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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	316617	A. BUILDING _____ B. WING _____	02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOVACARE REHABILITATION	733 ROUTE 72 WEST, UNIT 15E MANAHAWKIN, NJ 08050

(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
I 000	INITIAL COMMENTS This was a Federal Recertification Survey conducted at NovaCare Rehabilitation at Manahawkin NJ on 2/23/2021 to determine compliance with 42 CFR Part 485, Subpart H, Outpatient Physical Therapy Services. The facility is not in compliance with the following Conditions of Participation: I- 011: 485.709 Administrative Management I-117: 485.723 Physical Environment I-160: 485.725 Infection Control During this Federal Recertification Survey, two (2) Immediate Jeopardy (IJ's) were identified: 1. IJ#1 485.725 Condition of Participation: Infection Control a. The facility failed to ensure that single use suture kits were discarded after use. 2. IJ #2 485.723 Condition of Participation: Physical Environment. a. The facility failed to ensure that the rear door emergency exit was unobstructed. 3. The Facility Administrator was informed of the above IJ's and provided with the IJ templates on 2/23/2021 at 3 PM. 4. A Partial Removal Plan was implemented for IJ #1 at 3:30 PM by the facility. The facility discarded the six (6) used Dynarex Suture Removal Kits at 3:30 PM.	I 000		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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I 000	Continued From page 1 5. On 2/23/21, IJ#1 and IJ#2 were not removed by the end of the survey day. A 2567 Form has been completed for IJ#1 and IJ #2 and sent to the facility on 2/26/2021.	I 000		
I 117	PHYSICAL ENVIRONMENT CFR(s): 485.723 The building housing the organization is constructed, equipped, and maintained to protect the health and safety of patients, personnel, and the public and provides a functional, sanitary, and comfortable environment. This CONDITION is not met as evidenced by: Based on observation on 2/23/21, review of facility documents, and staff interview, it was determined that the facility failed to ensure that the building housing the organization was maintained to provide a safe and a sanitary environment for patients, staff, and visitors. Findings include: 1. The facility failed to ensure that emergency exits were maintained free from obstructions. (Cross refer to Regulation 485.723 (a) Tag I-118, Part A) 2. The facility failed to document monthly inspections of the fire extinguishers. (Cross refer to Regulation 485.723 (a) Tag I-118, Part B) 3. The facility failed to have an eye wash available for staff use while mixing cleaning	I 117		

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I 117	Continued From page 2 agents as required by the manufacturer's instructions for use for the treatment of accidental contact with eyes. (Cross refer to Regulation 485.723 (a) Tag I-118, Part C) 4. The facility failed to maintain therapy equipment clean to site and touch. (Cross refer to Regulation 485.723 (b) Tag I-121, Part A) 5. The facility failed to maintain a sanitary environment in the occupational therapy room. (Cross refer to Regulation 485.723 (b) Tag I-121, Part B)	I 117		
I 118	SAFETY OF PATIENTS CFR(s): 485.723(a) The organization satisfies the following requirements: (1) It complies with all applicable State and local building, fire, and safety codes. (2) Permanently attached automatic fire-extinguishing systems of adequate capacity are installed in all areas of the premises considered to have special fire hazards. Fire extinguishers are conveniently located on each floor of the premises. Fire regulations are prominently posted. (3) Doorways, passageways, and stairwells negotiated by patients are of adequate width to allow for easy movement of all patients (including those on stretchers or in wheelchairs), free from obstruction at all times, and, in the case of stairwells, equipped with firmly attached handrails on at least one side. (4) Lights are placed at exits and in corridors used by patients and are supported by an emergency power source.	I 118		

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I 118	Continued From page 3 (5) A fire alarm system with local alarm capability and, where applicable, an emergency power source is functional. (6) At least two persons are on duty on the premises of the organization whenever a patient is being treated. (7) No occupancies or activities undesirable or injurious to the health and safety of patients are located in the building. This STANDARD is not met as evidenced by: A. Based on observation of one (1) of two (2) required emergency exits on 2/23/21, the facility failed to ensure that emergency exits were maintained free from obstructions. Findings include: 1. At 11:30 AM in the presence of Staff #6, it was observed that the rear emergency exit was obstructed by the use of a flush mounted slide-bolt. The flush mounted slide-bolt was found in the locked position while the building was occupied by patients and staff. 2. This finding was confirmed with Staff #6 at 12:30 PM. B. Based on observation on 2/23/21 of two (2) of two (2) portable fire extinguishers, it was determined that the facility failed to document monthly inspections. Findings include: 1. At 12:30 PM in the presence of Staff #6, the	I 118		

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I 118	Continued From page 4 portable fire extinguishers located at the front and rear exit were missing the tag indicating that there were monthly inspections. C. Based on observation on 2/23/21 and review of manufacturer's instructions, an eye wash was not available for staff use while mixing cleaning agents as required by the manufacturer's instructions for use for the treatment of accidental contact with eyes. Findings include: Reference #1: Federal Occupational Safety Health Administration, 1910.151(c) Where the eyes or body of any person may be exposed to injurious corrosive materials, suitable facilities for quick drenching or flushing of the eyes and body shall be provided within the work area for immediate emergency use. Reference #2: Pur.One Product label States, "HAZARDS TO HUMANS AND DOMESTIC ANIMALS DANGER: Corrosive. Causes irreversible eye damage. Harmful if swallowed, inhaled, or absorbed through skin. Do not get in eyes, on skin, or clothing. Avoid breathing dust. Wear chemical-resistant gloves and safety glasses or face shield when making up solution. ... First Aid. If in eyes: Hold eye open and rinse slowly and gently with water for 15-20 minutes..." 1. During an interview at 1:20 PM in the Private Exam Room, Staff #6 confirmed the following: a. Staff mix the cleaning agent "PUR.ONE" by breaking the solid tablet in half and putting the broken tablet into a one-gallon jug of water to dissolve.	I 118		

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I 118	Continued From page 5 b. Staff do not wear gloves when handling the tablets. c. The facility does not have equipment for quick drenching or flushing of the eyes available for employees use while mixing the cleaning agent as indicated on the PUR.ONE Product label.	I 118		
I 121	MAINTENANCE OF EQUIPMENT/BUILDINGS/GROUNDS CFR(s): 485.723(b) The organization establishes a written preventive maintenance program to ensure that the equipment is operative and is properly calibrated, and the interior and exterior of the building are clean and orderly and maintained free of any defects which are a potential hazard to patients, personnel, and the public. This STANDARD is not met as evidenced by: A. Based on observation, facility policy review and staff interview on 2/23/2021, it was determined that the facility failed to maintain therapy equipment clean to site and touch and maintain a sanitary environment. Findings include: Reference #1: The facility policy and procedure titled, "Therapeutic Equipment Cleaning and Maintenance" states, "... All equipment used for the provision of patient care services will be maintained and tested to ensure safe operation and for the prevention of injury to patients and employees. ... 3) Cold Pack Unit: a) Once every three months, or as needed, the Cold Pack Unit will be defrosted... e) Document cleaning and	I 121		

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I 121	Continued From page 6 maintenance on the Equipment Cleaning & Maintenance Log (9.17), or similar log, and maintain in the Center Handbook. 4) Fluidotherapy: b) Follow manufacturer's guidelines for maintaining and inspecting unit. ... d) Document cleaning and maintenance on the Equipment Cleaning & Maintenance Log (9.17), or similar log, and maintain in the Center Handbook...11) Reusable Supplies (i.e., Thera-Band, rice and beans, putty etc) a) Inspect for tears and crack, and replace when necessary for patient safety and the prevention infection...13) All equipment will be stored in a clean area, off the floor and covered if appropriate. ..." Reference #2: The manufacturer's instructions for the Fluidotherapy unit states, "... Weekly Maintenance: Each week all sleeves of the Fluidotherapy unit should be laundered in a mild antibacterial detergent. ..." Reference#3: The facility policy and procedure titled, "Hydrocullator Machine Maintenance and Cleaning" states, "... Cleaning Procedures: Hydrocullator machines must be cleaned at least quarterly or more frequently as necessary. I) Check temperature after 2-3 hours. Document cleaning and maintenance on the Equipment Log (9.17), or similar log, and maintain in the Center Handbook." Reference #4: The facility policy and procedure titled, "Paraffin Bath Cleaning and Maintenance" states, "... The paraffin bath is cleaned and the paraffin was replaced every three months or sooner depending upon manufacturer's recommendations and patient use."	I 121		

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I 121	Continued From page 7 1. During a tour of the facility treatment area, in the presence of Staff #1 at 9:50 AM the following was observed: a. The fluidotherapy unit located in the Occupational Therapy area of the treatment room had dust visible to sight and touch. (Refer to Reference #1 and #2) (i) During interview, at 10:15 AM, Staff #3 stated that he/she does not know when the fluidotherapy equipment was last used to provide therapy for a patient. b. The Paraffin Bath located in the Occupational Therapy Cabinet area had dust to sight and touch with paraffin wax that was solidified. (Refer to Reference #1 and #4) (i) During interview, at 10:15 AM, Staff #3 stated that he/she has not used the Paraffin Bath since October 2020, and does not know when the paraffin wax equipment was last cleaned. c. The hydrocullator machine located in the Physical Therapy area, next to the cold pack freezer, had orange/brown discoloration inside the cover and brown/orange visible residue on the edges of the cover. The water in the hydrocullator was brown with a gray fluffy substance floating on the surface of the water. (Refer to Reference #1 and #3) (i) Upon request, Staff #1 was unable to provide the last date of cleaning of the hydrocullator unit. (ii) Review of the temperature and cleaning logs for the months of October 2020 to February 2021 revealed that the column for documenting the	I 121		

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I 121	Continued From page 8 date of cleaning the hydrocullator unit, was blank for all the months reviewed. (iii) The temperature logs provided by Staff #1 had a minimum required temperature range of "150 - 170 degrees F" (Fahrenheit). The temperature failed to reach the minimum temperature of 150 degrees F for all five (5) months reviewed. (iv) During interview at 1:30 PM, Staff #1 confirmed that this is not in accordance to facility policy as stated above. d. The cold pack freezer unit in the Physical Therapy area had heavy accumulation of ice with frozen ice packs at the bottom of the unit. (Refer to Reference #1) (i) During interview at 10:30 AM, Staff #1 was unable to provide evidence of when the cold pack freezer unit was last defrosted. This is not in accordance with facility policy as stated above. e. The Physical Therapy treatment floor had the following therapy equipment in direct contact with the floor: (Refer to Reference #1) (i) Three (3) blue Therabands were tied to the legs of therapy tables and were in direct contact with the floor. The Therabands had a covering of dust and debris and were sticky to the touch. (ii) Four (4) Forty-five pound bar bell weights placed under a equipment rack were in direct contact with the floor. (iii) Three (3) Bolsters were placed next to treatment tables and were in direct contact with	I 121		

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I 121	Continued From page 9 the floor. f. The Physical Therapy area had the following items with visible tears: (Refer to Reference #1) (i) Trampoline side cover was torn on one side exposing the interior material. (ii) A rolling stool seat had a split seam in the cover, exposing the interior material. 2. The above findings were confirmed with Staff #1 and Staff #6 at 3:15 PM. B. Based on observation, facility policy review and staff interview on 2/23/2021, it was determined that the facility failed to maintain a sanitary environment in the occupational therapy room. Findings include: 1. The cabinet behind the Occupational Therapy area had seventeen (17) 3.4 ounce saline solution bottles with an expiration date of 8/2016. a. During interview at 1:30 PM, Staff #1 was unsure why the cabinet had saline solution.	I 121		
I 160	INFECTION CONTROL CFR(s): 485.725 The organization that provides outpatient physical therapy services establishes an infection control committee of representative professional staff with responsibility for overall infection control. All necessary housekeeping and maintenance services are provided to maintain a sanitary and	I 160		

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I 160	Continued From page 10 comfortable environment and to help prevent the development and transmission of infection. This CONDITION is not met as evidenced by: Based on observation, document review and staff interview on 2/23/21, it was determined that the facility failed to ensure that there is an effective infection control program to prevent the development and transmission of infection for patients receiving therapy services. Findings include: 1. The facility failed to have an Infection Control Committee to review and monitor the execution of policies and procedures for investigating, controlling and preventing infections in the agency. (Cross Refer to Regulation 485.725 (a), Tag I 161, Part A) 2. The facility failed to ensure that everyone entering the facility are provided screening to identify and isolate Coronavirus Disease 2019 (COVID-19) in accordance with facility policy and procedures and Centers for Disease Control (CDC) guidelines. (Cross Refer to Regulation 485.725 (a), Tag I 161, Part B) 3. The facility failed to ensure implementation of facility policy, "Blood Borne Pathogen Exposure Control Plan" to prevent wound infections. (Cross Refer to Regulation 485.725 (a), Tag I 161, Part C) a. Upon review, two (2) of two (2) employee files revealed that Staff #1 and Staff #3 failed to have education regarding the Blood Borne Pathogen Control Plan policy and procedure. b. The above finding was confirmed with Staff #1	I 160		

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I 160	Continued From page 11 and Staff #6 at 3:30 PM. Staff #1 stated that no staff members have been educated on the Blood Borne Pathogen Exposure Control Plan. 4. The facility failed to ensure that facility policy and procedure are implemented by providing facility approved Environmental Protection Agency (EPA) registered disinfectants. (Cross Refer to Regulation 485.725 (a), Tag I 161, Part D) 5. The facility failed to ensure that disinfectants used for patient care equipment and environmental surfaces are clearly labeled, stored and staff educated on cleaning disinfectant clearing contact time. (Cross Refer to Regulation 485.725 (a), Tag I 161, Part E) 6. The facility failed to ensure that staff maintain sterility of Dynarex Suture Removal Kits. (Cross Refer to Regulation 485.725 (b), Tag I 163) a. Upon review, the facility policy titled, "Blood Pathogen Exposure Control Plan" states, "...All sterile items are used for single patient use and are disposable..." b. "Dynarex Suture Removal Kit" states, "single use, sterile unless pouch is opened or damaged." c. During a tour of the treatment area at 12:36 PM, (6) opened single use Dynarex Suture Removal Kits were found in the Occupational Therapy area. The following was observed: (i) The Dynarex Suture Removal Kits each contained - 1 Littauer Scissors, 1 Metal Forceps, and 1 (4 inch) Gauze Sponge.	I 160		

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I 160	Continued From page 12 (ii) There was a patient's first name and last name initial written in ink on each of the six (6) Dynarex Suture Removal Kits. (iii) Two (2) of the Six (6) Dynarex Suture Removal Kits had visible gauze with red discoloration. d. During interview at 2:30 PM, Staff #1, Staff #2, and Staff #6 stated that the single use Dynarex Suture Removal Kits are being reused. Staff #1 stated that the kits are sprayed clean with "PUR.ONE" disinfectant prior to placing back in packaging, however, should have been thrown out. Staff #2 stated that the Dynarex Suture Removal Kits are used for wound care and stitches removal by therapy staff.	I 160		
I 161	7. The facility failed to maintain, handle and process all linens in such a manner as to prevent the spread of infection. (Cross Refer to Regulation 485.725(d), Tag I-167). INFECTION CONTROL COMMITTEE CFR(s): 485.725(a) The infection control committee establishes policies and procedures for investigating, controlling, and preventing infections in the organization and monitors staff performance to ensure that the policies and procedures are executed. This STANDARD is not met as evidenced by: A. Based on staff interview on 2/23/2021, it was determined that the facility failed to have an	I 161		

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I 161	Continued From page 13 infection control committee to review and monitor the implementation of policies and procedures for investigating, controlling and preventing infections in the agency. Findings include: 1. Upon request, the facility could not provide evidence of an infection control committee. 2. On 2/23/2021 at 12:45 PM, Staff #1 confirmed that the facility did not have an infection control committee. B. Based on observation, five (5) of five (5) staff interviews (#1, #3, #5, #6, #7), and review of facility documents, it was determined that the facility failed to ensure that everyone entering the facility are provided screening to identify and isolate Coronavirus Disease 2019 (COVID-19) in accordance with facility COVID-19 plan and Centers for Disease Control (CDC) guidelines. Findings include: Reference #1: CDC Interim Infection Prevention and Control Recommendations for Healthcare Personnel [HCP] During the Coronavirus Disease 2019 (COVID-19) Pandemic Infection Control Guidance (updated December 14, 2020) states, "... Recommended routine infection prevention and control (IPC) practices during the COVID-19 Pandemic ...Screen and Triage Everyone Entering a Healthcare Facility for Signs and Symptoms of COVID-19 ...Establish a process to ensure everyone (patients, healthcare personnel, and visitors) entering the facility is assessed for symptoms of COVID-19, or exposure to others with suspected or confirmed SARS-CoV-2	I 161		

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	316617	A. BUILDING _____ B. WING _____	02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOVACARE REHABILITATION	733 ROUTE 72 WEST, UNIT 15E MANAHAWKIN, NJ 08050

(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
I 161	Continued From page 14 infection and that they are practicing source control. Options could include (but are not limited to): individual screening on arrival at the facility; or implementing an electronic monitoring system in which, prior to arrival at the facility, people report absence of fever and symptoms of COVID-19, absence of a diagnosis of SARS-CoV-2 infection in the prior 10 days, and confirm they have not been exposed to others with SARS-CoV-2 infection during the prior 14 days." Reference #2: Facility document titled, "COVID-19 Pandemic Outpatient Division Emergency Plan states, "...Screening ... Patients and Visitors ... Existing patients and visitors are screened upon entry to the center at the time of every visit using the OP COVID-19 Patient/Visitor Screening Tool." Reference #3: Facility Screening Tool for Coronavirus Disease (COVID-19) - Colleagues states, "...Screening (including temperature check) is completed daily for every colleague at the start of their workday and must be logged." 1. Upon arrival to the facility on 2/23/21 at 9:30 AM, two (2) out of three (3) surveyors were not asked screening questions for COVID-19. 2. A review of facility document "Staff health check log (2/8/21-2/23/21)" revealed that absence of illness was not part of the documentation used to log COVID-19 signs and symptoms. 3. During interviews with Staff #3 at 10:05 AM, Staff #5 at 9:51 AM, and Staff #7 at 9:58 AM, stated that screening questions are not asked	I 161		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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I 161	Continued From page 15 daily upon entrance. 4. The above findings were confirmed with Staff #1 and Staff #6 at 3:15 PM. C. Based on observation, staff interview, and document review of two (2) of two (2) employee files (Staff #1, Staff #3) on 2/23/2021 at 12:36 PM, it was determined that the facility failed to ensure implementation of facility policy, "Blood Borne Pathogen Exposure Control Plan" to prevent wound infections. Findings include: Reference: The facility policy titled, "Blood Borne Pathogen Exposure Control Plan" states, "... All sterile items are used for single patient use and are disposable. ..." 1. Upon review, two (2) of two (2) employee files revealed that Staff #1 and Staff #3 failed to have education regarding the Blood Borne Pathogen Control Plan policy and procedure. 2. The above finding was confirmed with Staff #1 and Staff # 6 at 3:30 PM. Staff #1 stated that no staff members have been educated on the Blood Borne Pathogen Exposure Control Plan. D. Based on two of two (2 of 2) staff interviews, and review of facility documents, it was determined that the facility failed to ensure that facility policy and procedures are implemented by providing facility approved Environmental Protection Agency (EPA) registered disinfectants. Findings include:	I 161		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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I 161	Continued From page 16 Reference: Facility document titled, "COVID-19 Pandemic Outpatient Division Emergency Plan" states, "... COVID-19 Pandemic Procedures ...Infection Control: Facility: Clean and disinfect all frequently touched surfaces and patient equipment. Diluted bleach, EPA List N approved cleaners or cleaners with at least 60-70% alcohol content ..." 1. On 2/23/21 at 11:30 AM, during an interview with Staff #1, a request was made for the facility approved Environmental Protection Agency (EPA) list of registered disinfectants for patient equipment and environmental surfaces. Staff #1 stated that the facility does not have a facility approved EPA list. 2. This was confirmed with Staff #6 at 3:15 PM. E. Based on observation and six (6) of six (6) staff interviews (Staff #1, #3, #5, #6, #7 and #8), it was determined that the facility failed to ensure that disinfectants used for patient care equipment and environmental surfaces are clearly labeled, stored and used according to manufacturer's instructions for use. Findings include: Reference: Pur.One Product label States, "... Apply to pre-cleaned surface with mop, cloth, sponge, brush, wipes, or coarse trigger sprayer. Allow surface to remain wet for 10 minutes, then remove product by wiping with brush, sponge, or cloth, or allow to air dry." 1. On 2/23/21, during observation of the patient treatment area, six (6) clear bottles filled with a clear fluid labeled "Pur.One" were discovered.	I 161		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	316617	A. BUILDING _____ B. WING _____	02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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I 161	Continued From page 17 These bottles were not clearly labeled with an expiration date. 2. During interview, Staff #1 stated that these six (6) clear bottles filled with fluid are mixed by staff to clean and disinfect patient equipment and environmental surfaces. 3. During interviews with Staff #3 at 10:05 AM, Staff #5 at 9:51 AM, and Staff #7 at 9:58 AM, and Staff #8 at 10:00 AM, the staff members were unable to state the contact time of the disinfectant, PUR.ONE, in accordance to manufacturer's instructions. 4. The above findings were confirmed with Staff #1 and Staff #6 at 3:15 PM.	I 161		
I 163	ASEPTIC & ISOLATTION TECHNIQUES CFR(s): 485.725(b) All personnel follow written procedures for effective aseptic techniques. The procedures are reviewed annually and revised if necessary to improve them. This STANDARD is not met as evidenced by: Based on observation, facility policy review, and three (3) of three (3) staff interviews (Staff #1, Staff #2 and Staff #6) on 2/23/2021, it was determined that the facility failed to ensure that staff maintain sterility of Dynarex Suture Removal Kits.	I 163		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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I 163	Continued From page 18 Findings include: 1. Upon review, the facility policy titled, "Blood Pathogen Exposure Control Plan" states, "...All sterile items are used for single patient use and are disposable..." 2. "Dynarex Suture Removal Kit" states, "single use, sterile unless pouch is opened or damaged." 3. During a tour of the treatment area at 12:36 PM, (6) opened single use Dynarex Suture Removal Kits were found in the Occupational Therapy area. The following was observed: a. The Dynarex Suture Removal Kits each contained - 1 Littauer Scissors, 1 Metal Forceps, and 1 (4 inch) Gauze Sponge. b. There was a patient's first name and last name initial written in ink on each of the six (6) Dynarex Suture Removal Kits. c. Two (2) of the Six (6) Dynarex Suture Removal Kits had visible gauze with red discoloration. d. During interview at 2:30 PM, Staff #1, Staff #2, and Staff #6 stated that the single use Dynarex Suture Removal Kits are being reused. Staff #1 stated that the kits are sprayed clean with "PUR.ONE" disinfectant prior to placing back in packaging, however, should have been thrown out. Staff #2 stated that the Dynarex Suture Removal Kits are used for wound care and stitches removal by therapy staff.	I 163		
I 167	LINEN CFR(s): 485.725(d)	I 167		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	316617	A. BUILDING _____ B. WING _____	02/23/2021

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I 167	Continued From page 19 The organization has available at all times a quantity of linen essential for proper care and comfort of patients. Linens are handled, stored, processed, and transported in such a manner as to prevent the spread of infection. This STANDARD is not met as evidenced by: Based on observation, staff interview, and a review of facility policy on 2/23/2021, it was determined that the facility failed to ensure laundry is washed in accordance with facility policy. Findings include: Reference: Facility Policy 9.15, titled Laundry Handling, revised 5/1/2019 states,"...(b) All laundry will be laundered using the hot water cycle of the washer. Whenever possible, the water temperature should be 140 - 160 degrees. (c) One-quarter cup of bleach will be added to the wash cycle if the water temperature does not reach 140 degrees, or if linen is contaminated." 1. During an interview on 2/23/21 at 1:45 PM, Staff #6 confirmed the following: a. Therapy towels are laundered at the facility with laundry detergent. b. Staff do not check the water temperature to ensure the hot water reaches 140 degrees. c. Bleach is not used in the facility for any	I 167		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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I 167	Continued From page 20 reason.	I 167		

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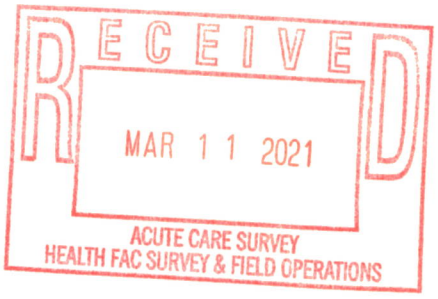

Shilpa Rathore, MS, RD
Survey and Certification
NJ Department of Health
Health Facility and Field Operations
PO Box 367
Trenton, NJ 08625-0367

March 5th, 2021

RE: Plan of Correction for NovaCare Rehabilitation – NovaCare Rehabilitation- Manahawkin
Provider Identification Number # 316617

Dear Ms. Rathore,

This letter is in response to the survey report resulting from a site visit conducted by the NJ Department of Health on February 23rd, 2021. At this time, the deficiencies reported are being addressed and corrected. Enclosed is our Plan of Correction, including the monitoring tools we have implemented to track and deter potential reoccurrences.

Thank you for the opportunity to provide feedback. Should you require any additional information, please do not hesitate to contact me at (609) 978-1001.

Sincerely,

Robert J Alegre, PT, DPT
Administrator / Regional Director

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	316617	A. BUILDING _____ B. WING _____	02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOVACARE REHABILITATION	733 ROUTE 72 WEST, UNIT 15E MANAHAWKIN, NJ 08050

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I 000	INITIAL COMMENTS This was a Federal recertification survey conducted at NovaCare Rehabilitation at Manahawkin NJ on 2/23/2021 to determine compliance with 42 CFR Part 485, Subpart H, Outpatient Physical Therapy Services. During this Federal recertification survey, two (2) Immediate Jeopardy (IJ's) were identified: 1. IJ#1 485.725 Condition of Participation: Infection Control a. The facility failed to ensure that single use suture kits were discarded after use. 2. IJ #2 485.723 Condition of Participation: Physical Environment. a. The facility failed to ensure that the rear door emergency exit was unobstructed. 3. The Facility Administrator was informed of the above IJ's and provided with the IJ templates on 2/23/2021 at 3 PM. 4. A Partial Removal Plan was implemented for IJ #1 at 3:30 PM by the facility. The facility discarded the six (6) used Dynarex Suture Removal Kits at 3:30 PM. 5. On 2/23/21, IJ#1 and IJ#2 were not removed by the end of the survey day. At this time, a 2567 Form has been completed for IJ#1 and IJ #2 only.	I 000	RECEIVED MAR 11 2021 ACUTE CARE SURVEY HEALTH FAC SURVEY & FIELD OPERATIONS	
I 117	PHYSICAL ENVIRONMENT CFR(s): 485.723 The building housing the organization is	I 117		

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

Ronald St. Dept | Regional Director | 3/8/21

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Plan of Correction for NovaCare Rehabilitation- Manahawkin
Medicare Rehabilitation Agency Provider # 316617

Site visit by NJ Department of Health: February 23rd, 2021

Plan of Correction Completed: March 5th, 2021 by Robert J Alegre, PT, DPT, Regional Director

(X4) ID Prefix Tag	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
I 117	PHYSICAL ENVIRONMENT CFR(s): 485.723 This CONDITION is not met as evidenced by: 1. The facility failed to ensure that emergency exits were maintained free from obstructions (Cross refer to Regulation 485.723(a) Tag 1 118)	The Center Manager enlisted a General Contractor to remove the flush mounted slide bolt on the rear exit door and repair the existing door hardware for instant use in an emergency. The Center Manager will ensure the door remains free of obstructions. This will be monitored on an annual basis during quality assurance physical inspections.	2/25/21
I 118	SAFETY OF PATIENTS CFR(S): 485.723(a) This STANDARD is not met as evidenced by: Based on observation of one (1) of two (2) required emergency exits on 2/23/21, the facility failed to ensure that emergency exits were maintained free from obstructions. Cross refer to Tag: 485.723 (a)	The Center Manager enlisted a General Contractor to remove the flush mounted slide bolt on the rear exit door and repair the existing door hardware for instant use in an emergency. The Center Manager will ensure the door remains free of obstructions. This will be monitored on an annual basis during quality assurance physical inspections.	2/25/21
I 160	INFECTION CONTROL CFR(s): 485.725 This CONDITION is not met as evidenced by: The facility failed to ensure that there is an effective infection control program to prevent the development and transmission of infection for patients receiving therapy services. Findings include. 1. The facility failed to ensure implementation of facility policy, "Blood Borne Pathogen Exposure	1. All staff are trained on our Bloodborne Pathogen Exposure Plan on an annual basis by way of our online training platform (Select University). All employee training records are retained on our online training platform. In addition, record of most recent training is printed for each staff member and retained within their employee file. Staff members are required to review all policies on an annual basis. Additionally, to ensure awareness related to infection control; Policy 9.10 Infection Control	3/5/21 3/11/21

	Control Plan" to prevent wound infections. (Cross refer to Regulation 485.725 Tag 1 161) 2. The facility failed to ensure that staff maintain sterility of Dynarex Suture Removal Kits. (Cross refer to regulation 485.725 (b), Tag 1 163)	and Asepsis and Policy 9.11 Bloodborne Pathogen Exposure Control Plan will be reviewed at a staff meeting led by the Center Manager. Record of this meeting and attendees will be retained in a binder with record of other center staff meetings. In the future, the Center Manger will ensure all staff will complete Blood Borne Pathogen ECP training and policy review upon hire and on an annual basis by monitoring successful completion in our online learning system. To monitor understanding and compliance of these policies, the Center Manager will review content during a staff meetings annually. 2. The Center Manager will ensure all suture removal kits will be appropriately disposed of after a single use per Policy 9.11 Bloodborne Pathogen Exposure Control Plan. To prevent future inappropriate use of disposable suture removal kits, all staff was educated to only use suture removal kits for single use and to dispose of appropriately in a sharps container. Staff will acquire a pair of scissors for non-patient care use. The Center Manager or designee will monitor use of disposable suture removal kits as part of quality assurance audits that occur quarterly.	2/24/21
I 161	INFECTION CONTROL COMMITTEE CFR(s): 485.725(a) This STANDARD is not met as evidenced by: The facility failed to ensure implementation of facility policy, "Blood Borne Pathogen Exposure Control Plan" to prevent wound infections. Findings include. Reference: The facility policy titled, "Blood Borne Pathogen Exposure Control Plan" states, "...All sterile items are used for single patient use and are disposable.	All staff are trained on our Bloodborne Pathogen Exposure Plan on an annual basis by way of our online training platform (Select University). All employee training records are retained on our online training platform. In addition, record of most recent training is printed for each staff member and retained within their employee file. Staff members are required to review all policies on an annual basis. Additionally, to ensure awareness related to infection control; Policy 9.10 Infection Control and Asepsis and Policy 9.11 Bloodborne Pathogen Exposure Control Plan will be reviewed at a staff meeting led by the	3/5/21 3/11/21

	1. Employee files failed to have education regarding the Blood Borne Pathogen Control Plan policy and procedure.	Center Manager. Record of this meeting and attendees will be retained in a binder with record of other center staff meetings. In the future, the Center Manger will ensure all staff will complete Blood Borne Pathogen ECP training and policy review upon hire and on an annual basis by monitoring successful completion in our online learning system. To monitor understanding and compliance of these policies, the Center Manager will review content during a staff meetings annually.	
I 163	ASEPTIC & ISOLATION TECHNIQUES CFR(s): 485.825(b) This STANDARD is not met as evidenced by: The facility failed to ensure that staff maintain sterility of Dynarex Suture Removal Kits.	The Center Manager will ensure all suture removal kits will be appropriately disposed of after a single use per Policy 9.11 Bloodborne Pathogen Exposure Control Plan. To prevent future inappropriate use of disposable suture removal kits, all staff was educated to only use suture removal kits for single use and to dispose of appropriately in a sharps container. Staff will acquire a pair of scissors for non-patient care use. The Center Manager or designee will monitor use of disposable suture removal kits as part of quality assurance audits that occur quarterly.	2/24/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	316617	A. BUILDING _____ B. WING _____	R 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOVACARE REHABILITATION	**733 ROUTE 72 WEST, UNIT 15E MANAHAWKIN, NJ 08050**

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{I 000}	INITIAL COMMENTS	{I 000}		
{I 117}	PHYSICAL ENVIRONMENT CFR(s): 485.723 The building housing the organization is constructed, equipped, and maintained to protect the health and safety of patients, personnel, and the public and provides a functional, sanitary, and comfortable environment. This CONDITION is not met as evidenced by:	{I 117}		
{I 118}	SAFETY OF PATIENTS CFR(s): 485.723(a) The organization satisfies the following requirements: (1) It complies with all applicable State and local building, fire, and safety codes. (2) Permanently attached automatic fire-extinguishing systems of adequate capacity are installed in all areas of the premises considered to have special fire hazards. Fire extinguishers are conveniently located on each floor of the premises. Fire regulations are prominently posted. (3) Doorways, passageways, and stairwells negotiated by patients are of adequate width to allow for easy movement of all patients (including those on stretchers or in wheelchairs), free from obstruction at all times, and, in the case of stairwells, equipped with firmly attached handrails on at least one side.	{I 118}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 04/12/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{I 118}	Continued From page 1 (4) Lights are placed at exits and in corridors used by patients and are supported by an emergency power source. (5) A fire alarm system with local alarm capability and, where applicable, an emergency power source is functional. (6) At least two persons are on duty on the premises of the organization whenever a patient is being treated. (7) No occupancies or activities undesirable or injurious to the health and safety of patients are located in the building. This STANDARD is not met as evidenced by:	{I 118}		
{I 121}	MAINTENANCE OF EQUIPMENT/BUILDINGS/GROUNDS CFR(s): 485.723(b) The organization establishes a written preventive maintenance program to ensure that the equipment is operative and is properly calibrated, and the interior and exterior of the building are clean and orderly and maintained free of any defects which are a potential hazard to patients, personnel, and the public. This STANDARD is not met as evidenced by:	{I 121}		
{I 160}	INFECTION CONTROL CFR(s): 485.725 The organization that provides outpatient physical therapy services establishes an infection control committee of representative professional staff	{I 160}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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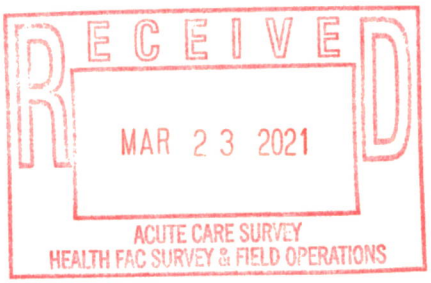
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{I 160}	Continued From page 2 with responsibility for overall infection control. All necessary housekeeping and maintenance services are provided to maintain a sanitary and comfortable environment and to help prevent the development and transmission of infection. This CONDITION is not met as evidenced by:	{I 160}		
{I 161}	INFECTION CONTROL COMMITTEE CFR(s): 485.725(a) The infection control committee establishes policies and procedures for investigating, controlling, and preventing infections in the organization and monitors staff performance to ensure that the policies and procedures are executed. This STANDARD is not met as evidenced by:	{I 161}		
{I 163}	ASEPTIC & ISOLATTION TECHNIQUES CFR(s): 485.725(b) All personnel follow written procedures for effective aseptic techniques. The procedures are reviewed annually and revised if necessary to improve them. This STANDARD is not met as evidenced by:	{I 163}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	316617	A. BUILDING _____ B. WING _____	R 03/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOVACARE REHABILITATION	**733 ROUTE 72 WEST, UNIT 15E MANAHAWKIN, NJ 08050**

(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
{I 167}	LINEN CFR(s): 485.725(d) The organization has available at all times a quantity of linen essential for proper care and comfort of patients. Linens are handled, stored, processed, and transported in such a manner as to prevent the spread of infection. This STANDARD is not met as evidenced by:	{I 167}		

NovaCare™
REHABILITATION
a Select Medical company



Shilpa Rathore, MS, RD
Survey and Certification
NJ Department of Health
Health Facility and Field Operations
PO Box 367
Trenton, NJ 08625-0367

March 18th, 2021

RE: Plan of Correction for NovaCare Rehabilitation – NovaCare Rehabilitation- Manahawkin
Provider Identification Number # 316617

Dear Ms. Rathore,

This letter is in response to the survey report resulting from a site visit conducted by the NJ Department of Health on February 23rd, 2021. At this time, the deficiencies reported are being addressed and corrected. Enclosed is our Plan of Correction, including the monitoring tools we have implemented to track and deter potential reoccurrences.

Thank you for the opportunity to provide feedback. Should you require any additional information, please do not hesitate to contact me at (609) 978-1001.

Sincerely,

Robert J Alegre, PT, DPT
Administrator / Regional Director

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	316617	A. BUILDING _____ B. WING _____	02/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOVACARE REHABILITATION	733 ROUTE 72 WEST, UNIT 15E MANAHAWKIN, NJ 08050

(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
I 000	INITIAL COMMENTS	I 000		

This was a Federal Recertification Survey conducted at NovaCare Rehabilitation at Manahawkin NJ on 2/23/2021 to determine compliance with 42 CFR Part 485, Subpart H, Outpatient Physical Therapy Services. The facility is not in compliance with the following Conditions of Participation:

I- 011: 485.709 Administrative Management

I-117: 485.723 Physical Environment

I-160: 485.725 Infection Control

During this Federal Recertification Survey, two (2) Immediate Jeopardy (IJ's) were identified:

1. IJ#1 485.725 Condition of Participation: Infection Control

a. The facility failed to ensure that single use suture kits were discarded after use.

2. IJ #2 485.723 Condition of Participation: Physical Environment.

a. The facility failed to ensure that the rear door emergency exit was unobstructed.

3. The Facility Administrator was informed of the above IJ's and provided with the IJ templates on 2/23/2021 at 3 PM.

4. A Partial Removal Plan was implemented for IJ #1 at 3:30 PM by the facility. The facility discarded the six (6) used Dynarex Suture Removal Kits at 3:30 PM.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Ronald S	R, DPT Regional Director	3/15/21

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

Plan of Correction for NovaCare Rehabilitation- Manahawkin
Medicare Rehabilitation Agency Provider # 316617

Site visit by NJ Department of Health: February 23rd, 2021

Plan of Correction Completed: March 18th, 2021 by Robert J Alegre, PT, DPT, Regional Director

(X4) ID Prefix Tag	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
I 117	PHYSICAL ENVIRONMENT CFR(s): 485.723 This CONDITION is not met as evidenced by: 1. The facility failed to ensure that emergency exits were maintained free from obstructions	1. The Center Manager enlisted a General Contractor to remove the flush mounted slide bolt on the rear exit door and repair the existing door hardware for instant use in an emergency. The Center Manager will ensure the door remains free of obstructions. This will be monitored on an annual basis during quality assurance physical inspections.	2/25/21
I117	2. The facility failed to document monthly inspections of fire extinguishers. (Cross refer to Regulation 485.723(a) Tag I-118, Part B)	2. The Center Manager has secured a licensed fire protection company to certify the fire extinguishers. The Center Manager or designee will perform monthly checks to assess the status of the extinguishers. To ensure ongoing working fire extinguishers, the Center Manager will contract the same company to return annually for certification of the extinguishers. Monthly checks and annual inspection will be monitored quarterly via completion of a quarterly audit using the Quality Assurance Audit system.	3/11/21
I117	3. The facility failed to have an eye wash available for staff use while mixing cleaning agents as required by the manufacturer's instructions for use for the treatment of accidental contact with the eyes. (Cross refer to Regulation 485.723(a) Tag 1 118, Part C)	3. The center manager has purchased portable eye wash stations which will be installed in the clinic. The stations will be checked monthly by designated staff members to ensure that supplies remain sealed for use and remain within proper expiration dates. Monthly checks will be documented using the Equipment Maintenance & Cleaning Log. The center manager will monitor completion of the monthly checks quarterly which will be documented in the Quality Assurance system.	3/15/21

I117	4. The facility failed to maintain therapy equipment clean to side and touch. (Cross refer to Regulation485.723 (b) Tag I-121, Part A)	4. The Center Manager and designated staff members have thoroughly cleaned all equipment, particularly those items identified during the initial site visit. Surfaces of patient care equipment which are in contact with patients are cleaned after each use. Non- contact surfaces of patient care equipment and treatment tables are clean on a weekly basis, or sooner if necessary, and documented on a cleaning Equipment Maintenance & Cleaning Log. The center manager will monitor completion and documentation of the weekly cleaning quarterly which will be documented in the Quality Assurance system. Equipment not currently in use has been removed from the treatment area, cleaned, and covered. In the future, the Center Manager will immediately remove any equipment from the treatment area if deemed no longer in use or not in working order until maintenance can be completed by a qualified technician.	3/8/21
I117	5. The facility failed to maintain a sanitary environment in the occupational therapy room (Cross refer to Regulation 485.723 (b) Tag I-121, Part B)	5. The occupational therapy staff have cleaned occupational therapy area and discarded all supplies past expiration date. The staff will thoroughly clean the area weekly and will examine the storage cabinets to remove unused or expired supplies and document on an Equipment Maintenance & Cleaning Log. The center manager will monitor completion of the weekly cleaning on a quarterly basis which will be documented in the Quality Assurance system.	2/24/21
I 118	SAFETY OF PATIENTS CFR(S): 485.723(a) This STANDARD is not met as evidenced by: A. The facility failed to ensure that emergency exits were maintained free from obstructions. The rear emergency exit was obstructed by the use of a flush-	The Center Manager enlisted a General Contractor to remove the flush mounted slide bolt on the rear exit door and repair the existing door hardware for instant use in an emergency. The Center Manager will ensure the door remains free of obstructions. This will be monitored on an	2/25/21

	mounted slide-bolt. The slide-bolt was found in the locked position while the building was occupied by patients and staff	annual basis during quality assurance physical inspections.	
I 118	B. The facility failed to document monthly inspections.	The Center Manager has secured a licensed fire protection company to certify the fire extinguishers. The Center Manager or designee will perform monthly checks to assess the status of the extinguishers. To ensure ongoing working fire extinguishers, the Center Manager will contract the same company to return annually for certification of the extinguishers. Monthly checks and annual inspection will be monitored quarterly via completion of a quarterly audit using the Quality Assurance Audit system.	3/11/21
I 118	C. The facility failed to have an eye wash available for staff use while mixing cleaning agents as required by the manufacturer's instructions for use for the treatment of accidental contact with the eyes. Staff do not wear gloves when handling the tablets.	The center manager has purchased portable eye wash stations which will be installed in the clinic. The stations will be checked monthly by designated staff members to ensure that supplies remain sealed for use and remain within proper expiration dates. Monthly checks will be documented using the Equipment Maintenance & Cleaning Log. The center manager will monitor completion of the monthly checks quarterly which will be documented in the Quality Assurance system. Gloves are available throughout the facility and staff have been educated in proper handling, mixing, and refilling of the cleaning materials with the use of protective gloves. The center manager will educate the staff in safety guidelines for all new sanitizing products and remind all staff to use gloves when handling sanitizing products. This education and review of glove use with sanitizing products will be occur during monthly staff meetings and documented in minutes of those meetings.	3/12/21 3/18/21
I 121	MAINTENANCE OF EQUIPMENT/ BUILDING/ GROUNDS CFR(s): 485.723 (b)		

	A. The facility failed to maintain therapy equipment clean to side and touch and maintain a sanitary environment. 1. The fluidotherapy unit had dust visible to sight and touch. (Refer to Reference #1 and #2).	Currently, the fluidotherapy machine is not in use due to COVID19 pandemic and has been removed from the patient care area, cleaned, and covered until such time that it will be safe to use. When the unit returns to operation, occupational therapy staff will be trained and then they will clean the patient sleeves on a weekly basis or sooner if necessary, and document cleaning on an Equipment Cleaning & Maintenance log. The center manager will monitor completion of the weekly cleaning on a quarterly basis which will be documented in the Quality Assurance system.	2/24/21
I 121	2. The paraffin unit had dust to sight and touch, with paraffin wax that was solidified.	Currently, the paraffin bath is not in use due to COVID19 pandemic and has been removed from the patient care area, cleaned, and covered until such time that it will be safe to use. When the unit returns to operation, staff will be trained and the paraffin bath will be emptied and cleaned by the occupational therapy staff on a quarterly basis or sooner if necessary, and documented on the Equipment Maintenance & Cleaning Log. The center manager will monitor completion of the cleaning on a quarterly basis which will be documented in the Quality Assurance system.	3/1/21
I 121	3. The hydrocollator machine had orange/ brown discoloration inside the cover and on the edges of the cover. The water in the unit was brown with a gray fluffy substance floating on the surface of the water. The temperature failed to reach the minimum temperature of 150 degrees F for all five (5) months reviewed.	The center manager will replace the hydrocollator unit for the hot packs. Staff will be trained and then will perform and document daily temperature checks and cleaning will be performed quarterly or sooner if needed, and will be documented on the Equipment Maintenance & Cleaning Log. In addition to the daily temperature checks, the heating unit will have the temperature checked 2-3 hours following the cleaning cycle. The center manager has updated the Equipment Maintenance & Cleaning Log to properly represent the manufacturer's guidelines for the current model of hot packs being used. The center manager will monitor logs for daily temperature recording and completion of the cleaning on a quarterly basis which will	4/18/21

		be documented in the Quality Assurance system.	
I 121	4. The cold pack freezer unit had heavy accumulation of ice with frozen ice packs at the bottom of the unit.	The freezer holding the cold packs has been defrosted and the inside has been cleaned in accordance with manufacturer guidelines. The cold packs in the freezer were cleaned, removing accumulated ice, and returned to the unit. Clinical staff has been trained and will defrost the freezer and wipe it clean on a quarterly basis or sooner if needed. Defrosting and cleaning will be documented in the Equipment Maintenance & Cleaning Log. The center manager will review the Equipment Maintenance & Cleaning Log on a quarterly basis which will be documented in the Quality Assurance system.	2/26/21
I 121	5. The physical therapy treatment floor had the following therapy equipment in direct contact with the floor: i. three (3) blue TheraBands were tied to the legs of the therapy tables. The TheraBands had a covering of dust and debris and were sticky to the touch. ii. Four (4) forty-five pound barbell weights placed under an equipment rack. iii. Three (3) bolsters were placed next to treatment tables.	i. TheraBand loops have been removed from table legs and discarded. New TheraBands have been put into use and will be stored on hooks and handles throughout the clinic to prevent them from being in direct contact with the floor. Staff will be educated on proper care, handling and storage of patient care equipment during the next monthly staff meeting. ii. The barbell weights were removed from the floor, wiped clean, and placed on the activity rack. Staff will be educated on proper care and handling of patient care equipment during the next monthly staff meeting. iii. The center manager purchased plastic containers and risers that have been placed throughout the clinic for which patient care equipment is placed to avoid direct contact with the floor. Staff will be educated on proper care, handling and storage of patient care equipment during the next monthly staff meeting.	3/18/21

		To ensure there is no recurrence, all clinical staff will monitor proper handling of patient care equipment and make immediate corrections when needed. All clinical staff will be responsible for performing an equipment check at the end of the day to ensure that all equipment is stored safely and properly. The center manager will regularly (at least weekly) review the status of patient care equipment storage and report any inconsistencies to the infection control committee on a quarterly basis. Instruction of proper care of patient care equipment will be provided during monthly staff meetings when new staff members are present and annually for all staff, or sooner if needed.	
I 121	6. The physical therapy area had items with visible tears: i. trampoline side cover was torn on one side exposing the interior material. ii. a rolling stool seat had a split seam in the cover, exposing the interior material.	i. A new cover for the trampoline was installed on the unit and the torn one was discarded. ii. New rolling stools have been purchased and those with ripped material have been discarded. On a monthly basis, staff will monitor the condition of patient care equipment, treatment tables, stools and chairs throughout the clinic and report any deficiencies to the center manager. Monthly checks will be documented on the Equipment Maintenance & Cleaning Log. The center manager will be responsible for timely replacement of torn or defective equipment. The center manager will review the Equipment Maintenance & Cleaning Log that includes monthly checks of equipment, tables, stools and chairs on a quarterly basis which will be documented in the Quality Assurance system; and report any significant issues to the Infection Control Committee	3/30/21
I 121	B. The cabinet behind the occupational therapy area had seventeen (17) 3.4 ounce solution bottles with an expiration date of 8/2016.	The Center Manager discarded all expired saline bottles and purchased new bottles of saline solution. The center manager reviewed with all staff the proper use and disposal of the saline solution, as well as any other patient care item that has an expiration date.	2/23/21

		The staff will thoroughly clean the area weekly and will examine the storage cabinets to remove unused or expired supplies and document on an Equipment Maintenance & Cleaning Log. The center manager will monitor completion of the weekly cleaning on a quarterly basis which will be documented in the Quality Assurance system. The center manager will report any significant findings to the infection control committee on a quarterly basis.	
I 160	INFECTION CONTROL CFR(s): 485.725 This CONDITION is not met as evidenced by: The facility failed to ensure that there is an effective infection control program to prevent the development and transmission of infection for patients receiving therapy services.		
I 160	1. The facility failed to have an infection control committee to review and monitor, the execution of policies and procedures for investigating, controlling, and preventing infections in the agency. (Cross refer to regulation 485.725 (a), Tag I 161, Part A).	The Center Manager has identified an infection control that includes staff members from the two disciplines (Physical Therapy & Occupational Therapy), front desk staff, and management. The committee will review and educate staff on any new policies and procedures regarding infection control; maintain and review a list of any issues that arise; and make recommendations for improvement as it pertains to infection control. The committee will meet quarterly, review information and report findings and activities to the Patient Care Committee. Minutes of these meetings will be incorporated into minutes of quarterly Patient Care Committee meetings and the Center Manager will post the minutes in the staff break room for access to all staff. The center manager will monitor completion of the meetings and minutes on a quarterly basis which will be documented in the Quality Assurance.	3/1/21
I 160	2. The facility failed to ensure that everyone entering the facility are provided screening to identify and isolate Coronavirus Disease 2019	The Center Manager has reeducated all staff members on the proper COVID19 screening procedures for all patients and visitors that enter the facility. Training included all	3/11/21

	(COVID-19) in accordance with the facility policy and procedures and Centers for Disease Control (CDC) guidelines. (Cross refer to regulation 485.725 (a), Tag I, 161, Part B)	screening procedures and flow chart for decisions based on screening responses. All staff were instructed that all visitors require proper and thorough screening, regardless of activity or length of stay in the center. Daily visitor screening and temperature logs will be maintained at the front desk. Patients will complete an initial COVID screening questionnaire, which will be retained in the patient's electronic medical record. Subsequent patient visit screening will be verbal and logged on the Patient Sign in Sheet. Staff were also instructed to refer to the Select Medical Portal for to the most up-to-date COVID19 guidance and procedures. The center manager will monitor visitor logs weekly to ensure compliance with the procedures. The center manager will report any significant findings to the infection control committee on a quarterly basis.	
I 160	3. The facility failed to ensure implementation of facility policy, "Blood Borne Pathogen Exposure Control Plan" to prevent wound infections. (Cross refer to Regulation 485.725 (a), Tag I 161, Part C) Staff failed to have education regarding the Blood Borne Pathogen Control policy and procedure.	All staff have completed Bloodborne Pathogen Exposure Plan training. Training is completed and recorded annually in an online training platform (Select University). All employee training records are retained on our online training platform. In addition, record of most recent training is printed for each staff member and retained within their employee file. Staff members are required to review all policies on an annual basis. Additionally, to ensure awareness related to infection control; Policy 9.10 Infection Control and Asepsis and Policy 9.11 Bloodborne Pathogen Exposure Control Plan will be reviewed at a staff meeting led by the Center Manager. Record of this meeting and attendees will be retained in a binder with record of other center staff meetings. In the future, the Center Manger will ensure all staff will complete Blood Borne Pathogen ECP training and policy review upon hire and on an annual basis by monitoring successful completion in our online learning system. To monitor understanding and compliance of these policies, the Center Manager will	3/11/21

		review content during a staff meetings annually.	
I 160	4. The facility failed to ensure use of approved Environmental Protection Agency (EPA) registered disinfectants. (Cross Refer to Regulation 485.725 (a), Tag I 161, Part D)	The center manager will compile a list of all disinfectants and cleaning solutions currently being used in the facility and verify compliance with Environmental Protection Agency standards. EPA-approved disinfectants will continue to be used in the facility for cleaning procedures. Any disinfectant that is not EPA-approved will be removed from use and discarded according to manufacturer's recommendations. Staff will be educated regarding the proper use, handling, and storage of the EPA-approved disinfectants during a staff meeting. The center manager will maintain the log for all currently approved disinfectants and SDS documents for each product in a binder, will also include manufacturer's recommendations for safe use. This binder will be stored on a shelf in the manager's office and will be accessible for all employees during operating hours. The center manager will report any changes, additions, or deletions from the disinfectant list to the infection control committee on a quarterly basis.	4/1/21
I 160	5. The facility failed to ensure that disinfectants used for patient care equipment and environmental surfaces are clearly labeled, stored, and staff educated on cleaning disinfectant cleaning contact time. (Cross Refer to Regulation 485.725 (a), tag I 161, Part E)	The center manager has labeled all generic spray bottles that are filled with a disinfectant solution. Information provided on the bottle includes the product name, fill date, and expiration date. Specific usage, including effective contact time and handling procedures will be referenced in the disinfectant list maintained in the SDS manual. Any cleaning products that reach the expiration date will be proper discarded according to manufacturer's guidelines on that day and refilled with a fresh disinfectant solution. Designated staff member will perform a daily review of disinfectant spray bottles to check for expiration dates and refill the bottles with a fresh amount of solution as necessary. The center manager will maintain the manufacturer's guidelines along with the SDS and update that list as new products are added or products are deleted.	2/24/21

		The center manager will report any significant findings and provide an updated disinfectant list to the infection control committee on a quarterly basis.	
I 160	6. The facility failed to ensure that staff maintain sterility of Dynarex Suture Removal Kits (Cross Refer to Regulation 485.725 (b), Tag I 163)	The Center Manager will ensure all suture removal kits will be appropriately disposed of after a single use per Policy 9.11 Bloodborne Pathogen Exposure Control Plan. To prevent future inappropriate use of disposable suture removal kits, all staff was educated to only use suture removal kits for single use and to dispose of appropriately in a sharps container. Staff will acquire a pair of scissors for non-patient care use. The Center Manager or designee will monitor use of disposable suture removal kits as part of quality assurance audits that occur quarterly.	3/18/21
I 160	7. The facility failed to maintain, handle and process all linens in such a manner as to prevent the spread of infection. (Cross refer to regulation 485.725(d). Tag 1 167)	The center manager has reviewed Policy 9.15 Laundry Handling with all employees to include proper handling and cleaning technique. Staff will record washing machine water temperature on a weekly basis. Any findings below 140 degree as outlined in the policy will be reported to the center manager. The center manager will be responsible for making appropriate adjustments to the hot water heater and/or contact a licensed appliance technician or plumber for repairs in order to achieve proper temperatures. The center manager has purchased and will maintain a supply of liquid bleach, which will be safely stored in the facility according to manufacturer guidelines to use when washing linens in the event the water temperature falls below 140 degrees, or if linen is contaminated. The center manager will monitor the Equipment Maintenance & Cleaning Log for documentation of washer temperature quarterly which will be documented in the Quality Assurance system.	3/18/21
I 161	INFECTION CONTROL COMMITTEE CFR(s): 485.725(a) This STANDARD is not met as evidenced by:	All staff have completed Bloodborne Pathogen Exposure Plan training. Training is completed and recorded annually in an online training platform (Select University). All employee training records are retained on our online training platform. In addition,	3/11/21

	The facility failed to ensure implementation of facility policy, "Blood Borne Pathogen Exposure Control Plan" to prevent wound infections. Findings include. Reference: The facility policy titled, "Blood Borne Pathogen Exposure Control Plan" states, "...All sterile items are used for single patient use and are disposable. 1. Employee files failed to have education regarding the Blood Borne Pathogen Control Plan policy and procedure.	record of most recent training is printed for each staff member and retained within their employee file. Staff members are required to review all policies on an annual basis. Additionally, to ensure awareness related to infection control; Policy 9.10 Infection Control and Asepsis and Policy 9.11 Bloodborne Pathogen Exposure Control Plan will be reviewed at a staff meeting led by the Center Manager. Record of this meeting and attendees will be retained in a binder with record of other center staff meetings. In the future, the Center Manger will ensure all staff will complete Blood Borne Pathogen ECP training and policy review upon hire and on an annual basis by monitoring successful completion in our online learning system. To monitor understanding and compliance of these policies, the Center Manager will review content during a staff meetings annually.	
I 161	INFECTION CONTROL COMMITTEE CFR(s): 485.725 (a) A. The facility failed to have an infection control committee to review and monitor the implementation of policies and procedures for investigating, controlling and preventing infections in the agency.	The Center Manager has identified an infection control that includes staff members from the two disciplines (Physical Therapy & Occupational Therapy), front desk staff, and management. The committee will review and educate staff on any new policies and procedures regarding infection control; maintain and review a list of any issues that arise; and make recommendations for improvement as it pertains to infection control. The committee will meet quarterly, review information and report findings and activities to the Patient Care Committee. Minutes of these meetings will be incorporated into minutes of quarterly Patient Care Committee meetings and the Center Manager will post the minutes in the staff break room for access to all staff. The center manager will monitor completion of the meetings and minutes on a quarterly basis which will be documented in the Quality Assurance.	3/1/21

I 161	B. The facility failed to ensure that everyone entering the facility are provided screening to identify and isolate Coronavirus Disease 2019 (COVID-19) in accordance with facility COVID-19 plan and Centers for Disease Control (CDC) guidelines.	The Center Manager has reeducated all staff members on the proper COVID19 screening procedures for all patients and visitors that enter the facility. Training included all screening procedures and flow chart for decisions based on screening responses. All staff were instructed that all visitors require proper and thorough screening, regardless of activity or length of stay in the center. Daily visitor screening and temperature logs will be maintained at the front desk. Patients will complete an initial COVID screening questionnaire, which will be retained in the patient's electronic medical record. Subsequent patient visit screening will be verbal and logged on the Patient Sign in Sheet. Staff were also instructed to refer to the Select Medical Portal for to the most up-to-date COVID19 guidance and procedures. The center manager will monitor visitor logs weekly to ensure compliance with the procedures. The center manager will report any significant findings to the infection control committee on a quarterly basis.	3/11/21
I 161	C. The facility failed to ensure implementation of the facility policy "Blood Borne Pathogen Exposure Control Plan" to prevent wound infections.	All staff have completed Bloodborne Pathogen Exposure Plan training. Training is completed and recorded annually in an online training platform (Select University). All employee training records are retained on our online training platform. In addition, record of most recent training is printed for each staff member and retained within their employee file. Staff members are required to review all policies on an annual basis. Additionally, to ensure awareness related to infection control; Policy 9.10 Infection Control and Asepsis and Policy 9.11 Bloodborne Pathogen Exposure Control Plan will be reviewed at a staff meeting led by the Center Manager. Record of this meeting and attendees will be retained in a binder with record of other center staff meetings. In the future, the Center Manger will ensure all staff will complete Blood Borne Pathogen ECP training and policy review upon hire and	3/11/21

		on an annual basis by monitoring successful completion in our online learning system. To monitor understanding and compliance of these policies, the Center Manager will review content during a staff meetings annually.	
I 161	D. The facility failed to ensure that facility policy and procedures are implemented by providing facility approved Environmental Protection Agency (EPA) registered disinfectants.	The center manager will compile a list of all disinfectants and cleaning solutions currently being used in the facility and verify compliance with Environmental Protection Agency standards. EPA-approved disinfectants will continue to be used in the facility for cleaning procedures. Any disinfectant that is not EPA-approved will be removed from use and discarded according to manufacturer's recommendations. Staff will be educated regarding the proper use, handling, and storage of the EPA-approved disinfectants during a staff meeting. The center manager will maintain the log for all currently approved disinfectants and SDS documents for each product in a binder, will also include manufacturer's recommendations for safe use. This binder will be stored on a shelf in the manager's office and will be accessible for all employees during operating hours. The center manager will report any changes, additions, or deletions from the disinfectant list to the infection control committee on a quarterly basis.	4/1/21
I 161	E. The facility failed to ensure that disinfectants used for patient care equipment and environmental surfaces are clearly labeled, stored, and used in accordance to manufacturer's instructions for use.	The center manager has labeled all generic spray bottles that are filled with a disinfectant solution. Information provided on the bottle includes the product name, fill date, and expiration date. Specific usage, including effective contact time and handling procedures will be referenced in the disinfectant list maintained in the SDS manual. Any cleaning products that reach the expiration date will be proper discarded according to manufacturer's guidelines on that day and refilled with a fresh disinfectant solution. Designated staff member will perform a daily review of disinfectant spray bottles to check for expiration dates and refill the bottles with a fresh amount of solution as necessary.	2/24/21

		The center manager will maintain the manufacturer's guidelines along with the SDS and update that list as new products are added or products are deleted. The center manager will report any significant findings and provide an updated disinfectant list to the infection control committee on a quarterly basis.	
I 163	ASEPTIC & ISOLATION TECHNIQUES CFR(s): 485.825(b) This STANDARD is not met as evidenced by: The facility failed to ensure that staff maintain sterility of Dynarex Suture Removal Kits.	The Center Manager will ensure all suture removal kits will be appropriately disposed of after a single use per Policy 9.11 Bloodborne Pathogen Exposure Control Plan. To prevent future inappropriate use of disposable suture removal kits, all staff was educated to only use suture removal kits for single use and to dispose of appropriately in a sharps container. Staff will acquire a pair of scissors for non-patient care use. The Center Manager or designee will monitor use of disposable suture removal kits as part of quality assurance audits that occur quarterly.	3/18/21
I 167	LINEN CFR(s): 485.725 (d) The facility failed to ensure laundry is washed in accordance with the facility policy. a) Therapy towels are laundered at the facility with laundry detergent. b) Staff do not check the water temperature to ensure the water reaches 140 degrees. c) Bleach is not used in the facility for any reason.	The center manager has reviewed Policy 9.15 Laundry Handling with all employees to include proper handling and cleaning technique. Staff will record washing machine water temperature on a weekly basis. Any findings below 140 degree as outlined in the policy will be reported to the center manager. The center manager will be responsible for making appropriate adjustments to the hot water heater and/or contact a licensed appliance technician or plumber for repairs in order to achieve proper temperatures. The center manager has purchased and will maintain a supply of liquid bleach, which will be safely stored in the facility according to manufacturer guidelines to use when washing linens in the event the water temperature falls below 140 degrees, or if linen is contaminated. The center manager will monitor the Equipment Maintenance & Cleaning Log for documentation of washer temperature quarterly which will be documented in the Quality Assurance system.	3/18/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	316617	A. BUILDING _____ B. WING _____	R 04/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NOVACARE REHABILITATION	**733 ROUTE 72 WEST, UNIT 15E MANAHAWKIN, NJ 08050**

(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
{I 000}	INITIAL COMMENTS	{I 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 04/12/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.