STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315463	A. BUILDING _____ B. WING _____	C 07/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILLS POST ACUTE MATAWAN	**38 FRENEAU AVENUE MATAWAN, NJ 07747**

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F 000	INITIAL COMMENTS	F 000		

NJ00165644

Survey Date: 07/18/23

Census: 101

Sample: 3

A Complaint Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this complaint survey.

The following immediate jeopardy (IJ) situation was identified during this survey:

F 880 L

The facility failed to:

Follow the Centers for Disease Control and Prevention (CDC) guidance related to infection control practices for the Personal Protective Equipment (PPE) to be worn to reduce or prevent the spread of infection, and follow facility posted signage for PPE to be worn in resident rooms on transmission-based precautions.

The IJ situation was identified during an onsite survey and the facility was notified of the IJ situation on 07/14/23 at 3:09 PM.

The facility submitted an acceptable removal plan on 0717/23 at 3:47 PM.

The survey team verified the removal plan was implemented on 07/18/23 at 10:19 AM.

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

Electronically Signed | 08/01/2023

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 835 SS=F	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of medical records and review of facility provided documents, it was determined that the facility Licensed Nursing Home Administrator (LNHA) failed to ensure the Infection Control Program was effectively implemented to prevent the spread of infection during an outbreak of Multidrug-Resistance Organisms (MDRO) of Carbapenem-resistant Acinetobacter baumannii Ex.Order 26.4(b)(1) bacteria resistant to nearly all antibiotics and difficult to remove from the environment) and Ex.Order 26.4(b)(1) - a dangerous fungus that can be difficult to identify and treat). This deficient practice was evidenced by the following: Refer to 880L A review of the facility provided, Administrator Job Description, updated 05/23, revealed duties and responsibilities that included but were not limited to: Plans, develops, organizes, implements, evaluates, and directs the overall operation of the facility as well as its programs and activities, in accordance with state and federal laws and regulations. Leads and coordinates ... ...management team meetings to discuss priorities and develop solutions ... ...such as clinical health ...	F 835	1. Corrective actions for residents found to be affected. • No residents were affected. Review of the complete surveillance line listing, with the NJ DOH CDS, determined that there are no active infections- all cases are colonized. 2. Identify other residents having the potential to be affected. • All residents have the potential to be affected. 3. Measures put in place, Ex.Order 26.4(b)(1) changes. • The Administrator's job description and responsibilities were reviewed with him by the consultant Administrator. • All information pertaining to MDRO cases involved in the outbreak were reviewed by the Administrator, Director of Nursing, Regional Nurses, and Infection Preventionist. This information was used to create a surveillance line listing for each MDRO (Ex.Order 26.4(b)(1)). The line listing was reviewed with the NJ DOH CDS and local health department. • The line listing was put into a shared folder that is accessible by the Administrator, Director of Nursing, Infection Preventionist and Regional	8/8/23

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F 835	Continued From page 2 Knows and understands general nursing practices and procedures. Ensures delivery of compassionate quality care and services .....as evidenced by adequate, and competent facility staff .... Identified and collaborates .....to identify opportunities for enhanced services to the residents and/or resolve issues. Performs rounds to observe residents and ensure overall needs are being met. Communicates directly with residents, medical and nursing staff, family members, department heads .....to coordinate care and services. Follows established infection control policies and procedures. On 7/14/23 at 9:10 AM, during an interview with the surveyors, the LNHA stated that the facility was currrently in an outbreak of Ex Order 26. 4B1 that began in January 2023. The survey team requested the ongoing facility line listing (an infection surveillance document that contains the incidence and prevalence of infection cases during an identified outbreak and includes the origination date of the outbreak). On 07/14/23 at 12:07 PM, the LNHA provided the survey team with the Current Isolation/Precautions list (CPL) which documented 12 residents names. The CPL failed to document the onset date of all of the infections and also failed to identify if any residents had been removed from isolation. The LNHA stated the CPLwas the facility's line listing (LL). On 07/14/23 at 12:30 PM, the LNHA provided a second CPL which documented the first "onset" of Ex Order 26. 4B dated as 03/10/23 and failed to identify the onset of one of the listed residents who had	F 835	Nurse. • The Administrator is copied on all correspondence between the IP and NJ DOH CDS including test results from ongoing surveillance. • The IP distributes to facility management daily a listing of all residents on transmission-based precautions that includes onset date and the specific organisms necessitating the precautions. • The Administrator reviewed the job description and responsibilities with the Infection Preventionist. 4. Monitoring • The Administrator or designee will audit the surveillance line listing weekly, comparing it to any new surveillance testing results, to ensure it has been updated accordingly, for 3 months. Findings will be reported to the Regional Nurse or designee, and the QAPI committee, which meets quarterly and as needed. • The Infection Preventionist will report at the daily clinical meeting on any new cases of MDRO. • The Regional Nurse will audit the surveillance line listing weekly for 3 months to ensure all information is completed and updated. Findings will be reported to the Administrator and the QAPI committee, which meets quarterly and as needed. • A directed plan of correction was mandated and completed.	

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F 835	Continued From page 3	F 835		

Ex Order 26. 4B1 [redacted] in the [redacted]. When questioned, the LNHA confirmed the outbreak of [redacted] began in January 2023. The LNHA stated the Infection Preventionist Registered Nurse (IP RN) was on vacation and unavailable, and that he also had an IP certification and had been working together with the Assistant Director of Nursing (ADON) in the interim.

On 07/14/23 at 1:35 PM, the LNHA provided the survey team with a new titled document, the Surveillance Line List (SLL). The SLL included 11 residents names. The SLL failed to document an onset date for all 11 residents, if the infection was facility acquired (fa) or community acquired (ca), date of specimen collection, and any symptom reduction dated as the columns were blank.

On 07/17/23 at 9:09 AM, the ADON provided a third CPL which now listed 12 residents names, and differed from the SLL that had been provided on 07/14/23. The CPL again documented the first onset of [redacted] as 03/10/23 and failed to document if any residents have been taken off of isolation.

On 07/17/23 at 9:45 AM, the LNHA provided a SLL with 13 residents (two additional) names listed and was incomplete. The SLL failed to document all, but one, onset date, if the infection was fa or ca, all specimen collection dates, and any symptom reduction dates.

On 07/18/23 at 8:52 AM, the LNHA provided a third SLL which now listed 19 residents names. The third SLL failed to document all, but three, infection onset dates, if the infection was fa or ca,

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F 835	Continued From page 4 and any symptom reduction dates. On 07/18/23 at 9:26 AM, the Regional Nurse (RN) provided a fourth SLL which now listed 14 residents names. The fourth SLL failed to document all, but three, infection onset dates and symptom reduction dates. On 07/18/23 at 9:30 AM, the same RN provided a fifth SLL which now listed 11 residents names. The fifth SLL documented a different fa/ca status on one resident, failed to document all, but two, onset dates and symptom reduction dates. On 07/18/23 at 10:10 AM, the same RN provided a sixth and final SLL which now listed 19 resident names and differed from the list she had provided at 9:30 AM. The sixth SLL documented changes in the fa/ca status on two residents, and remained incomplete by not documenting all, but two, onset dates and any symptom reduction dates. On 07/18/23 at 8:29 AM, the IP RN had returned and stated to the survey team that there were three in house acquired Ex Order 26. 4B1 cases. The IP RN further stated he was responsible for completing the facility line listing. The IP RN confirmed he had not conducted any investigations regarding the increasing outbreak of Ex Order 26. 4B1 and had not alerted the local health department of the current outbreak. On 07/18/23 at 8:50 AM, during an interview with Surveyor #1, the LNHA stated he "only found out on 7/14/23", when the surveyors brought it to his attention, that the SLL was not being completed. The LNHA stated that the line listing was to ensure infections were being tracked, and for information such as where an infection was	F 835		

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F 835	Continued From page 5	F 835		

acquired. The LNHA stated if there were in house infections, a MDRO investigation along with contact tracing should be completed to try to identify any common factors. The LNHA stated that the IP RN would report to the Director of Nursing and the LNHA. When asked if he had ever reviewed the line listing, the LNHA replied, "no, I did not review it." The survey team requested the communication documentation with any either the state or local department of health.

On 07/18/23 at 8:57 AM, Surveyor #2 interviewed the LNHA, in the presence of the survey team and in the presence of two Regional Registered Nurses (RRN) and a Regional Administrator. Surveyor #2 asked the Regional Administrator, and two RRNs if they were aware that a SLL was not being completed, and all three confirmed they were unaware.

On 7/18/23, the day of exit, the survey team was provided with email communications between the LNHA and the State Department of Health Epidemiology (DOHE). The first dated email, 01/5/23, was sent from DOHE to the LNHA regarding a facility resident who had tested [redacted] for [redacted] on 12/25/22. The email also included a line list template for the facility to utilize and infection prevention and control recommendations.

An email dated 01/9/23, from DOHE to the LNHA was an inquiry about a resident and if that resident was at the facility the end of November or beginning of December 2022. The email informed the LNHA that a resident tested [redacted] for [redacted] at the hospital on [redacted].

A review of the Surveillance Line List provided on

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F 835	Continued From page 6 07/18/23 at 9:26 AM, confirmed the resident in question had been a resident at the facility since [redacted] and had been admitted to the [redacted] on [redacted] from the facility. The SLL further revealed that the [redacted] was "FA" for facility acquired. This was the first time that resident was documented on the facility provided line listing as FA. The last line listing provided at 10:10 AM, had the resident status documented as "CA" for community acquired, which was incorrect. An email dated 01/17/23, from DOHE to the LNHA was a follow up regarding the above-mentioned resident who had been at the facility. The email went on to reveal that [redacted] "is of high concern both to the CDC and the [State] Department of Health and considered to be an urgent threat due to the very limited available treatment options for infected patients. ....that the resistant gene (of [redacted]) is a very environmentally hardy organism capable of persisting in the environment for up to several months." A review of the facility provided, "Infection Prevention and Control Program", undated, included but was not limited to; Policy: an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the transmission of communicable diseases and infections. Policy Explanation and Compliance Guidelines: 2. All staff are responsible for following all policies and procedures related to the program. 16. Staff Education: a. all staff shall receive training, regarding the facility's infection prevention and control program. A review of the facility provided, "MDRO Infection"	F 835		

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F 835	Continued From page 7	F 835		

policy, undated, included but was not limited to; Policy: implement facility-wide strategies for preventing the spread of infections with MDRO. MDROs are bacteria and other microorganisms that have developed resistance to one or more classes of antimicrobial drugs. Infections with MDRO are difficult to treat and are associated with increased mortality rates. Policy Explanation and Compliance Guidelines: 2. Information related to a resident with known MDRO will be communicated: d. report to IP for surveillance and other infection prevention and control activities, including the reporting to the local and state health department as indicated. 6. Active surveillance cultures for MDRO colonization will not be performed routinely. They may be performed when the facility implements intensified MDRO control efforts: b. when the incidence or prevalence of a particular MDRO is elevated despite the use of routine control measures, or c. the facility experiences an outbreak of an MDRO. 7. Additional efforts may be implemented as needed, after additional surveillance. Ex: b. evaluating facility systems, such as training, available resources, and performance monitoring, that may be contributing to the problem. c. additional individual or departmental education. f. increase frequency or intensity of surveillance activities. 14. Care related for [redacted]: c. the organisms are spread by direct contact. 15. Care considerations for [redacted]: d. it is spread by direct contact.

According to the CDC, [redacted] poses a serious threat to public health. Infections with [redacted] are difficult to treat and have been associated with mortality (death) rates of up to 50% for hospitalized residents. Healthcare facilities should recognize these organisms as important to

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F 835	Continued From page 8 patient safety and adhere to public health guidance for detection, tracking and reporting. Ensure that the facility has a policy in place to alert clinical and infection prevention staff when the infection is identified.	F 835		
F 880 SS=L	NJAC 8:39-9.2(a), 19.4(a)(d)(e)(f)(g)(n) 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; §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	F 880		8/8/23

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F 880	Continued From page 9 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. §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: Complaint NJ #165644	F 880	1. Corrective action for residents found	

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F 880	Continued From page 10 Part A Based on observation, interview, record review, and review of documentation, it was determined that the facility, who has been in an active outbreak of the multi- drug resistant organism (MDRO) of *Ex Order 26. 4B1* [redacted] and *Ex Order 26. 4B1* [redacted] since 01/2023, failed to: 1) follow the Centers for Disease Control (CDC) guidance related to infection control practices for the Personal Protective Equipment (PPE) to be worn to reduce or prevent the spread of infection, and 2.) follow facility posted signage for PPE to be worn. This deficient practice was identified on 2 of 3 resident units, which included the *Ex Order 26. 4B1* [redacted]. The facility's system wide failure to ensure all staff followed the appropriate PPE guidelines to prevent the transmission of the MDROs posed a serious and immediate risk to the health and well-being of all residents who resided at the facility and was a public health concern for the potential transmission of the contagious potentially deadly MDRO to staff and visitors. A serious adverse outcome occurred as the identified non-compliance resulted in an Immediate Jeopardy (IJ) situation that was identified on 7/14/23 at 3:09 PM. On 7/18/23 at 10:19 AM, the survey team verified	F 880	to be affected. " No residents were affected. Review of the complete surveillance line listing, with the NJ DOH CDS, determined that there are no active infections- all cases are colonized. There have been no deaths or active infections attributed to the MDROs. 2. Identify other residents having the potential to be affected. " All residents have the potential to be affected. 3. Measures put in place, systemic changes " NA #1 was removed from patient care and re-educated immediately. " NA #2 was educated on *Ex Order 26. 4B1* [redacted] and *Ex Order 26. 4B1* and required precautions for both. " NA #3 was educated on Hand Hygiene and donning and doffing PPE. " CNA #1 was educated on Hand Hygiene and donning and doffing PPE. " RT was educated on donning and doffing PPE. " NA #2 was educated on donning and doffing PPE. " LPN #3 was educated on signs and symptoms to monitor for regarding *Ex Order 26. 4B1* and *Ex Order 26. 4B1*. " All staff were educated on MDRO, including *Ex Order 26. 4B1* and *Ex Order 26. 4B1*. All staff were educated on donning and doffing PPE, Transmission Based Precautions, MDRO policy, Hand Hygiene. " All information pertaining to MDRO cases involved in the outbreak were reviewed by the Administrator, Director of Nursing, Regional Nurses, and Infection	

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F 880	Continued From page 11 the removal plan to remove the immediacy was implemented. On 7/14/23 at 9:10 AM, during an interview with the surveyors, the LNHA stated that the facility was in an outbreak of Ex Order 26. 4B1 and Ex.Ord that began in January 2023. The survey team requested an ongoing line listing (a document that contains incidence and prevalence of infections) on 07/14/23 at 12:07 PM. The LNHA provided the survey team with the "Current Isolation/Precautions" list. The list included areas to document the name, room, type of isolation/precaution, reason for isolation, onset, and off isolation. The list provided failed to identify the onset date of the infections and if any residents were taken off isolation. At that time, the LNHA stated the Infection Preventionist Registered Nurse (IP RN) was on vacation and that he would print another "list". The LNHA did not reference a line listing (LL) for the infections and referred to the Current Isolation/Precaution list as the facility LL. On 07/14/23 at 12:30 PM, the LNHA provided a second list which documented the first "onset" for Ex Order 26. 4B1 as 3/10/23. The survey team questioned the LNHA about the 3/10/23 "onset" as the LNHA informed the survey team that the outbreak began in January 2023, and the LNHA then confirmed the outbreak of Ex Order 26. 4B1 began in January 2023. Reference: CDC Donning (putting on) and Doffing (removing) PPE https://www.cdc.gov/HAI/pdfs/ppe/ppeposter148.pdf The evidence was as follows: 1.) On 07/14/23 at 9:10 AM, the surveyors toured	F 880	Preventionist. This information was used to create a surveillance line listing for each MDRO *Ex Order 26. 4B1* . " The line listing was reviewed with the NJ DOH CDS and local health department. " The line listing was put into a shared folder that is accessible by the Administrator, Director of Nursing, Infection Preventionist and Regional Nurse. The Administrator is copied on all correspondence between the IP and NJ DOH CDS including test results from ongoing surveillance. " The IP distributes to facility management daily a listing of all residents on transmission-based precautions that includes onset date and the specific organisms necessitating the precautions. " The Administrator reviewed the job description and responsibilities with the Infection Preventionist. 4. Monitoring " The Administrator or designee will audit the surveillance line listing weekly, comparing it to any new surveillance testing results, to ensure it has been updated accordingly, for 3 months. Findings will be reported to the Regional Nurse or designee, and the QAPI committee, which meets quarterly and as needed. " The Infection Preventionist will report at the daily clinical meeting on any new cases of MDRO. " The Regional Nurse will audit the surveillance line listing weekly for 3 months to ensure all information is completed and updated. Findings will be	

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F 880	Continued From page 12 the first floor of the facility and observed signages posted in the hallway for COVID-19 prevention which indicated the PPE required and sequence for donning and doffing PPE. On 07/14/23 at 9:30 AM, while on the first-floor Ventilator Unit, Surveyor #1 observed a Nursing Assistant (NA) #1, through an open door and in direct sight, wearing only a surgical mask, no eye protection, no gloves, and no PPE gown were observed being worn by NA #1, and was inside a resident room at the resident's bedside. The resident was observed to be connected to a *Ex Order 26. 4B1* and the NA #1 was in close proximity and was communicating with the resident. The Surveyor #1 observed signage posted directly outside of the resident room which indicated Contact Precautions and Droplet Precautions. The Contact Precautions sign indicated "EVERYONE MUST:" clean their hands, including before entering and when leaving the room; put on gloves before room entry. Discard gloves before room exit; put on gown before room entry. Discard gown before room exit; do not wear the same gown and gloves for the care of more than one person; use dedicated or disposable equipment. Clean and disinfect reusable equipment before use on another person. The Droplet Precautions sign with a RED stop sign indicated "EVERYONE MUST:" clean their hands, including before entering and when leaving the room; make sure their eyes, nose and mouth are fully covered before room entry; remove face protection before room exit. Surveyor #1 observed NA #1 positioned on the left side of the bed, adjusting the bed linen while interacting with Resident #1 who was lying in bed. NA #1 then using her bare hand, reached into a	F 880	reported to the Administrator and the QAPI committee, which meets quarterly and as needed. " The Director of Nursing or designee will observe donning and doffing of PPE on 5 employees weekly for 3 months. Findings will be reported to the Administrator and QAPI committee which meets quarterly and as needed. " The director of nursing or designee will interview 5 employees weekly for 3 months on signs and symptoms of MDRO infection, transmission-based precautions and PPE usage. Findings will be reported to the Administrator and QAPI committee which meets quarterly and as needed. " A directed plan of correction was mandated and completed.	

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F 880	Continued From page 13 cardboard glove box, then retrieved a single glove but did not don (put on) the glove and proceeded to use the glove to pick up and remove a soiled tissue that was observed to be directly rested on the resident's bed. NA #1 placed the glove and soiled tissue in the garbage can inside the resident room, and then without first performing hand hygiene or washing her hands, proceeded to exit the room wearing the same surgical mask. NA #1 was observed to begin walking in the hallway when Surveyor #1 asked her to stop. At that time, a PPE bin with supplies was observed as being easily accessible outside of the resident's room. NA #1 was not wearing the PPE (gown, gloves, or eye protection) as indicated by the signage posted at the entrance door. The signage indicated, "Contact and Droplets Precautions" and instructed to perform hand hygiene, wear a surgical mask, gown, and gloves prior to entering and exiting the room. On 07/14/23 at 9:35 AM, Surveyor #1 attempted to interview NA #1 regarding infection control prevention. NA #1 attempted to exit down the hallway away from the surveyor, and the surveyor asked her to stay present. The NA #1 refused to provide the surveyor with her name and was not wearing a name tag. NA #1 then informed Surveyor #1 that she went to school to become a Certified Nursing Assistant but had not taken the certification test yet. NA #1 could not elaborate on the rationale for not wearing the proper PPE, or for not performing hand hygiene prior to entering and exiting the isolation room. Surveyor #1 then asked NA #1 to elaborate on her failure to follow the posted signage and the significance of the signage noted at the entrance door. NA #1 was	F 880		

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unable to communicate with the surveyor and appeared to have a language barrier. NA #1, then without first performing hand hygiene, reached into her pocket for her cell phone and proceeded to call another staff member.

Another surveyor was also present in the hallway during Surveyor #1's observations and confirmed NA #1 was inside the [redacted] room wearing only a surgical mask. Surveyor #2 summoned the charge nurse to the hallway where the charge nurse also observed that NA #1 was inside of the [redacted] room without wearing the proper PPE. The charge nurse then communicated to NA #1, in her native language, that she should have on a PPE gown and gloves prior to entering the room. The Assistant Director of Nursing (ADON) was also present on the first-floor [redacted] and was made aware of the incident.

At that time, the ADON stated that staff were provided PPE and were aware to don and doff (remove) the PPE. The ADON further stated that the purpose of the PPE was to contain infection and not spread any infections. The ADON stated that NA #1 was now "contaminated" and then escorted the NA to the ADON's office. The ADON stated that the NA needed to be reeducated and NA #1 was assigned seven residents to care for on her assignment. Four of the seven residents were on Contact and Droplet precautions for [redacted] and [redacted], and one resident was also on contact isolation for [redacted].

A review of Resident #1's medical records revealed an Admission Record which indicated Resident #1 had been admitted to the facility on [redacted], with diagnoses which included but were

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F 880	Continued From page 15 not limited to; Ex Order 26. 4B1 [redacted]. A review of the Order Summary Report revealed a physician's phone order dated 06/21/23, for transmission-based precautions: contact and droplet precautions for Ex Order 26. 4B1 [redacted] in the [redacted]. A review of Resident #1's on-going care plan included a focus area of contact and droplet isolation precautions secondary to [redacted] and [redacted]. Interventions included but were not limited to; place PPE /isolation station at entrance of room, and signage on door. A review of the Admission Minimum Data Set (MDS -an assessment tool to facilitate care) dated 5/17/23, revealed a Brief Mental Status (BIMS) score of [redacted]/15 which indicated Ex Order 26. 4B1 [redacted]. On 07/14/23 at 9:38 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) #1 assigned to the Ventilator Unit. She stated that out of the 16 residents, 9 residents were [redacted] for [redacted] and [redacted]. Surveyor #1 then inquired what the process was prior to entering any [redacted] room. LPN #1 stated that staff were to observe and follow the signage at the entrance of the resident's door. LPN #1 stated that prior to entering the room, all staff "must don gloves and a PPE gown." Staff were to follow the sequence for PPE removal and perform hand hygiene prior to exiting the room. LPN #1 stated that the IP RN placed the signage at the door to indicate the types of [redacted] and the PPE required. On 07/14/23 at 12:15 PM, the surveyor interviewed NA #2 assigned to the Ventilator Unit. NA #2 stated that during orientation he was educated on donning and doffing and hand hygiene. NA #2 stated he was not educated on Ex Order 26. 4B1 infection precautions.	F 880		

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F 880	Continued From page 16 On 07/14/23 at 10:13 AM, Surveyor #1 toured the 2nd floor unit (Long-Term Care) and observed a NA #3 exiting a resident's room (Room [redacted]) wearing gloves and entering another resident room (Room [redacted]). LPN #2 was observed at the medication cart in the same hallway. An interview with NA #3 revealed that he was assisting the resident to the bathroom, and he heard a noise. He exited the room to ensure the other resident who occupied Room [redacted] was safe. He acknowledged he omitted to remove his contaminated gloves and disinfect his hands prior to exiting the room. Surveyor #1 observed NA #3 remove the soiled gloves and don another set of gloves while in the hallway. NA #3 then returned to Room [redacted] to attend to the resident who was noted sitting in the bathroom. On 07/14/21 at 10:21 AM, the surveyor continued the tour of the second floor and observed a Certified Nursing Assistant (CNA) #1 wearing gloves in the hallway and was assisting a resident in a [redacted]. When the CNA #1 noticed the surveyor, she left the resident in the hallway and returned to the room. Surveyor #1 followed CNA #1 into the room and then observed CNA #1 remove her soiled gloves and don another pair of gloves without first performing hand hygiene. During an interview with Surveyor #1, CNA #1 stated that she forgot to remove the soiled gloves prior to exiting the room. The CNA stated that she had been working at the facility as a CNA for 5 years and acknowledged that she had been educated on infection control practices and PPE. On 07/14/23 at 10:30 AM, Surveyor #1 observed NA #3 performing hand hygiene with soap and	F 880		

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F 880	Continued From page 17 water. The NA wet his hands and proceeded to apply friction without applying soap. NA #3 then applied soap and washed his hands for 6.78 seconds. On 07/14/23 at 11:05 AM, Surveyor #1 conducted an interview with the ADON who was also identified as the nurse educator. The surveyor discussed the above concerns with the ADON. The ADON stated that staff should not be wearing gloves in the common areas, and she would need to reeducate both staff on infection control. 2.) On 7/14/23 at 9:26 AM, Surveyor #2 observed room [redacted] with signage on the door for Contact Precautions and Droplet Precautions. The Contact Precautions sign indicated "EVERYONE MUST:" clean their hands, including before entering and when leaving the room; put on gloves before room entry. Discard gloves before room exit; put on gown before room entry. Discard gown before room exit; do not wear the same gown and gloves for the care of more than one person; use dedicated or disposable equipment. Clean and disinfect reusable equipment before use on another person. The Droplet Precautions sign indicated "EVERYONE MUST:" clean their hands, including before entering and when leaving the room; make sure their eyes, nose and mouth are fully covered before room entry; remove face protection before room exit. Surveyor #2 observed a staff member inside the room wearing a surgical mask, eye protection, gloves, and a PPE gown which was not secured in the back and flowing freely. Surveyor #2 observed the staff member directly next to the resident in door bed (Resident #2).	F 880		

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F 880	Continued From page 18 On 7/14/23 at 9:29 AM, during an interview with Surveyor #2, the staff member identified himself as the lead Respiratory Therapist (RT). The RT was unable to say what either resident required isolation precautions for. The RT stated he had been trained on the use of PPE and that PPE was intended to protect the residents. The RT acknowledged that his PPE gown had not been secured in the back and stated, "Oh yeah that should be tied." A review of Resident #2's medical records included an Admission Record which indicated Resident #2 had been admitted Ex Order 26. 4B1, with diagnoses which included but were not limited to; Ex Order 26. 4B1 A review of the Order Summary Report revealed a physician's telephone order dated 7/14/23, for transmission-based precautions: contact and droplet precautions for Ex Order 26. 4B1 in the Ex Order 26. 4B1 6/17/23. A review of the on-going care plan included a focus area of requires contact and droplet Ex Order 26. 4B1 secondary to the presence of Ex Order 26. 4B1 in the Ex Order 26. 4B1 with interventions that included but were not limited to; place PPE and isolation station at entrance of room and place signage on door. A review of the most recent quarterly MDS dated 7/4/23, included but was not limited to; a BIMS of Ex Or/15 which indicated Ex Order 26. 4B1 . On 7/14/23 at 10:05 AM, Surveyor #2 observed a staff member don a PPE gown but failed to tie or secure the back and the PPE gown was flowing freely. The staff member then donned gloves and had been wearing a surgical mask. The staff	F 880		

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F 880	Continued From page 19 member entered room [redacted] leaned over with his PPE gown flowing towards the floor and opened a drawer of the Resident #2 in the [redacted] Then the staff member walked to the [redacted] (Resident #3) turned, and headed toward the door. At that time, Surveyor #2 interviewed the staff member who was identified as NA #2. NA #2 stated he had been trained on washing his hands, and how to use PPE. He stated the PPE was to protect the residents and "myself" and that he intentionally did not tie the back of his PPE gown because he was just going into the room to check supplies. A review of Resident #3's medical records included an Admission Record which indicated Resident #3 had been admitted to the facility on [redacted], with diagnoses which included but were not limited to; *Ex Order 26. 4B1* [redacted] A review of the Order Summary Report revealed a physician's phone order dated 5/12/23, for contact and droplet precautions for [redacted] in the [redacted]. A review of the on-going care plan included a focus area of requires contact and droplet [redacted] secondary to the presence of *Ex Order 26. 4B1* in the [redacted] with interventions that included place PPE and isolation station at entrance of room and place signage on door. A review of the most recent quarterly MDS dated 6/22/23, included but was not limited to a BIMS which [redacted]. A review of the facility provided, "Transmission-Based (Isolation) Precautions",	F 880		

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F 880	Continued From page 20 undated, included but was not limited to Policy: to take appropriate precautions to prevent transmission of pathogens. Policy Explanation and Compliance Guidelines: 1. Apply Transmission-Based Precautions, in addition to standard precautions, to residents with known or suspected to be infected or colonized with certain infectious agents. 2. Use standard approaches, as defined by the CDC, for transmission-based precautions: airborne, contact, and droplet. The category will determine the type of PPE to be used. 7. b. nursing staff receive training on signs and symptoms of infection, common organisms that require additional control measures, and considerations for residents colonized with infectious organisms. Recommendation for PPE included but was not limited to Contact: gloves when touching the patient's intact skin or surfaces and articles in close proximity (bed rails), Don gloves upon entry into the room. Gown when anticipating clothing will have direct contact with the patient or potentially contaminated environmental surfaces in close proximity to the patient. Don gown upon entry into the room. Droplet: gloves, gown as per standard precautions and mask upon entry into the patient room. A review of the facility provided, "Infection Prevention and Control Program", undated, included but was not limited to Policy: an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the transmission of communicable diseases and infections. Policy Explanation and Compliance Guidelines: 2. All staff are responsible for following all policies and procedures related to the program. 4. Standard Precautions: c. all staff shall use PPE according	F 880		

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F 880	Continued From page 21 to established facility policy governing the use of PPE. 5. Isolation Protocol (Transmission-Based Precautions): a. a resident with an infection or communicable disease shall be placed on transmission-based precautions as recommended by CDC guidelines. 16. Staff Education: a. all staff shall receive training, regarding the facility's infection prevention and control program. A review of the facility provided, "MDRO Infection" policy, undated, included but was not limited to Policy: implement facility-wide strategies for preventing the spread of infections with MDRO. MDROs are bacteria and other microorganisms that have developed resistance to one or more classes of antimicrobial drugs. Infections with MDRO are difficult to treat and are associated with increased mortality rates. Policy Explanation and Compliance Guidelines: 2. Information related to a resident with known MDRO will be communicated: d. report to IP for surveillance and other infection prevention and control activities, including the reporting to the local and state health department as indicated. 3. Infection Control Precautions: a. staff will use contact precautions in addition to standard precautions for residents with MDRO infection. B. signage at entry of the resident's room shall indicate "Contact Precautions" and the type of PPE that is required upon entry into the room. 6. Active surveillance cultures for MDRO colonization will not be performed routinely. They may be performed when the facility implements intensified MDRO control efforts: b. when the incidence or prevalence of a particular MDRO is elevated despite the use of routine control measures, or c. the facility experiences an outbreak of an MDRO. 7. Additional efforts may	F 880		

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F 880	Continued From page 22 be implemented as needed, after additional surveillance. Ex: b. evaluating facility systems, such as training, available resources, and performance monitoring, that may be contributing to the problem. c. additional individual or departmental education. f. increase frequency or intensity of surveillance activities. 14. Care related for Ex.Order 26.4(b): c. the organisms are spread by direct contact. 15. Care considerations for Ex.Order d. it is spread by direct contact. According to the CDC, Ex.Order 26.4(b) poses a serious threat to public health. Infections with Ex.Order 26.4(b) are difficult to treat and have been associated with mortality rates of up to 50% for hospitalized residents. Healthcare facilities should recognize these organisms as important to patient safety and adhere to public health guidance for detection, tracking and reporting. Ensure that the facility has a policy in place to alert clinical and infection prevention staff when the infection is identified. Ensure precautions are implemented Ex.Order 26.4(b)(1) colonized or infected residents. Whenever possible, place acute care patients currently or previously colonized or infected in a private room with a bathroom and dedicate noncritical equipment (e.g., stethoscope, blood pressure cuff) to Ex.Order 26.4(b) residents. The facility should have and enforce a policy for using gown and gloves when caring for residents with Ex.Order 26.4(b); have and enforce policies for healthcare personnel hand hygiene before and after contact with residents or their environment and increase emphasis on hand hygiene on a unit caring for residents with Ex.Order 26.4(b). The facility should have a system in place to assess at admission, if residents have received medical care somewhere, including other facilities.	F 880		

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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
F 880	Continued From page 23 A review of the CDC Sequence for Donning PPE included but was not limited to 1. Gown: fasten in back of neck and waist. Part B F 880 remains a deficiency at a scope and severity of an F based on the following: Based on interview and review of facility provided documents, it was determined that the facility failed to: 1) ensure a process was in place and was followed for infectious disease surveillance, and 2) all staff were educated on infection control related to the specific MDRO infections in the facility. The deficient practice affected 3 of 3 resident units and was evidenced by the following: On 7/14/23 at 9:10 AM, during an interview with the surveyors, the LNHA stated that the facility was currently in an outbreak of *Ex Order 26. 4B1* that began in January 2023. The surveyors requested an ongoing line listing and was provided with the "Current Isolation/Precautions" list. The list failed to document the onset of the infection. The LNHA stated the Infection Preventionist Registered Nurse (IP RN) was on vacation and that he would print another list. The LNHA provided a second list which started with the onset date of 3/10/23. When questioned about the 3/10/23 date, the LNHA confirmed the outbreak began and the first facility case was in January 2023. On 7/14/23 at 11:22 AM, during an interview with surveyors, the LNHA stated that the outbreak	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315463	A. BUILDING _____ B. WING _____	C 07/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILLS POST ACUTE MATAWAN	**38 FRENEAU AVENUE MATAWAN, NJ 07747**

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F 880	Continued From page 24 affected 16 of 22 residents of the Ex.Order 26.4(b)(1) [redacted] residents. The LNHA stated the facility communicated weekly with the State Department of Health (DOH) and that he "believes the local health department was aware." When asked how many of the communications or phone calls the LNHA had been involved with, the LNHA stated "not many." On 07/17/23 at 8:09 AM, the LNHA provided the surveyors with his CDC Nursing Home Infection Preventionist Training Course, dated 03/19/23, and stated he was assisting the Assistant Director of Nursing (ADON) with the Infection Preventionist duties while the IP RN was on vacation from 7/10/23 and would return 7/18/23. The LNHA also provided the proof of completion for Nursing Home Infection Preventionist Training Course for the IP RN. On 7/17/23 at 8:52 AM, during an interview with Surveyor #2, LPN #3 stated she was educated on hand hygiene, donning and doffing PPE. LPN #3 further stated that all residents were monitored for signs of infection. LPN #3 stated she was not aware of any signs or symptoms to monitor residents for regarding *Ex Order 26. 4B1*. On 7/17/23 at 9:45 AM, the LNHA stated that the facility conducted routine respiratory assessment monitoring but "nothing new" related to the Ex Order 26. 4B1 outbreak. The LNHA stated he was still unaware if the local health department had been alerted of the *Ex Order 26. 4B1* cases on the ventilator unit. When asked if the facility had an increase or decrease in Ex Order 26. 4B1, the LNHA stated "the cases were increasing." When asked if the staff had been educated on what should be monitored regarding Ex Order 26. 4B1, the LNHA stated, "I'll have to	F 880		

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	315463	A. BUILDING _____ B. WING _____	C 07/18/2023

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F 880	Continued From page 25 check. I don't know exactly." Surveyor #2 questioned if the residents who were on the assignment of NA #1 and the RT were being monitored given the observation of the breaks in infection control. The LNHA stated he was unable to provide that information to the surveyors. The LNHA then provided a census sheet for the first-floor ventilator unit with two handwritten notes documented on the bottom: 7/15 res (residents) evaluated for any change in condition. There was no documentation to indicate what the residents were specifically being monitored for, and no documentation was provided for 7/16/23. The LNHA also provided another "Respiratory Surveillance List" which listed 12 residents. The Respiratory Surveillance List included areas to document name, age, gender, if resident or staff, resident's floor, resident's room number, symptom onset date (mm/yy), *Ex Order 26. 4B1* [redacted] additional documented s/s (signs and symptoms), other s/s, *Ex Order 26. 4B1* [redacted] Only one of the 12 residents had a symptom onset date documented. All 12 residents had a type of specimen collected documented but only three of the 12 had the specimen collection date documented. When the surveyor questioned the LNHA on the blank areas, the LNHA stated, "Oh I thought it did have that." When asked about any staff education specific to *Ex Order 26. 4B1*, the LNHA stated it was covered under the MDRO policy. When asked how *Ex Order 26. 4B1* could be spread, the LNHA stated,	F 880		

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F 880	Continued From page 26 "direct contact and air". Surveyor #1 showed the LNHA the facility provided MDRO policy which revealed: Care considerations related to [redacted]: a. [redacted] is a drug-resistant strain of certain bacteria normally present in the human intestines. b. the bacteria produce enzymes that breakdown carbapenems (a class of antibiotics) and make them ineffective. c. the organisms are spread by direct contact. Care considerations related to [redacted]: a. [redacted] that has become resistant to antifungal medications commonly used to treat [redacted] infections. b. it is an emerging infectious disease (relatively new). c. it has caused bloodstream and wound infections and has been isolated from respiratory and urine specimens. d. it is spread by direct contact. The LNHA acknowledged the MDRO policy in use was incorrect and that [redacted] was also "spread in the air". On 7/18/23 at 8:14 AM, during an interview with Surveyor #3, the IP RN stated he began working as the facility IP RN on 1/31/23. The surveyor asked the IP RN what his job responsibilities included, and he stated the "main thing was to prevent any spread of infection". The IP RN stated he would also educate housekeeping staff on droplet and contact precautions and Surveyor #3 asked if chemicals could kill the [redacted] and [redacted]. The IP RN stated that "the main way to fight these infections is to wear PPE". The IP RN confirmed that infection surveillance was part of his job responsibilities and specifically to monitor MDROs. The IP RN stated that there was one case of [redacted] when he started his position and [redacted] was also prevalent in the facility. Surveyor #3 asked the IP RN what his responsibility was to control [redacted]. The IP RN stated there was no antibiotic to treat the [redacted] and the main thing	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 880	Continued From page 27 was to "stop the spread." The IP RN stated that most staff can "transmit the infection through droplet and contact" with the MDRO, and the "main way to fight infection was to wear PPE". When asked if he had contacted the local department of health for guidance, the IP RN stated, "no." He stated the Director of Nursing was responsible for that. Surveyor #3 asked the IP RN for a copy of the facility LL. The IP RN provided Surveyor #3 with a copy of the undated "Current Isolation/Precautions" list. Surveyor #3 again, requested a LL from the IP RN. The IP RN stated, "we don't have a line listing per se". The IP RN confirmed that he was not using a LL and was using the "Current Isolation/Precautions" in lieu of a LL. Surveyor #3 reviewed the "Current Isolation/Precautions" in the presence of the IP RN, which documented Name, Room Type of Isolation/Precaution, Reason for Isolation, Onset and Off Isolation. The Off Isolation section was completely blank. The document revealed thirteen names and included five residents identified with [redacted], four residents with [redacted] and [redacted], one resident with *Ex Order 26. 4B1* [redacted] *Ex Order 26. 4B1* [redacted] and three residents with *Ex Order 26. 4B1* [redacted] one resident with [redacted] and *Ex Order 26. 4B1* [redacted] Surveyor #3 asked the IP RN to clarify where the cases of [redacted] originated from since he confirmed that there was only one case in the building when he assumed the IP RN position on January 31, 2023. On 07/18/23 at 8:29 AM, The IP RN stated that there were three in house acquired [redacted] cases, and the surveyor asked the IP RN if he had conducted an investigation regarding the three	F 880		

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F 880	Continued From page 28	F 880		

new cases of [redacted]. The IP RN stated, "What do you mean, investigation" and stated that he sent the information to the state Department of Health. When asked if there was documentation regarding communication to the state Department of Health, he stated "yes" we provided then with a list. Surveyor #3 asked about any communication with the local Department of Health and he confirmed that they have not been contacted and stated he has not spoken with anyone from the county [local Department of Health] regarding the current outbreak.

On 7/18/23 at 8:50 AM, during an interview with Surveyor #2, the LNHA stated that all the documentation to support the facility's actions during the outbreak had been provided. When asked about a completed updated LL, the LNHA stated, "I have to get that." The LNHA further stated that the process was for the IP RN to send out a list to the staff of all residents on isolation. The LNHA stated he only found out on 7/14/23, when the surveyors brought it to his attention, that a line listing was not being completed. The LNHA stated that the line listing was to ensure infections were being tracked for information such as where an infection was acquired. He stated that information could show any infections spreading in house (at the facility). The LNHA stated if there were in house infections, a MDRO investigation with contact tracing should be done to try to identify any common factors. The LNHA stated that the IP RN would report to the Director of Nursing and the LNHA. When asked if he had ever reviewed the line listing, the LNHA replied, "no I did not review it" and confirmed that what the IP RN used to document the infections was not a LL and was a created list. The LNHA stated that he reached out via email to the local health

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F 880	Continued From page 29	F 880		

department on 7/17/23. The survey team requested the communication documentation with any department of health.

On 07/18/23 at 8:57 AM, surveyor #3 interviewed the LNHA in the presence of the survey team and in the presence of two Regional Registered Nurses (RRN) and a Regional Administrator. Surveyor #3 asked the LNHA when he became aware that there was no LL completed, and he stated when the current survey began. Surveyor #3 asked the LNHA if he had ever reviewed the LL, and he stated "no", he did not review it. At 9:30 AM, Surveyor #3 asked the Regional Administrator, and two RRNs if they were aware that a LL was not being completed and all three confirmed they had been unaware.

On 7/18/23, the day of exit, the survey team was provided with email communication between the LNHA and the New Jersey Department of Health Epidemiology (NJDOHE). The first dated email, 1/5/23, was sent from NJDOHE to the LNHA and a facility resident who had tested Ex Order 26. 4B1 for Ex Order on 12/25/22. The email further revealed instructions to Ex Order 26. 4B1 from the residents on the ventilator unit and that a line list template was included for the facility's use as well as infection prevention and control recommendations.
An email dated 1/9/23, from NJDOHE to the LNHA was an inquiry about a resident and if that resident was at the facility the end of November or beginning of December 2022. The email informed the LNHA that the resident, who had been at the facility at that time, had a diagnosis of Ex Order 26. 4B1 that had been collected on Ex Order 26. 4B1.

An email dated 1/17/23, from NJDOHE to the

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F 880	Continued From page 30 LNHA was a follow up regarding the above-mentioned resident who had been at the facility. The email went on to reveal that [redacted] "is of high concern both to the CDC and the New Jersey Department of Health and considered to be an urgent threat due to the very limited available treatment options for infected patients. ....that the resistant gene [redacted] is a very environmentally hardy organism capable of persisting in the environment for up to several months." NJAC 8:39-19.4(a)(d)(e)(g)	F 880		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	556200	A. BUILDING: _____ B. WING _____	C 07/18/2023

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S 000	Initial Comments Complaint # NJ00165644 The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff-to-shift ratios as mandated by the state of New Jersey for 14 of 14 day shifts. This deficient practice was evidenced by the following: Reference: New Jersey Department of Health (NJDOH) memo, dated 1/28/21, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey	S 560	1. No residents were affected. 2. All residents have the potential to be affected. 3. The facility has ongoing staff recruitment efforts that include job postings on online job sites, outreach to local nursing and CNA schools, sign on bonuses, referral bonuses. The Staffing Coordinator monitors the number of aides on each shift and the census of each unit and reports to the Administrator and Director of Nursing or their designees. The Regional Director of Recruitment educated the Administrator, Director of Nursing, and Staffing Coordinator on	8/8/23

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

Electronically Signed | 08/01/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	556200	A. BUILDING: _____ B. WING _____	C 07/18/2023

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S 560	Continued From page 1 Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 2/01/21: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. The survey team requested staffing for weeks of 06/25/2023 to 07/08/2023 for the 07/14/2023. The facility was deficient in CNA staffing for residents on 14 of 14 day shifts as follows ... -06/25/23 had 7 CNAs for 103 residents on the day shift, required 13 CNAs. -06/26/23 had 11 CNAs for 102 residents on the day shift, required 13 CNAs. -06/27/23 had 11 CNAs for 102 residents on the day shift, required 13 CNAs. -06/28/23 had 11 CNAs for 100 residents on the day shift, required 12 CNAs. -06/29/23 had 11 CNAs for 99 residents on the day shift, required 12 CNAs. -06/30/23 had 11 CNAs for 99 residents on the day shift, required 12 CNAs. -07/01/23 had 8 CNAs for 99 residents on	S 560	required staffing ratios. 4. The staffing coordinator will calculate the ratio of CNA to residents for each unit daily, for each shift. Finding will be submitted to the Administrator and Director of Nursing, and the QAPI committee which meets quarterly and as needed.	

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	556200	A. BUILDING: _____ B. WING _____	C 07/18/2023

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S 560	Continued From page 2 the day shift, required 12 CNAs. -07/02/23 had 11 CNAs for 99 residents on the day shift, required 12 CNAs. -07/03/23 had 11 CNAs for 100 residents on the day shift, required 12 CNAs. -07/04/23 had 11 CNAs for 99 residents on the day shift, required 12 CNAs. -07/05/23 had 11 CNAs for 99 residents on the day shift, required 12 CNAs. -07/06/23 had 10 CNAs for 98 residents on the day shift, required 12 CNAs. -07/07/23 had 8 CNAs for 96 residents on the day shift, required 12 CNAs. -07/08/23 had 10 CNAs for 96 residents on the day shift, required 12 CNAs. On 07/18/23 at 8:44 AM, during an interview with the surveyor, the facility Staffing Coordinator stated that he had been "instructed" that the staffing requirements were 1 CNA to every 8 residents during the day shift, 1 CNA to every 10 residents during the evening shift and 1 CNA to every 14 residents during the night shift. The Staffing Coordinator further stated that he believed the facility had been meeting the requirements.	S 560		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315463 Y1	A. Building B. Wing Y2	9/1/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILLS POST ACUTE MATAWAN	38 FRENEAU AVENUE MATAWAN, NJ 07747

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 F0835	Correction	ID Prefix F0880	Correction	ID Prefix	Correction
Reg. # 483.70	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. #	Completed
LSC	08/08/2023	LSC	08/08/2023	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
7/18/2023	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
556200 Y1	A. Building B. Wing Y2	9/1/2023 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRING HILLS POST ACUTE MATAWAN	38 FRENEAU AVENUE MATAWAN, NJ 07747

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix S0560	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 8:39-5.1(a)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	08/08/2023	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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	
7/18/2023	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO