STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315019	A. BUILDING _____ B. WING _____	09/22/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DWELLING PLACE AT ST CLARES	**400 WEST BLACKWELL ST DOVER, NJ 07801**

(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: 09/22/21 Census: 17 Sample: 8 + 2 = 10 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	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 conducted according to §483.70(e) and following accepted national standards;	F 880		12/7/21

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

Electronically Signed | 10/11/2021

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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F 880	Continued From page 1 §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 infection.	F 880		

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F 880	Continued From page 2 §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.) maintain medication carts in a clean and sanitary manner to prevent the spread of infection, and b.) don (put on) the appropriate personal protective equipment (PPE) prior to entering a resident room that required transmission based precautions (TBP) due to a contagious infectious disease. This deficient practice was identified for 2 of 3 medication carts inspected, and 1 of 1 resident, (Resident #16) reviewed for TBP. This deficient practice was evidenced by the following: 1. On 09/19/21 at 7:46 PM, the surveyor inspected a medication cart in the presence of the Licensed Practical Nurse (LPN), who identified the medication cart as "Medication Cart #2". The surveyor observed that the interior drawers of Medication Cart #2, where medications were stored, were covered with a white substance and caked on gray debris. The surveyor interviewed the LPN at that time who stated that the white powdery substance was, "possibly pill debris." The surveyor asked the LPN how frequently the medication carts were cleaned, and the LPN stated, "I don't know. Sometimes I'll clean out the bottom of the carts where the liquids are because they spill."	F 880	1). How the corrective action will be accomplished for those residents found to have been affected by the deficient practice. a. The medication carts #2 and #3 were thoroughly cleaned using an EPA approved disinfectant on 9/20/2021. The staff member who identified that medication carts #2 and #3 had white substance and caked debris was provided re-education by the Director of Nursing regarding nursing responsibility in cleaning of medication carts on 9/21/2021. b. The Maintenance staff member who was identified in Resident #16s room without having donned the appropriate personal protective equipment (PPE) was provided re-education on Contact Precautions and appropriate PPE by RN/ Infection Preventionist on 9/21/2021. 2). How the facility will identify other residents having the potential to be affected by the same deficient practice. a. The facility recognizes that residents receiving medications stored in medication cart #2 and #3 have the	

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F 880	Continued From page 3 On 09/19/21 at 7:53 PM, the surveyor inspected a medication cart in the presence of the LPN who identified the medication cart as "Medication Cart #3". The LPN and the surveyor observed a white and gray layer of a dust like substance and debris throughout the interior of the drawers of the medication cart. The LPN stated the purpose of a clean medication cart would be to prevent cross contamination. On 09/20/21 at 12:35 PM, the surveyor performed a second inspection of Medication Cart #2 and Medication Cart #3 in the presences of the Registered Nurse (RN). The surveyor, again, observed the white and gray caked on debris scattered throughout the interior drawers of both medication carts. The surveyor interviewed the RN at that time. The RN stated that the outside, not the inside, of the medication carts, were wiped down at the end of every shift. The RN further stated that the medication carts needed "power washing" in the inside of the drawers. On 09/20/21 at 1:10 PM, the surveyor interviewed the Director of Nursing (DON) who stated that cleaning the medication carts was "on going", and was the responsibility of the nursing and housekeeping staff. The DON further added that the cleaning schedule for the medication carts consisted of the housekeeping department vacuuming the carts quarterly, and that in August the medication carts may have been cleaned with a vacuum cleaner, however, she was uncertain. The DON stated that if the nurses identified that the medication carts were dirty, they should have been cleaned as best as they could, and notified the DON. Upon surveyor inquiry,	F 880	potential to be affected by the same deficient practice, therefore the findings and corrective actions were shared with all staff to ensure compliance. b. The facility recognizes that residents on contact precautions for clostridium difficile colitis have the potential to be affected by the same deficient practice, therefore the findings and corrective actions were shared with all staff to ensure compliance. 3). What measures will be put into place or systematic changes made to ensure that the deficient practice will not recur? a. Nursing staff members were provided re-education regarding nursing responsibility in cleaning of medication carts by the Director of Nursing from 9/21/2021- 9/28/2021. Daily cleaning of the medication carts will be documented each shift by the assigned nurse on a tracking log. Thorough cleaning of the medication carts will be documented monthly by the assigned nurse on a tracking log. b. Staff members and non-clinical employees, including maintenance employees, that enter resident rooms were provided re-education on Contact Precautions and appropriate PPE by RN/ Infection Preventionist from 9/21/2021-9/28/2021. The RN/ Infection Preventionist or designee will observe a	

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F 880	Continued From page 4 the DON was unable to speak to having a specific schedule for cleaning the medication carts, and unable to provide an accountability record for the cleaning of the medication carts. 2. On 09/19/21 at 6:52 PM, the surveyor observed a sign located inside of a yellow holder attached to Resident #16's door. The sign indicated, "enhanced barrier precautions" and contained PPE. The surveyors observed that the sign, "enhanced barrier precautions" had pictures of a gowns, gloves, and a mask on it. The surveyor donned the required PPE that was displayed on the sign prior to entering the resident's room, and observed Resident #16 lying in bed with his/her eyes closed and appeared sleeping. On 09/21/21 at 10:03 AM, the surveyor observed a yellow PPE holder hanging on the door outside of Resident #16's room. The holder contained disposable PPE gowns, three sizes of gloves, and disinfectant wipes. The yellow PPE holder had a sign attached to it which indicated, "Contact Precautions. Report to Nurses' Station before you enter this room." The sign further indicated with pictures and in writing, to wear gloves, a gown, and wash hands prior to entering the resident's room. At that time, while in the hallway and having a clear unobstructed view, the surveyor observed that a maintenance staff member was inside Resident #16's room and was working on a television that was located in front of the resident's bed. The maintenance staff member was observed to be wearing an N95 mask and eye protection, and was not observed wearing a gown or gloves as the sign on the resident's door indicated was to be worn while	F 880	staff member on each shift entering a Transmission Based Precautions room per day to observe for appropriate use of PPE and document findings on a tracking log including if an opportunity for re-education is identified and what education was provided. 4). How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e., what program ill be put into place to monitor the continued effectiveness of the systemic changes? a). The Director of Nursing or designee will conduct three time a week audits of the medication carts to ensure they are maintained in clean and sanitary manner and three time a week audits of the tracking log to ensure they are completed each shift by the assigned nurse. Audits will continue three times a week for one month and then monthly for three months. Audits of the monthly thorough cleaning tracking log will be conducted monthly for three months. The Director of Nursing or designee will report their findings at the Quarterly Quality Assurance Performance Improvement (QAPI) and the Infection Control Committee. b). The RN/ Infection Preventionist or designee will conduct three time a week audits of staff members entering Transmission Based Precautions rooms on each shift and three time a week	

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F 880	Continued From page 5 inside the room. The surveyor conducted an interview with the maintenance staff member upon exiting Resident #16's room. The maintenance staff stated that he was "just working on the television", so he did not have to wear the PPE (gown and gloves). The maintenance staff member further stated that he did not know the resident was on contact precautions, he did not speak to the nurse prior to entering the resident's room, and confirmed he was educated on what PPE to wear prior to entering a resident room who was on TBP. On 09/21/21 at 10:03 AM, the surveyor interviewed Resident #16's RN. The RN stated that Resident #16 was on contact precautions for NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. [redacted]) which indicated that staff would have to wear full PPE while in the resident's room. The RN stated full PPE included gloves and a gown. On 09/21/21 at 10:09 AM, the surveyor interviewed the DON who stated that Resident #16 was on contact precautions and that the maintenance staff member did not have to wear PPE while inside of the resident's room because he was not touching the resident. The surveyor observed that the maintenance staff was in direct contact with the resident's environment. On 09/21/21 at 10:54 AM, the surveyor interviewed the Registered Nurse/Infection Preventionist (RN/IP) who stated that the facility policy indicated that "all staff were required" to don PPE prior to entering a resident's room who was on contact precautions. The RN/IP further	F 880	audits of the tracking log to ensure staff members are wearing appropriate PPE when entering Transmission Based Precaution rooms. Audits will continue three times a week for one month and then monthly for three months. The RN/ Infection Preventionist or designee will report their findings at the Quarterly Quality Assurance Performance Improvement (QAPI) and the Infection Control Committee. Any episodes of non-compliance may result in disciplinary action. Findings from Recertification Survey with Covid-19 Focused Infection Control Findings: September 22, 2021 Directed Plan of Correction Root Cause Analysis An RCA was completed on both deficiencies and findings were as follows: a). The nurse did not clean the medication cart as per policy for monthly cleaning. During the RCA/discovery period, it was learned that the nurse did not comprehend that the daily schedule along with the monthly schedule for the deep cleaning of the medication carts was a primary and needed focus for infection prevention. This resulted into more oversight and reeducation of nursing staff by nursing leadership and administrative	

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F 880	Continued From page 6 explained what "contact precautions" indicated. She stated that prior to crossing the threshold of a resident's room, who was on contact precautions, the required PPE must be worn. She stated the required PPE must be worn while touching the resident and while also having indirect contact with the resident's environment. The RN/IP further stated, "all staff wear PPE regardless, no exceptions." The surveyor reviewed the medical record for Resident #16 which revealed the following: The Admission Record reflected that the resident was admitted to the facility in the and had diagnoses which included dependence on NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. [redacted]). The admission Minimum Data Set, an assessment tool used to facilitate the management of care, dated [redacted], reflected that Resident #16 had a Brief Interview for Mental Status score of [redacted] which indicated that the resident was [redacted]. Review of a laboratory result, dated [redacted], at 10:09 AM, indicated that the resident had [redacted] present in his/her [redacted]. The September 2021 Active Physician Orders indicated a physician order, dated 09/15/21, at 10:33 AM, for Contact Isolation related to [redacted]. The Care Plan, updated 09/15/21, reflected a	F 880	leadership to decrease in infection control issues and errors. The policy was updated to include daily cleaning of the medication carts and documented each shift by the assigned nurse on a tracking log. Thorough cleaning will be scheduled and tracked monthly by the assigned nurse on a tracking log for each medication cart. Spot Checking and Medication Carts will be reviewed by Director of Nursing or designee on a weekly basis for the first month, biweekly for two months and then monthly continuously. b). The maintenance staff did not comprehend PPE education and protocol. The maintenance team member proposed that due to the fact that he was not completing patient care and was not in the clinical vicinity of the resident, full PPE was not a requirement. The maintenance staff member, along with the maintenance department was fully educated on the need to follow all infection control guidelines and preventive measures per policy to reduce the spread of infections. Yearly competency for maintenance staff will included these in-services with return demonstration for appropriate PPE based on the infective agent. c). All DPOC assigned education and in-service was completed as follows: Frontline staff completed the following: Frontline staff includes: All Nurses, Certified Nursing Assistants,	

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F 880	Continued From page 7 problem area that the resident was positive for c[NJAC 8:4]. The goal of the resident's CP indicated that the [NJAC 8:43E-2.1 and Exec Order 26, 4. b, 1.] would resolve with [NJAC 8:43E-2.1 and E] treatment. The interventions for the resident's CP included to start the resident on [NJAC 8:43E-2.1 and E] treatment and contact precautions. Review of the facility's [NJAC 8:43E-] Infection Control Policy and Procedure revised 06/16/21 indicated, "It has firmly established that person to person transmission can occur in the hospital setting and indeed major outbreaks have resulted. Staff hands are the most important mode of transmission, but studies have also demonstrated that [NJAC 8:43E-2.1 and E], as a spore forming organism, can survive for long periods of time in the environment and on contaminated equipment. The facility's [NJAC 8:43E-] Infection Control Policy and Procedure further indicated that gowns and gloves were required when entering a resident's room who was placed on contact precautions for [NJAC 8:43E-] Review of the maintenance staff members education transcript dated 09/22/21 through 09/21/21 indicated that the maintenance staff member was educated on contact precautions and that barriers such as a gown and gloves were required to be worn when in direct contact with the resident and environmental surfaces. NJAC 8:39-27.1(a)	F 880	Housekeeping, Physical Therapy, Occupational Therapy, Speech Language Pathologist, Respiratory Therapy, Activities, Dietary, Licensed Social Worker,MDS CDC Covid-19 Prevention Messages for Front Line Long-Term Care Staff: Keep COVID 19 out! CDC Covid-19 Prevention Messages for Front Line Long-Term Staff: Sparking Surfaces YouTube Videos Module 6B □ Principles of Transmission based Precautions: CDC Train Module 11B □ Environmental Cleaning and Disinfection: CDC Train Maintenance Staff Completed: All Maintenance Staff/Plant Engineers CDC Covid-19 Prevention Messages for Front Line Long-Term Care Staff: Use PPE Correctly for Covid-19: You Tube Video Module 6B □ Principles of Transmission based Precautions: CDC Train Module 11B □ Environmental Cleaning and Disinfection: CDC Train Topline Staff Completed: This includes: Administrator x two:(outgoing and incoming), Director of Nursing, Infection Preventionists, Chief Operating Officer, Director of Quality and Performance Improvement, Director of Rehabilitation Services and Sports Medicine, CDC Covid-19 Prevention Messages for Front Line Long-Term Care Staff: Keep Covid-19 Out!:	

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F 880	Continued From page 8	F 880	YouTube Video CDC Covid-19 Prevention Messages for Front Line Long-Term Care Staff: Sparking Surfaces: YouTube Video CDC Covid-19 Prevention Messages for Front Line Long-Term Care Staff: Use PPE Correctly for Covid-19 YouTube Video Module 1 □ Infection Prevention & Control Program: CDC Train Module 5 - Outbreaks: CDC Train Module 6B □ Principles of Transmission based Precautions: CDC Train Module 11B □ Environmental Cleaning and Disinfection	

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)
315019		12/22/2021

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
DWELLING PLACE AT ST CLARES	400 WEST BLACKWELL ST DOVER, NJ 07801

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 12/07/2021	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
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
9/22/2021	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO