STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315297	A. BUILDING _____ B. WING _____	05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGRIA AT THE FOUNTAINS	114 HAYES MILL ROAD ATCO, NJ 08004

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F 000	INITIAL COMMENTS Survey Date: 05/03/21 Census: 43 Sample Size: 18 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. During the Recertification Survey conducted on 05/03/21, it was determined that effective 04/28/21, the facility was found to have been in Immediate Jeopardy (IJ) for F880. On 04/28/21, the Department of Health notified the Administrator of the IJ and provided the IJ template to the Facility Administration. The facility failed to: - implement appropriate infection control practices related to the use of Personal Protective Equipment (PPE) - post appropriate transmission based precaution signage - provide the appropriate bins for PPE storage and disposal in a manner to prevent the transmission of COVID-19 On 04/29/21, the Department of Health received an acceptable removal plan for the removal of the Immediate Jeopardy. On 04/29/21, while the recertification survey was	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/20/2021

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F 000	Continued From page 1 in progress, the Department of Health verified the implementation of the Removal Plan and determined that the Immediacy of the Jeopardy could be removed effective 04/29/21. The facility continues to remain out of compliance for F880, but at a pattern with no actual harm with potential for more than minimal harm that is not immediate jeopardy.	F 000		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to	F 756		5/28/21

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F 756	Continued From page 2 be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to ensure that a rationale was provided in response to a recommendation made by the Consultant Pharmacist (CP) during the Monthly Medication Review (medication review). This deficient practice was identified for 1 of 5 residents reviewed for unnecessary medications (Residents #12) and was evidenced by the following: According to the Admission Face Sheet, Resident #12 was admitted to the facility with [redacted] On 02/10/20 at 9:30 AM, the surveyor reviewed the Consultant Pharmacist Evaluation sheet (CP/ES) for Resident #12 filed in the resident's chart. The CP/ES reflected a 03/31/21 CP notation to evaluate iron (supplement) twice daily and recommended a dosage reduction. A review of Resident #12's Physician Order Form (POS) for active orders as of [redacted] revealed a	F 756	1. The resident's physician reviewed the recommendation and provided rationale for continuing the medication as ordered. 2. All residents who have recommendations made by the Consultant Pharmacist during the monthly medication review have the potential to be affected by this practice. 3. The charge nurse or designee will review all reported irregularities with the resident's physician during his/her next scheduled visit. The charge nurse or designee will work with the physician to ensure that he/she documents in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is no change in the medication, the physician should document his or her rationale in the resident's medical record. 4. The Director of Nursing or designee will conduct monthly audits of the Consultant	

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F 756	Continued From page 3 physician order (order) dated Executive Order 26, 4.b for Executive Order 26, 4.b. A review of Resident #12's Executive Order 26, 4.b. and Executive Order 26, 4.b. Electronic Medication Administration Record (eMAR) revealed the corresponding order fo Executive Order 26, 4.b. During an interview with the surveyor on 04/30/21 at 12:40 PM, the surveyor requested all the CP reports for Resident #12 from the Director of Nursing (DON). At which time, the DON stated that she did not have any further documentation from the CP and provided the surveyor with a 12/13/20 Electronic Pharmacist Information Consultant Report. On 04/30/21 at 12:47 PM, the surveyor conducted a telephone interview with the CP representative, who stated that CP medication reviews were conducted remotely from Executive Order 26, 4.b. due to the pandemic. The CP representative further stated that she would gather the CP medication reviews for Resident #12 and email them to the surveyor. On 04/30/21 at 1:17 PM, the surveyor reviewed the 04/30/21 Custom Comments Report (CCR) provided by the CP representative. The CCR reflected a 03/31/21 CP recommendation that "More than once daily Executive Order 26, 4.b. is not recommended as it provides Executive Order 26, 4.b. Executive Order 26, 4.b. Executive Order 26, 4.b.	F 756	Pharmacist reports to identify noted irregularities and ensure that the physician documents as required. The results of these audits will be submitted to the QAPI committee, which meets on a quarterly basis, for the remainder of 2021. Based on the results of these audits, a decision will be made regarding the need for continued submission and reporting.	

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F 756	Continued From page 4	F 756		

Executive Order 26, 4.b. ."

During a follow-up interview with the surveyor on 05/03/21 at 10:40 AM, the DON stated the CP would make recommendations and the nurses would review the recommendations with the physician. The DON further said the nurse would then make a notation on the resident's Consultant Pharmacist Sheet (CP sheet) and place it in the resident's chart. The DON stated that she was aware that the nursing staff was not filing the CP sheets correctly and did not have a good filing system. The DON noted that they did not have a unit secretary on the unit and that the nurses were falling behind in their filing.

During an interview with the surveyor on 05/03/21 at 10:43 AM, the Licensed Practical Nurse (LPN #4) stated that pharmacy recommendations were faxed to the facility. The previous DON was responsible for taking care of the CP recommendations and assisting as needed. LPN #4 further stated that the CP recommendations were called into the physician and then placed in the physician's box for review on their next visit. LPN #4 noted that the CP recommendations that include medication change recommendations were called into the physician. LPN #4 stated that the physician would either give a new medication order, address it on the next visit, or not accept the CP recommendation. LPN #4 said that she would then document the physician's response in a nurse's note.

On 05/03/21 at 12:25 PM, the surveyor reviewed Resident #12's CP sheet, with the print date of Executive Order 26, 4, provided by LPN #4. The Executive Order 26, 4 CP sheet revealed the corresponding Executive Order 26, 4 CP recommendation. The surveyor observed a

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F 756	Continued From page 5 handwritten notation of "Per MD no new order at this time." The surveyor further observed that the physician signed the CP recommendation on [redacted] but did not provide a rationale for continuing the medication. A review of Resident #12's progress notes for [redacted] and [redacted] did not reveal documentation that the physician had been informed of the [redacted] recommendation from the CP. The surveyor observed that the progress notes did not reflect that the physician made a notation or provide a rationale for the [redacted] recommendation from the CP. During a follow-up interview with the surveyor on [redacted] at 1:15 PM, the DON stated that if the physician said he had no changes, he had no changes. The DON stated that most physicians did not provide a rationale for CP recommendations and that the physicians would need to be educated. The DON said no policy addressed the nursing process for following up with the CP recommendations. NJAC 8:39-29.3(a)	F 756		
F 880 SS=K	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.	F 880		8/4/21

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F 880	Continued From page 6 §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 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	F 880		

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F 880	Continued From page 7 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: Based on observation, interview, medical record review, and review of other facility documentation, it was determined that the facility failed to: a.) implement appropriate infection control practices related to hand hygiene and the use of Personal Protective Equipment (PPE); b.) post appropriate transmission-based precaution signage; and, c.) provide the appropriate bins for PPE storage and disposal in a manner to prevent the transmission of COVID-19 in accordance with the Center for Disease Control and Prevention (CDC) and New Jersey Department of Health (NJ DOH) guidelines. This deficient practice was identified for 1 of 3 units [redacted] Unit) during the Recertification survey conducted 05/03/21. The [redacted] Unit was the designated unit for Persons Under Investigations (PUI) for COVID-19.	F 880	1. All rooms that had any Person Under Investigation (PUI) for COVID-19 had proper signage placed on the doors to indicate transmission-based precautions are in place and what PPE is required prior to entrance to the room. PPE bins with available PPE were placed outside of these rooms. Staff received in-service education on the necessity and proper use of PPE when caring for any person designated as a PUI, in addition to proper hand sanitizing. Covered trash bins designated for used PPE were placed in these rooms. All visitors were required to see a nurse prior to entering the room of any person designated as a PUI. All residents of the facility and all staff who worked within the past two days were tested for the presence of COVID-19.	

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F 880	Continued From page 8 A review of the resident roster of the [redacted] unit revealed 2 of 10 residents (Residents #243 and #244) [redacted] The facility's failure on the [redacted] unit to implement the use of N95 masks, eye protection, gowns, and gloves while caring for residents, post appropriate transmission-based precaution signage designating the required PPE for staff to utilize when entering a resident's room, provide PPE bins with available PPE outside of the resident rooms and provide bins to discard the used PPE inside of the rooms exposed residents to COVID-19 infection and posed a serious and immediate threat to the safety and wellbeing of all [redacted] The facility was notified of the Immediate Jeopardy situation on 04/28/21 at 4:15 PM. On 04/29/21, the facility submitted an acceptable removal plan to the NJ DOH. On 04/29/21, while the recertification survey was in progress, the surveyors verified the implementation of the Removal Plan and determined that the Immediacy of the Jeopardy could be removed effective 04/29/21. The deficient practice was evidenced by the following: On 04/27/21 at 8:30 AM, the surveyors entered the facility and interviewed the Infection Preventionist (IP). The IP stated that the required PPE on all units ([redacted] units) was a surgical mask and that the facility was currently not in an outbreak. The IP explained that the [redacted]	F 880	2. Any resident who is an unvaccinated Person Under Investigation has the potential to be affected by this practice. 3. Consistent with the NJDOH/CDS Guidelines dated 3/25/21 titled "Considerations for Cohorting COVID-19 Patients in Post-Acute Care Facilities", the unit for people designated as a PUI was consolidated and used only for those who meet the definition of Cohort 4 - New or Re-admission Observation. Appropriate infection control practices related to hand hygiene and the use of Personal Protective Equipment (PPE) are in use, appropriate transmission-based precaution signage is in place and appropriate bins for PPE storage and disposal are used. In addition, the facility is in compliance with the Directed Plan of Correction, which includes retention of a Certified Infection Control Practitioner consultant; completion of a Root Cause Analysis that indicated that lapses occurred due to misinterpretation of guidelines, forgetfulness and noncompliance; implementation of an appropriate infection prevention and intervention plan which addresses system changes and monitoring; completion of a long-term care infection control self assessment; and directed in-service training. Topline staff and Infection Preventionist viewed Module 1, 6A and 6B; Frontline staff viewed Keep Covid-19 out; and all staff viewed Module 6A and 6B.	

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F 880	Continued From page 9 Unit was the observation or [redacted] unit where the residents were quarantined for 14 days upon admission or readmission to the facility. On 04/27/21 at 10:30 AM, the surveyor observed a dry erase board, displayed on an easel, at the entrance of the [redacted] Unit, with a hand-written notification, "Please Do Not Pass this point * Thank You." The surveyor questioned LPN #1 about the signage, and she stated, "Don't worry about that." LPN #1 did not inform the surveyor that the [redacted] Unit was the [redacted] unit or the required PPE to be utilized while on the unit. While on the [redacted] unit, the surveyor observed that all nursing staff wore only surgical masks. The surveyor did not observe transmission-based precaution signage posted to indicate the required PPE for staff to utilize when entering a room, readily available PPE supplies (masks, gown, gloves, and eye protection), or bins located inside of each room to discard the used PPE. During an interview with the surveyor on 04/28/21 at 09:08 AM, the Director of Nursing (DON) stated that the facility was comprised of three units. The [redacted] Units housed [redacted], and the required PPE for those units were surgical masks. The [redacted] Unit (observation [redacted] unit) housed [redacted] and [redacted], and the required PPE were surgical masks and gloves. The DON further stated that the facility followed the recommendations of an independent Infection Control Consultant (IC Consultant), who came to the facility sometime in [redacted] or [redacted] to complete an infection control survey. At that time, the surveyor requested a copy of the consultant's recommendations, and the facility	F 880	4. The results of the actions completed in the Directed Plan of Correction will be reported to the QAPI committee, which meets on a quarterly basis, and will be used to determine and verify ongoing compliance.	

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F 880	Continued From page 10 failed to provide the surveyors with a copy. During a follow-up interview with the surveyor on 04/28/21 at 9:28 AM, the DON confirmed that the new Executive Order 26, 4.b. residents on the Executive unit were quarantined for 14 days and required a negative COVID-19 test prior to admission. During an interview with the surveyor on 04/28/21 at 10:12 AM, the Licensed Nursing Home Administrator (LNHA) stated that the facility required a negative COVID-19 test prior to admitting a resident from the community as well as to quarantine the resident for 14 days upon admission. The LNHA stated that their process was based on what they had been doing and that the facility had an independent infection control survey with a private IC Consultant in February or Executive Order 26, 4.b.. The LNHA stated that there should be signage on the residents' doors reflecting the required PPE and indicated that it was common knowledge with the staff and the therapists. The LNHA further stated, "They know the required PPE to wear." At that time, the surveyor reviewed with the LNHA the NJ DOH "Considerations for Cohorting COVID-19 Patients in Post-Acute Care Facilities" guidance dated March 25, 2021. The LNHA stated, "I believe this is the guidance that we're following, not sure if it's the updated guidance." The surveyor inquired if new admissions/readmission residents were assessed for COVID-19 exposure prior to the resident being admitted. The LNHA stated that all residents were tested before entering the facility and required a Executive Order 26, 4.b. . The LNHA further stated, "I don't know if we ask about	F 880		

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F 880	Continued From page 11	F 880		

COVID exposure prior to the resident being admitted." At that time, the surveyor requested copies of the facility's COVID-19 policies, the IC Consultant's report, and the facility's guidance for the [redacted] unit. The facility failed to provide the requested documents.

On 04/28/21 at 8:36 AM, while on the [redacted] unit, the surveyor observed Resident #246 in a [redacted] at the doorway of his/her room [redacted] asking the Certified Nursing Assistant (CNA) #1 [redacted]. CNA #1 wheeled Resident #246 back into the resident's room wearing only a surgical mask. CNA#1's PPE did not include an N95 mask, gown, gloves, or eye protection while providing direct care to Resident #246.

The surveyor further observed CNA #1 enter the following rooms to pass out breakfast trays: room [redacted] At that time, the surveyor observed that CNA #1's PPE consisted of only a surgical mask. CNA #1's PPE did not include an N95 mask, gown, gloves, or eye protection while delivering breakfast trays to the aforementioned residents.

On 04/28/21 at 9:15 AM, while on the [redacted] unit, the surveyor observed two staff members providing [redacted] for Resident #246. Both therapists were observed wearing a surgical mask over a KN95 mask, a face shield (eye protection), and gloves but not a gown. When interviewed at that time, the Occupational Therapist stated that the PPE required on the [redacted] unit was a mask with a face shield and only gloves when touching the resident but not a

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F 880	Continued From page 12	F 880		

gown.

On 04/28/21 at 9:07 AM, while on the [redacted] unit, the surveyor observed CNA #1 feeding two residents (Residents #21 and #341) in the same room. CNA #1's PPE consisted of only a surgical mask that was positioned below the nose. When interviewed at that time, CNA #1 stated the mask should cover the nose. CNA #1's PPE did not include an N95 mask, gown, gloves, or eye protection while providing Executive Order 26, 4.b. to Residents #21 and #341.

On 04/28/21 at 9:30 AM, while on the [redacted] unit, the surveyor observed CNA #2 removing breakfast trays from several resident rooms on the [redacted] unit wearing only a surgical mask positioned below the nose. CNA #2 was not wearing an N95 mask, gown, gloves, or eye protection. When interviewed at that time, CNA #2 stated that the [redacted] housed residents with Executive Order 26, 4.b. Executive Order 26, 4.b. [redacted]. CNA #2 further said that the staff needed to wear only a surgical mask on the [redacted] Unit.

On 04/28/21 at 11:22 AM, while on the [redacted] unit, the surveyor observed Resident #246's spouse visiting in the room without wearing a mask. The surveyor further observed the mask was lying on the bed. When interviewed at that time, Resident #246's spouse stated, "Ooh," and donned the mask lying on the bed.

On 04/28/21 at 11:24 AM, while on the [redacted] unit, the surveyor observed LPN #2 at the medication cart gathering supplies to obtain a resident's Executive Order 26, 4.b. [redacted]. LPN #2 enter Resident #342's room without performing hand hygiene or

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	315297	A. BUILDING _____ B. WING _____	05/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGRIA AT THE FOUNTAINS	114 HAYES MILL ROAD ATCO, NJ 08004

(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
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donning gloves, obtained the resident's [redacted] and exited the room without performing hand hygiene. At that time, the surveyor observed that LPN #2's PPE consisted of only a surgical mask. LPN #2's PPE did not include an N95 mask, gown, gloves, or eye protection while providing direct care to Resident #342. When interviewed at that time, LPN #2 stated, "I was educated on hand hygiene but don't work here that much."

Also, at that time, during an interview with the surveyor, LPN #3 stated that hand hygiene should be performed when entering and exiting the resident's room. LPN #3 further noted that hand hygiene should be performed before obtaining a [redacted] on a resident, gloves should be worn during the procedure, and hand hygiene should be performed after finishing the procedure.

During a follow-up interview with the surveyor on 04/28/21 at 11:34 AM, the DON stated that anyone going into a [redacted] was required to wear gloves. A surgical mask and hand hygiene should be performed when entering and exiting resident's rooms. The DON further stated that an independent IC Consultant advised that a surgical mask was the only PPE required on the [redacted] unit. At that time, the surveyor requested a copy of the IC Consultant's report, and the facility failed to provide the requested report.

On 04/28/21 at 12:43 PM, the IP provided the name of the IC Consultant but was unable to provide the IC Consultant's report. The IP stated that she was not present on the date the IC Consultant was in the facility but stated that the IC Consultant did not recommend that gowns

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were to be worn on the [redacted] Unit. The surveyor requested a copy of the COVID-19 guidance that the facility followed for the [redacted] unit; The facility failed to provide the guidance.

On 05/03/21 at 11:55 AM, the survey team interviewed the LNHA, DON, and IP. The IP stated that the facility followed the guidance from the NJ DOH if they needed to cohort residents. The IP further noted that the facility followed COVID-19 infection control guidelines from the CDC, but they usually followed the NJ DOH guidelines because "they were more stringent." The IP further stated that the facility discussed all updated guidance concerning COVID-19 infection control during morning and weekly meetings, which included all upper management staff, and stated, "We make decisions as a group."

The IP further stated that the Admissions Nurse Liaison ensures that all admissions had a negative COVID-19 test 72 hours prior to admission and were housed under observation for 14 days on the [redacted] unit. The IP then stated that on the [redacted] unit, the staff were to don gowns, gloves, surgical mask, and face shield before entering a resident's room and remove the PPE upon exiting the room, disposing of the PPE in a trash can located inside the resident's room. The IP stated that staff were to wear a surgical mask and face shield in the hallway of the [redacted] Unit.

During the same interview, the DON stated that Executive Order 26, 4.b. [redacted] were placed on the [redacted] Unit on droplet precautions Executive Order 26, 4.b. [redacted] Executive Order 26, 4.b. s. The IP stated that she was unsure if the Admissions Nurse

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F 880	Continued From page 15 Liaison addressed COVID-19 exposure prior to a resident's admission. During an interview with the survey team on 05/03/21 at 12:15 PM, the Admissions Nurse Liaison stated that all residents required a negative COVID-19 test within 72 hours prior to admission. The Admissions Nurse Liaison further noted that all residents were assessed for COVID-19 exposure by reviewing and discussing the medical record with the clinical team at the hospital. The Admissions Nurse Liaison added that if a resident had any potential exposure to COVID-19, the facility would not admit the resident to the facility. On 05/03/21 at approximately 1:30 PM, the LNHA provided the surveyors with a copy of the IC Consultant's report. The LNHA stated that the report was dated 03/25/21. The LNHA provided pages 4, 5, and 6 of the IP Consultant's report to the surveyors. He stated that pages 1, 2, and 3 contained an "internal quality report" for a different area of the facility. At that time, the facility was unable to provide the surveyors with the COVID-19 guidance they were following. The surveyor reviewed pages 4, 5, and 6 of the IC Consultant's report dated 03/25/21, which revealed the following recommendations: - Institute a formal hand hygiene surveillance program. - Re-educate staff on the appropriate use of gloves for standard precautions and transmission-based precautions. - Create a policy for face shield use, cleaning and disinfection, and storage if reused. Staff members should wear eye protection when	F 880	Executive Order 26, 4.b. Executive Order 26, 4.b.	

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residents can't comply with source control mask-wearing, such as those within their dementia unit.
- Ensure that all staff is wearing appropriate masks.
- Identify exposed individuals, test, and quarantine appropriately.
The IC Consultant's report further revealed, "Recommendations include but are not limited to full enforcement of source control masking, proper use of PPE, social distancing, appropriately isolating symptomatic residents, and education regarding cleaning and disinfection."

During an interview with the survey team on 05/03/21 at 02:00 PM, the IP stated that she reviewed the 03/25/21 IC Consultant's report and that the facility was following the IC Consultant's recommendations. The IP further noted that, "this correlated with the guidance we were following."

A review of the facility's undated "Outbreak Response Plan" under the heading "Isolation and Cohorting Isolation" revealed that when the facility is in an outbreak, "Anyone entering the room will don appropriate PPE before entering, in accordance with the current guidelines from the NJDOH, CDC or CMS. Most commonly, this would be face mask, gloves, gowns, and eye protection."

A review of the facility's "Isolation- Initiating Transmission Based Precautions" policy, reviewed 04/01/21, revealed that "When Transmission-Based Precautions are implemented, the Infection Preventionist (or designee): a) Clearly identifies the type of

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precautions, the anticipated duration, and the personal protective equipment (PPE) that must be used; ... d) Determines the appropriate notification on the room entrance door and on the front of the resident's chart so that personnel and visitors are aware of the need for and type of precautions: (1) The signage informs staff of the type of CDC precaution(s), instructions for the use of PPE, and/or instructions to see a nurse before entering the room. ... e) Ensures that protective equipment (i.e., gloves, gowns, masks, etc.) is maintained outside the resident's room so that anyone entering the room can apply the appropriate equipment; ... g. Ensures that an appropriate linen barrel/hamper and waste container, with appropriate liner, are placed in or near the resident's room. 4. Transmission-Based Precautions remain in effect until the Attending Physician or Infection Preventionist discontinues them, which occurs after criteria for discontinuation are met. ... e. Restrict or ban admissions ..."

A review of the facility's "Isolation - Categories of Transmission-Based Precautions" policy, reviewed 04/01/21, revealed under the heading "Droplet Precautions" "1. In addition to Standard Precautions, implement Droplet Precautions for an individual documented or suspected to be infected with microorganisms transmitted by droplets (large-particle droplets [larger than 5 microns in size] that can be generated by the individual coughing, sneezing, talking, or by the performance of procedures such as suctioning). ... 7. Signs - The facility will implement a system to alert staff and visitors to the type of precaution the resident requires."

A review of the NJ DOH/CDS Guidelines dated

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F 880	Continued From page 18 03/24/21 titled "Updates on Covid-19 Infection Prevention & Control Recommendations" revealed "Appropriate PPE - UNCHANGED All recommended COVID-19 PPE should be worn during care of residents under quarantine, which includes the use of: - N-95 or higher-level respirator (or well-fitting facemask if a respirator is not available) - Eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face) - Gloves - Gown" A review of the facility's "Handwashing/Hand Hygiene" policy, reviewed 04/1/21, revealed to "Use an alcohol-based hand rub containing at least 62% alcohol; alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations:" - Before and after direct contact with residents - After contact with blood and bodily fluids - After contact with objects (e.g., medical equipment) in the immediate vicinity of the resident - Before and after entering isolation precaution settings - Before and after assisting a resident with meals The facility continues to remain out of compliance for F880 but at a pattern with no actual harm with potential for more than minimal harm that is not immediate jeopardy. NJAC 8:39-19.4	F 880		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315297	A. Building B. Wing	9/14/2021

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ALLEGRIA AT THE FOUNTAINS	114 HAYES MILL ROAD ATCO, NJ 08004

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 F0756 Reg. # 483.45(c)(1)(2)(4)(5) LSC	Correction Completed 05/28/2021	ID Prefix F0880 Reg. # 483.80(a)(1)(2)(4)(e)(f) LSC	Correction Completed 08/04/2021	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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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	
5/3/2021	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO