides of the face) upon entry to the patient room or care area, if not already wearing as part of extended use strategies to optimize PPE supply.

Put on clean, non-sterile gloves upon entry into the patient room or care area.
Change gloves if they become torn or heavily contaminated. Remove and discard gloves before leaving the patient room or care area, and immediately perform hand hygiene.

Put on a clean isolation gown upon entry into the patient room or area. Change the gown if it becomes soiled. Remove and discard the gown in a dedicated container for waste or linen before leaving the patient room or care area. Disposable

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F 880	Continued From page 10 gowns should be discarded after use. Reusable (i.e., washable or cloth) gowns should be laundered after each use. NJAC 8:39-19.4(a), 27.1(a)	F 880		
F 882 SS=F	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4)(c) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP) (s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. §483.80 (c) IP participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of pertinent facility documentation, it was identified	F 882	Corrective Action:	11/25/20

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F 882	Continued From page 11 that the facility failed to have a designated Infection Preventionist who had completed specialized training in infection control and prevention. The deficient practice was evidenced by the following: On 11/10/2020 at from 9:21 AM to 10:00 AM, the surveyors conducted an entrance conference with the facilities Director of Nursing (DON) and Assistant Director of Nursing/Infection Preventionist (ADON/IP). The surveyors asked the ADON/IP to provide the surveyors with certificates of completion for her required education and training in her her role of ADON/IP. At 11:12 AM, the surveyors interviewed the ADON/IP in the presence of the DON. The ADON/IP stated that she had not completed all the modules and training for her role as Infection Preventionist. The ADON/IP stated that whenever she got a chance, she would work on completing the modules. The ADON/IP further stated that she participated in the Quality Assurance Improvement Committee at the facility at least quarterly in her role as ADON/IP. The DON then stated that ADON/IP had not completed the mandatory training for her role as Infection Preventionist, but another staff member who was a Licensed Practical Nurse/Unit Manager (LPN/UM) had completing the training but she was not acting in the role as an Infection Preventionist for the facility. At 1:40 PM, the surveyors interviewed the LPN/UM who stated that she had completed the Infection Preventionist training course in 2018	F 882	The Registered Nurse completed specialized training in infection prevention and control. Identification of Residents at Risk: All residents may be potentially at risk for this deficient practice. Systemic Changes: The facility will have a full-time Infection Preventionist on staff. Quality Assurance: Continuing education will be ongoing as changes and updates are made as recommended by the CDC, CMS and NJ DOH.	

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and would help assist the ADON/IP with conducting in-service education and training with staff. The LPN/UM stated that she also helped the ADON/IP with swabbing the residents and staff for COVID-19 testing. The LPN/UM further stated that she did not participate in the Quality Assurance Improvement Committee at the facility and spent approximately three to four hours a week helping out the ADON/IP at the facility.

The surveyors reviewed the Certificate of Training provided by the facility.
Review of the Certificate of Training, dated 09/18/2020, indicated that the ADON/IP had successfully completed Module 1 - Infection Prevention & Control Program from the CDC Nursing Home Infection Preventionist Training Course.

Review of the Certificate of Training, dated 11/06/2020, indicated that the ADON/IP had successfully completed Module 2 - Infection Preventionist from the CDC Nursing Home Infection Preventionist Training Course.

Review of the Certificate of Training, dated 11/06/2020, indicated that the ADON/IP had successfully completed Module 3 - Integrating Infection Prevention and Control into the Quality Assurance Performance Improvement Plan from the CDC Nursing Home Infection Preventionist Training Course.

Review of the Certificate of Training, dated 11/10/2020, indicated that the ADON/IP had successfully completed Module 9 - Respiratory Hygiene and Cough Etiquette from the CDC Nursing Home Infection Preventionist Training Course.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315195	A. BUILDING _____ B. WING _____	11/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT BERKELEY HEIGHTS	35 COTTAGE STREET BERKELEY HEIGHTS, NJ 07922

(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 882	Continued From page 13 Review of the Certificate of Training for Infection Prevention in Non- Acute Care Settings dated 09/05/2018 to 09/05/2018 indicated that the LPN/UM had successfully completed training in Infection Control. Review of the facility's Outbreak Response Plan reviewed and updated 07/29/2020 did not indicate the required background, education, or training required for the designated Infection Preventionist working at the facility. NJAC 8:39-19.1(b)	F 882		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
315195		11/30/2020

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT BERKELEY HEIGHTS	35 COTTAGE STREET BERKELEY HEIGHTS, NJ 07922

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 11/30/2020	ID Prefix F0882 Reg. # 483.80(b)(1)-(4)(c) LSC	Correction Completed 11/27/2020	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

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	
11/10/2020	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO