STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315061	A. BUILDING _____ B. WING _____	12/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH JERSEY EXTENDED CARE	99 MANHEIM AVENUE BRIDGETON, NJ 08302

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

STANDARD SURVEY: 12/30/21

CENSUS: 106

SAMPLE SIZE: 24

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.

It was determined that on 12/10/21, an Immediate Jeopardy (IJ) situation was identified for F835, which began on 12/03/21, and continued through 12/09/21. The facility was notified of the IJ on 12/10/21 at 12:27 PM.

The facility submitted an acceptable removal plan on 12/10/21.

The facility's Licensed Nursing Home Administrator (LNHA) failed to oversee the Infection Preventionist (IP) and Assistant Director of Nursing (ADON) to a) ensure that the facility followed their Outbreak Response Plan, b.) maintain compliance with Regulation F880, and c.) ensure the implementation of Transmission Based Precautions (TBP) in accordance with CDC guidance. This affected 11 unvaccinated residents with a known exposure to COVID-19, which are considered, according to CDC, as PUI (persons under investigation), for [redacted] units ([redacted] and [redacted] Units).

The LNHA's failure to oversee the IP and ADON posed a serious and immediate threat to the safety and wellbeing of all non-ill residents

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

Electronically Signed | 02/01/2022

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F 000	Continued From page 1 (residents who were negative for COVID-19). It was determined that on 12/09/21, an IJ situation was identified for F880, which began on 12/03/21, and continued through 12/09/21. The facility was notified of the IJ on 12/09/21 at 6:22 PM. The facility submitted an acceptable removal plan on 12/10/21. The IJ removal plan was verified as implemented during the Standard Survey on 12/10/21. The facility failed to appropriately identify residents exposed to COVID-19 as PUI for the COVID-19 virus, and as a result failed to implement TBP in a timely manner to prevent the transmission of COVID-19 for 11 of 11 residents (Resident #10, #11,# 5, #48, #51, #60, #63, #65, #73, #84, and #94) who were exposed to 4 known COVID-19 positive staff members on [redacted] nursing units ([redacted] unit and [redacted] unit) during a Standard Survey on 12/09/21. The facility's failure to identify residents exposed to COVID-19 positive staff and implement strategies to prevent the spread of COVID-19 posed a serious and immediate threat to the safety and wellbeing of all non-ill residents (residents who were negative for COVID-19). The non-compliance remained on 12/10/2021 for actual harm that is not immediate jeopardy based on the following:	F 000		
F 623 SS=D	Notice Requirements Before Transfer/Discharge	F 623		1/31/22

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F 623	Continued From page 2 CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs,	F 623		

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F 623	Continued From page 3 under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.	F 623		

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F 623	Continued From page 4 §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of other pertinent facility documentation, it was determined that the facility failed to provide written notification to a resident's Power of Attorney (POA) upon the emergency facility-initiated transfer to the hospital. This deficient practice was identified for Resident #106, [redacted] resident reviewed for hospitalizations. The deficient practice was evidenced by the following: A review of Resident #106's medical record revealed the resident was admitted to the facility with diagnoses which included but were not limited to [redacted]. A review of the admission documents revealed	F 623	F623 1. Resident #106 Power of Attorney was notified of the residents transfer to the hospital by letter on [redacted] 2. All residents have the potential to be affected by this deficient practice of failing to provide written notification to a resident□s family representative upon an emergency facility initiated transfer to the hospital. 3. The Director of Nursing (DON) will in-service all nurses and social worker regarding the appropriate procedure for emergency transferring and/or discharges of a resident with emphasis of written documentation to the family representative, contents contained within	

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F 623	Continued From page 5 that the resident's relative was the POA and signed on behalf of the resident. A review of the quarterly Minimum Data Set (MDS - an assessment tool) indicated the resident had a Brief Interview of Mental Status (BIMS) score of [redacted], which revealed the resident had [redacted]. A review of the Nurse's Notes revealed the following entries: [redacted] "Patient [redacted] Sent pt (patient) to ER (emergency room). [redacted] showed [redacted] awaiting [redacted] ([redacted] consult." [redacted] "Resident admitted to Hospital for [redacted] at 1250 AM." [redacted] Resident was found on the floor by CNA (Certified Nursing Assistant). The resident was [redacted] from [redacted] on the [redacted], and 911 was called. MD (medical doctor) notified. [redacted] "called to resident room r/t (related to) [redacted] attempts made to increase [redacted]. Resident remained [redacted], unable to obtain v/s (vital signs). 911 called, they arrived and cont. (continued) with CPR. Resident then transferred to ER." A review of the New Jersey Universal Transfer Forms included but was not limited to the POA listed on the forms dated [redacted] and [redacted] A review of the facility provided "Notice of Emergency Transfer" sheets revealed that on [redacted] and [redacted], the Long-Term Care Ombudsman office was notified via fax of Resident #106's transfers to the hospital.	F 623	the notification prior to discharge, and adequate time frame of notice. 4. The administrator or designee will monitor for one quarter completed documentation of family representative notification of all facility initiated emergency transfers. All findings will be reported to the quarterly quality assurance meeting.	

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F 623	Continued From page 6	F 623		

A review of the facility provided, "Confirmation of Telephone Notification: Bed Hold Policy" sheets revealed that on [redacted], and [redacted], the Social Worker had telephoned Resident #106's POA. The form reflected the date the POA was called, the POA's name, Resident #106's name, and that the telephone call was to confirm a telephone conversation concerning the bed hold status. The previous Social Worker signed the form.

On 12/21/21 at 12:07 PM, the survey team met with the facility administration team. The facility Regional Nurse stated that when a resident would be transferred to the hospital, the POA or resident representative would be notified with a telephone call only.

On 12/21/21 at 12:12 PM, the facility's current Social Worker stated that when a resident would be sent out to the hospital, she would call the resident representative and discuss the bed hold policy and why the resident was transferred out. The Social Worker stated this would be done verbally and that the notification to the Ombudsman would be sent via fax.

The facility was requested to provide policies and procedures. A review of the facility provided, "Bed-Holds and Returns" policy revised 3/2017, included but was not limited to that prior to transfers and therapeutic leaves, residents or resident representatives will be informed in writing of the bed-hold and return policy. There was no evidence that the POA was informed in writing.

NJAC 8:39-4.1(a)(31)(i); 5.3(c)

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F 658	Continued From page 7	F 658		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to a.) accurately transcribe a physician's order for compression stockings to the Treatment Administration Record (TAR), b.) notify the physician in a timely manner of a resident's refusal to wear [redacted], c.) accurately review and correct a monthly recapitulation of physician's orders to ensure the current physician's order for [redacted] and an [redacted] medication [redacted] were transcribed to the TAR and Medication Administration Record (MAR), and d.) ensure medications were accurately signed off in the MAR during a medication pass. This deficient practice was identified for [redacted] residents (Resident #14, #30, #37, #52, #56, #78, #100 and #103). The evidence was as follows: Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching,	F 658	F658 1. Resident #37 was educated regarding their medical condition warranting the use of [redacted]. Additional education consisted of the risks verses benefits of [redacted] application and the importance of adherence to the physician order. Due to the resident's continued refusal of application, the physician was informed and agreed to not initiate an order for the application and removal of the [redacted] to [redacted]. A nurses note was written indicating this update. The Treatment Administration Record (TAR) does not reflect the application or removal of [redacted] Resident #37 medical record was updated to reflect that the assigned physician was notified of the refusal to wear [redacted]. There was no need to initiate a new order for the [redacted] Resident #37 assigned physician was notified of the [redacted] consult updated	2/21/22

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F 658	Continued From page 8 health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling, and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist. 1. On 12/09/2021 at 10:42 AM, the surveyor observed Resident #37 sitting in a wheelchair. The resident's [redacted] were appeared to be [redacted] and he/she was not wearing [redacted]. On 12/13/2021 at 10:16 AM, the surveyor observed Resident #37 sitting in a wheelchair. The resident's [redacted] appeared to be [redacted] and he/she was not wearing [redacted]. On 12/14/2021 at 9:29 AM, the surveyor observed a staff member propelling Resident #37 in a wheelchair. The resident was not wearing [redacted]. The surveyor reviewed the medical record for Resident #37. According to the Admission Record face sheet	F 658	recommendations and hospitalization discharge orders updated recommendations with no new orders initiated. The facility [redacted] will evaluate Resident #37 to ensure the current order of [redacted] remains effective. Resident #14 two medications and one supplement were signed for by LPN #2, Resident #52 four medications and one supplement were signed for by LPN #2, Resident #78 four medications were signed for by LPN #2, Resident #100 one medication was signed for by LPN #2, Resident #103 two medications medications were signed for by LPN #2. LPN #2 was immediately in-serviced regarding the process of resident medication administration and the importance of signing after administering medication. 2. All residents have the potential to be affected by this deficient practice of failing to accurately transcribe a physician's order for [redacted] to the TAR, failing to notify the physician in a timely manner of a resident's refusal to wear [redacted], failing to accurately review and correct a monthly recapitulation of a physician's orders to ensure the current physician's order for [redacted] and an [redacted] medication are transcribed to the TAR and Medication Administration Record (MAR), and failing to ensure medications are accurately signed off in the MAR during medication administration pass.	

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F 658	Continued From page 9 (an admission summary), Resident #37 was admitted with diagnoses which included, but were not limited to: [redacted]) and [redacted] Review of the resident's Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted] included that the resident had a Brief Interview for Mental Status of [redacted] which indicated that the resident had a [redacted]. Review of the resident's Admission Nursing Evaluation dated 1[redacted], included that the resident had [redacted] to the [redacted] Review of the resident's admission Physician's Order Form (POF) dated [redacted], did not include a physician's order (PO) for [redacted] Further review of all hand-written physician orders from [redacted] to [redacted] did not include a PO for the application of [redacted] or that they had been discontinued by the physician. Review of the [redacted] TAR included an undated order to apply [redacted] to the [redacted] up to the [redacted] every morning and remove at bedtime. The order on the TAR was plotted for the nurse to apply and remove the [redacted], respectively. The TAR was signed by the nurses daily that they applied the [redacted] and removed them in accordance with this undated physician order from [redacted] to [redacted]. A nurse handwrote that the order had then been discontinued, but there was no evidence in the POF for [redacted] that reflected there was a physician's order for the	F 658	3. The DON will in-service all nurses regarding notifying assigned physicians of resident non-adherence, documentation, and discontinuation of physician orders. In-services with nurses will also consist of verifying all readmission orders upon return from the hospital and completing daily 24 hour checks. All nurses will be in-serviced regarding resident medication administration and the importance of signing after administering medications; the facility's pharmacy consultant will perform medication administration pass on nurses with adjustments to schedules as needed. All nurses will be in-serviced on the updated Admission and Readmission Policy which includes accurately prescribing treatment orders to the TAR. All nurses will be in-serviced on the updated Monthly Recap Policy and Procedure with emphasis of ensuring the physician order compliments the TAR. 4. The DON or designee will monitor for one month five resident charts weekly to ensure that all readmission orders have been accurately reconciled with the assigned physician. Additional monitoring will consist of reviewing five resident MARS and TARS for resident non-adherence and nurses notes indicated assigned physician notification weekly for one month. Five resident charts will be reviewed weekly for one month ensuring that 24 hour chart checks are performed daily and new orders are accurately transcribed, verified with the physician, and documented in the	

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F 658	Continued From page 10 [redacted] or that it had been discontinued by the physician. There was no documented evidence in the TAR that the resident had refused the [redacted]. During an interview with the surveyor on 12/14/2021 at 12:52 PM, the Licensed Practical Nurse #5 (LPN) stated that when a resident is re-admitted to the facility, new physician's orders would be obtained, and that none of the orders prior to the re-admission should be carried over to the new admission. LPN #5 then reviewed the resident's chart with the surveyor and stated that the [redacted] were not ordered on re-admission and therefore the admitting nurse should not have transcribed the [redacted] onto the TAR. On 12/20/21 at 10:02 AM, the surveyor interviewed the Assistant Director of Nursing (ADON) who stated that the physician had discontinued the [redacted] because the resident had refused to wear them and was "noncompliant." She acknowledged that it wasn't even ordered by the physician on the POF upon readmission. She stated that when the resident was readmitted to the facility, the nurse calls the Attending Physician for all orders, and the orders would be transcribed onto the POF and onto the Medication Administration Record (MAR) and TAR, respectively. She stated that if a resident were to refuse an order, the nurse would circle their initials that it was not done and indicate on the back of the MAR or TAR the reason why, such as "refused." The ADON acknowledged that there was a recapitalization error upon readmission and inaccurate documentation in the TAR but stated that it did not adversely affect the resident because the resident was "noncompliant	F 658	resident's chart. In addition, the DON or designee will evaluate three nurses per week for one month during resident medication administration pass to ensure completion of medication given as evidenced by the nurse's signature. The pharmacy consultant will perform medication administration pass monthly on two nurses per month for one quarter, ensuring that the procedure of medication administration is accurately followed. All findings will be reported to the quarterly quality assurance meeting.	

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F 658	Continued From page 11	F 658		

with it anyway."

Review of the facility's Admission and Re-Admission policy, with the review date of 01/20/21 did not address the procedure for accurately transcribing treatment orders to the TAR.

2. Review of the Resident #37's [redacted] POF pharmacy recap which included a re-admission date of [redacted], reflected that the resident had a back-dated PO for [redacted] to be applied from [redacted] every morning and removed at bedtime. The order on the [redacted] POF was dated [redacted]. However, a review of [redacted] POF did not reveal that this was ordered by the physician.

Review of the resident's [redacted] TAR included the aforementioned with a start date of [redacted] Further review of the TAR revealed that the nurses circled their initials from [redacted] through [redacted] and on the back of the TAR there were explanations of "refusal" or "refused," from [redacted] through [redacted]

Review of the resident's Nurse's Notes, from [redacted] through [redacted] revealed there was no documentation that the physician was notified of the resident's refusal to wear [redacted].

During an interview with surveyor on 12/14/2021 at 12:52 PM, LPN #5 stated that if a resident refuses a treatment, the nurse will circle his/her initials on the TAR and document the refusal on the back of the TAR. The LPN #5 further stated that if the resident refused three days in a row,

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the nurse should notify the physician.

At 1:00 PM, LPN #5 reviewed the resident's chart with the surveyor and stated that the [redacted] POF recap and [redacted] TAR should not have included a PO for [redacted], because they were not ordered when the resident was re-admitted to the facility on [redacted]. LPN #5 further stated that it was an error from the pharmacy because the recap included a previous admission date of [redacted] and at that time, there was an active order for [redacted]. Additionally, LPN #5 reviewed the TAR and the nurses' notes in the resident's chart and verified that there was no documentation that the physician was notified of the resident's refusals. LPN #5 then stated that if the nurse was unable to determine whether the physician was made aware of the refusals, the nurse should notify the physician. LPN #5 added that "sometimes" she documents when she notifies the physician of refusals.

On 12/20/21 at 10:02 AM, the surveyor interviewed the ADON who stated that the physician had discontinued the [redacted] because the resident had refused to wear them and was "noncompliant." She acknowledged that it wasn't even ordered by the physician on the POF upon readmission. She stated that when the resident was readmitted to the facility, the nurse calls the Attending Physician for all orders, and the orders would be transcribed onto the POF and onto the Medication Administration Record (MAR) and TAR, respectively. She stated that if a resident were to refuse an order, the nurse would circle their initials that it was not done and indicate on the back of the MAR or TAR the reason why, such as

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"refused." The ADON acknowledged that there was a recapitalization error upon readmission and inaccurate documentation in the TAR but stated that it did not adversely affect the resident because the resident was "noncompliant with it anyway."

Review of the facility's Refusing Treatment policy, revised 12/2016, included, "The healthcare practitioner must be notified of refusal of treatment, in a time frame determined by the resident's condition and potential serious consequences of the request."

Review of the facility's Monthly Recap Procedure policy, reviewed 08/11/2021, did not include the procedure to accurately ensure the TAR contains the current POs.

3. Further review of the Resident #37's [redacted] POF recap, which included the admission date of [redacted], revealed the resident had a PO for [redacted] milligrams (mg) orally daily and [redacted] mg orally twice daily, both dated [redacted]

Review of the resident's hand-written POs included a PO, dated [redacted], for [redacted] mg at bedtime and [redacted] mg every morning.

Review of the [redacted] MAR included the aforementioned orders from the [redacted] POF recap and revealed that the nurses signed for the [redacted] mg twice daily at 6:00 AM and 2:00 PM, but then crossed out the initials for the 2:00 PM doses. The order was then marked as "re-written" after the [redacted] 2:00 PM dose. On a subsequent page of the MAR, the Seroquel

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order was re-written as [redacted] mg orally every morning and was signed out by the nurse from [redacted] through [redacted]

During an interview with the surveyor on 12/14/2021 at 1:00 PM, LPN #5 stated that the resident's [redacted] POF recap was sent incorrectly from the pharmacy as it was from a previous admission dated [redacted], and the current admission date was [redacted]

On 12/20/21 at 10:49 AM, the surveyor interviewed the ADON who reviewed the documents with the surveyor. The ADON stated that the resident had a [redacted] consult on [redacted] and they recommended to administer [redacted] mg in the morning and [redacted] mg at bedtime (HS). She confirmed from 1[redacted] the MAR reflected that the dose was to be given at 6 AM and 2 PM which was not an HS dose. She stated that the nurse crossed it out and circled it on the MAR because the resident was to get [redacted] mg every HS in accordance with the [redacted] consultation, and not at 2 PM. She continued to state that the order written on the MAR was discontinued on [redacted] and that the nurses kept the order to reflect that the [redacted] mg was once a day for 6 am and continued it for the HS dose. She stated that only the 2 PM dose was circled and rewritten. The ADON confirmed the MAR was unclear and "it should have been re-written during the recap." She stated that the Pharmacy printed it as twice a day (BID) inaccurately. She stated that the order for the [redacted] mg at HS was sent to the pharmacy the same day and the pharmacy must not have picked it up. She stated that while the orders on the MAR should have been re-written to be clearer and the pharmacy should have been notified of the discrepancy in

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accordance with professional standards, she stated that the resident always received the correct doses at the correct time of the [redacted] in accordance with the [redacted] recommendations made on [redacted]

On 12/21/21 at 10:23 AM, the surveyor interviewed the Regional Registered Nurse and the ADON in the presence of the Director of Nursing (DON), Licensed Nursing Home Administrator (LNHA) and the survey team. The Regional Registered Nurse stated that the resident has had multiple hospitalizations and during a recent hospitalization, the hospital changed the [redacted] order to twice a day. She stated that upon return from the hospital the resident comes with hospital discharge instructions including medications. The ADON stated that the nurse would call the physician to go over the hospital discharge instructions to confirm if they wanted the orders to remain. She stated that the resident had a [redacted] follow up after their hospitalization and they weren't aware that the order was changed to twice a day when they made their recommendation. She stated that there was no worsening of symptoms. She stated that the [redacted] makes the recommendations, and the Attending Physician approves the order. The Regional Registered Nurse acknowledged the surveyor's findings of accurately recording orders onto the MAR and TAR upon readmission to the facility. The Regional Registered Nurse denied that the resident had an adverse outcome but confirmed the surveyor's findings was not following professional standards of nursing practice.

Review of the facility's Monthly Recap Procedure policy, reviewed 08/11/2021, revealed, "Using the

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chart and the Current MAR & POS verify the orders on the POS and make corrections to the POS & MAR. Correction to the POS: writing DC on the incorrect order on the POS and rewrite the order correctly below. Correction to the MAR: Yellow out the incorrect order and rewrite the order on the next available section of the MAR," and, "The night of change over, the nurse will check the NEW MAR to the OLD MAR (making adjustments if needed)."

4. On 12/13/21 at 9:12 AM, the surveyors observed LPN #2 administer medication to two residents in the facility. After giving medication to the second resident, LPN #2 advised the surveyors that the medication pass for the entire section of the nursing unit ([redacted] Unit) was complete.

During an interview with the surveyor on this date and time, LPN #2 advised the surveyors that there were [redacted] residents assigned to the unit. Only [redacted] were present due to one of the residents being hospitalized. The surveyor asked if all morning medications were given to each of the [redacted] residents on the unit. The LPN #2 confirmed that medications were given as per current orders. At the request of the surveyors, LPN #2 agreed to conduct an audit of the current MARs for each of the [redacted] residents.

A review of the MARs revealed that medication for five of the residents (Residents #14, #52, #78, #100, and 1#03) were not documented as administered, as follows:

The MAR for Resident #14 revealed that two medications and one supplement were not documented as administered, despite being given

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per LPN #2.

The MAR for Resident #52 revealed that four medications and one supplement were not documented as administered, despite being given per LPN #2.

The MAR for Resident #78 revealed that four medications were not documented as administered, despite being given per LPN #2.

The MAR for Resident #100 revealed that one medication was not documented as administered, despite being given per LPN #2.

The MAR for Resident #103 revealed that two medications were not documented as administered, despite being given per LPN #2.

During an interview with the surveyor on 12/13/21 at 10:00 AM, LPN #2 confirmed, once again, that all medications were given to the five residents, reviewed earlier in the morning. LPN #2 stated that daily medication pass time in the morning is 9 AM, which allows the nurse a one-hour period before or after 9 AM. The nurses can administer medication to the residents. LPN #2 further stated that medication administered to a resident should be documented as administered on the MAR immediately after the medication is given to the resident. LPN #2 acknowledged that the medications reviewed for the five residents should have been documented as administered, since she gave them earlier in the morning. She acknowledged that she did not sign the MAR in accordance with the policy and professional standards. When asked why the referenced medications for the five residents were not documented accordingly, LPN #2 stated it

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F 658	Continued From page 18 resulted from her rush to complete the medication pass. Review of the facility's Administering Medications/SJEC policy, revised December 2021, reflected that "The individual administering the medication must initial the resident's MAR on the appropriate line after giving each medication and before administering the next ones." NJAC 8:39-27.1(a)	F 658		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to: a.) provide a resident with the appropriate amount of medication after readmission to the facility, b.) follow up with a recommendation made by the [redacted] Nurse, and c.) appropriately document the changes in the resident's medication regime in the resident's medical record. This deficient practice was identified for one of five residents (Resident #103) reviewed for unnecessary medications and was evidenced by the following:	F 684	F684 1. Resident #103 [redacted] medication [redacted] was updated to reflect the newly obtained order from the assigned physician. 2. All residents have the potential to be affected by this deficient practice of failing to provide the appropriate medication after readmission to the facility, failing to follow up with a recommendation made by the [redacted] advance practitioner nurse,	2/21/22

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F 684	Continued From page 19 On 12/09/21 at 11:58 AM, the surveyor observed Resident #103 sitting upright in bed and dressed for the day. The resident smiled at the surveyor and stated that they were doing well. On 12/13/21 at 10:45 AM, the surveyor observed the resident lying in bed with their eyes closed. On 12/14/21 at 9:54 AM, the surveyor further observed Resident #103 dressed and sitting upright in bed, eating their breakfast meal. The resident smiled at the surveyor and stated that they were doing well that day. The resident further stated that they had a "rough" couple of months but was doing better now. The resident told the surveyor that they were offered medication for sleep but declined the medications because they had no problems sleeping at night. The resident stated that they could not remember anything further regarding their [redacted] medications and stated that their [redacted] was getting "better." The surveyor reviewed the Medical Record for Resident #103. A review of the Face Sheet (an admission summary) reflected that the resident was admitted to the facility in [redacted]. The resident diagnoses included but were not limited to [redacted]	F 684	and failing to appropriately document the changes in the resident's medication regime in the resident's medical record. 3. The DON will in-service all nurses regarding reviewing and reconciling all medications upon readmission. Additional education will consist of review of medical recommendations with assigned physicians as well as documentation in the resident's medical record of any changes related to the care of said resident. In-services with nurses will also consist of verifying all readmission orders upon return from the hospital and completing daily 24 hour checks. Assigned physicians will be in-serviced regarding recommendations from consulting physicians and the need to document approval of suggested orders. 4. The DON or designee will monitor five resident charts for one month ensuring that readmission residents medications have been reviewed and accurately plotted on the MAR. Recommendations documented in five resident charts from facility providers will be reviewed weekly for one month ensuring that all recommendations have been communicated with the assigned physician and orders were obtained and carried out. All findings will be reported at the next quarterly quality assurance meeting.	

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A review of the resident's most recent quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated [redacted], reflected that the resident's Brief Interview of Mental Status (BIMS) score was [redacted] out of [redacted], which indicated the resident was [redacted].

A review of the resident's [redacted] Evaluation (PE) completed by the [redacted] Nurse [redacted]) dated [redacted] indicated that the resident had a diagnosis of [redacted]. The PE further indicated that the resident recently had a loved one pass away. The resident was feeling an increase in [redacted] and [redacted] related to the loss of their loved one. The [redacted] recommended that the resident's [redacted] medication [redacted] be increased from [redacted] milligrams (mg) twice a day to three times a day.

A review of the [redacted] Physician Order Sheet (POS) reflected a Physician's Order (PO) dated [redacted] to increase [redacted] to [redacted] mg by mouth three times a day related to the diagnosis of [redacted].

A review of the [redacted] Medication Administration Record (MAR) reflected that [redacted] mg twice a day was discontinued on [redacted]. The [redacted] MAR further reflected that the medication [redacted] was plotted to be administered three times a day at 6:00 AM, 2:00 PM, and 10:00 PM starting 09/16/21 at 10:00 PM.

A review of the [redacted] POS reflected that the anti-anxiety medication [redacted] mg by

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F 684	Continued From page 21 mouth was discontinued on [redacted] and increased to three times a day for [redacted]. The resident was re-admitted to the facility on [redacted]. A review of the [redacted] POS reflected a readmission PO dated [redacted] for [redacted] mg, [redacted] tab by mouth every 12 hours. A review of the corresponding [redacted] MAR reflected that the resident was being administered [redacted] mg by mouth every 12 hours at 9:00 AM and 9:00 PM while the resident resided at the facility. The resident was re-admitted to the facility on [redacted]. A review of the [redacted] POS reflected a PO dated [redacted] for [redacted] mg by mouth every 12 hours. A review of the corresponding [redacted] MAR reflected that the resident was being administered [redacted] mg by mouth every 12 hours at 9:00 AM and 9:00 PM while the resident was at the facility. A review of the resident's PE completed by the [redacted] dated [redacted] indicated that Resident #103 was last seen on [redacted] and the resident continued to report feeling [redacted]. The recommendations further indicated to continue the [redacted] medication [redacted] mg three times= by mouth a day for [redacted] because the benefits of the medication outweighed the risk for the resident. An additional note documented by the PAPN reflected that the same recommendation was made on [redacted]. There was no documentation in the resident's medical record that indicated the [redacted] recommendations were addressed for the month of [redacted]	F 684		

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F 684	Continued From page 22 [redacted]. A review of the [redacted] POS dated [redacted] reflected a PO for the medication [redacted] mg by mouth every 12 hours. The corresponding [redacted] MAR review reflected that the resident was administered [redacted] mg by mouth every 12 hours at 9:00 AM and 9:00 PM. A review of the resident's progress notes from [redacted] to [redacted] did not reflect that changes had been made to the resident's medication regimen or the resident's primary care physician was made aware of the recommendations by the [redacted]. A review of the resident's Care Plan (CP) revised [redacted] reflected a problem area. The resident had a history of [redacted] and was experiencing [redacted], and [redacted] related to a loved one passing away. The goal of the resident's CP reflected that the resident would report a decrease in [redacted] and develop coping skills as well as go through the grieving process through the next review date. The interventions for the resident's CP included a [redacted] consult and treatment as needed. A further review of the resident's CP revised [redacted] reflected a problem area that the resident had an [redacted] related to [redacted], history of [redacted], and [redacted]. The goal of the resident's CP reflected that the resident would maintain baseline functioning on unit activities, programming, and socialization through the next review date. The resident's CP interventions included consulting	F 684		

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with [redacted] for medication management, monitor for changes in behavior, and notify the [redacted] and [redacted] consult on [redacted] due to the resident's continued feelings of [redacted] related to the death of a loved one.

On 12/14/21 at 10:01 AM, the surveyor interviewed the resident's Licensed Practical Nurse (LPN), who stated that when a resident received a new PO, the process was the physician would give the order verbally, the nurse would write the PO on the POS, fax the PO to the pharmacy and then transcribe the PO onto the MAR. The LPN further stated that the nurse who wrote the PO would document a corresponding nursing progress note which reflected the new medication regime and associated changes. The LPN further stated that the 11:00 PM to 7:00 AM nurses would perform a 24-hour chart check-in to review the resident's medical records to make sure POs were carried out appropriately. The LPN stated that when changes were made to a resident's [redacted] medication regimen, the resident would be monitored by nursing staff for 14 days, and the monitoring of the resident would be documented on a 24-hour reporting system. The LPN acknowledged in the presence of the surveyor that the PO for the [redacted] medication [redacted] mg was not being administered to the resident three times a day as the [redacted] recommended and stated that it did not appear that the change in the medication was currently implemented.

On 12/20/21 at 10:05 AM, the surveyor interviewed the resident's Certified Nursing Aide (CNA), who stated she was familiar with the resident. The resident was alert, oriented, and could make their needs known. The CNA told the

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surveyor that sometimes the resident was "a little bit'[redacted] and [redacted] because the resident recently had a loved one pass away. The CNA further stated that the resident had episodes of [redacted] when it first happened but has not [redacted] as much since then. The surveyor asked the CNA how she knew the resident was feeling [redacted] The CNA stated that she knew that the resident was [redacted] when the resident would keep to themself and had to, "lay down."

On 12/20/21 at 10:10 AM, the surveyor conducted a follow-up interview with the resident's LPN, who stated that the only behavior she thought the resident might have after their loved one passed away was '[redacted]." The LPN stated that the resident used to care more about themself before the resident experienced loss. The LPN stated the resident would "take [his/her] medications and no[redacted] as much." The LPN further stated that the resident was strong-minded and would do whatever he/she wanted to do despite being provided education from nursing and social services.

On 12/20/21 at 11:36 AM, the surveyor interviewed the resident's Licensed Practical Nurse/Unit Manager (LPN/UM), who stated that the resident was alert and oriented. Able to communicate their needs, had [redacted] issues, and was non-compliant when it came to [redacted] The LPN/UM stated that when a consulting physician made a recommendation, the recommendation would be reviewed with the resident's primary care physician. The LPN/UM further stated that if the primary care physician approved the recommendation, the nurse would write a PO, fax the PO to the pharmacy, transcribe the PO onto the MAR, and document a

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corresponding nursing progress note related to changes in the resident's care. The LPN/UM stated that the resident was back and forth from the hospital to the facility, and when the resident was re-admitted to the facility, the nurses followed the POs from the hospital. The LPN/UM did not speak to a facility process regarding the review of medication changes upon readmission to the facility. The LPN/UM further stated that if the [redacted] made a recommendation, there should be a corresponding nursing note to reflect the recommendation made by the [redacted].

On 12/20/21 at 11:56 AM, the surveyor called the resident's primary care physician and left a message requesting a call back with the physician's answering service. The surveyor never received a call back from the resident's primary care physician.

On 12/20/21 at 12:37 PM, the surveyor interviewed the resident's [redacted], who stated that she had recommended that the resident's [redacted] medication [redacted] be increased. It wasn't, and she wondered why. The [redacted] stated that sometimes when a resident left the facility and went to the hospital, the hospital did not update the resident's medication list. The [redacted] further stated that after she made a recommendation, the nurse would call the resident's primary care physician to review the recommendation before it was implemented. The [redacted] stated that the only reason the medication would not have been administered or carried out was if the resident's primary care physician did not want to carry out the order.

On 12/21/21 at 10:23 AM, the surveyor interviewed the Regional Nurse (RN) in the

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F 684	Continued From page 26 presence of the survey team, who stated that the facility received clarification from the resident's primary care physician and the resident should have been receiving the medication, [redacted] three times a day. At 10:24 AM, the Director of Nursing (DON) stated that the resident was re-admitted to the facility on [redacted]. The hospital orders indicated that the [redacted] medication be administered two times a day. The DON further stated that the [redacted] saw the resident in [redacted] and re-recommended that the [redacted] be increased to three times a day because the resident was [redacted] and [redacted] related to the loss of a loved one. At that time, the Assistant Director of Nursing (ADON) stated that she did not have an answer as to why the [redacted] was not increased to three times a day in [redacted] and if the resident's primary care physician did not want to follow the recommendation made by the [redacted] there should have been documentation in the resident's medical record reflecting that. A review of the facility's corrective action presented to the surveyors by the Administrative team on [redacted] reflected a corrective action indicating that a call was placed to Resident #103's primary care physician and the facility received a PO for [redacted] mg to be administered three times a day.	F 684		
F 698 SS=D	NJAC 8:39 27.1(a) Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who	F 698		2/21/22

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F 698	Continued From page 27 require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to ensure that medication administration times were scheduled to accommodate a resident's [redacted] times. This deficient practice was identified for [redacted] resident (Resident #44) reviewed for [redacted] This deficient practice was evidenced by the following: On Tuesday, 12/09/21 at 10:17 AM, Resident #44 was not observed in their room and was possibly at [redacted]). On Tuesday, 12/14/21, at 09:34 AM, Resident #44 was not observed in their room due to attending [redacted] On Thursday, 12/16/21, at 09:42 AM, Resident #44 was not observed in their room due to attending [redacted]. According to the Face Sheet, Resident #44 was admitted with diagnoses that included, but were not limited to: [redacted] Review of the Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the	F 698	F698 1. Resident #44 medication times were changed to reflect administration of medications according to resident [redacted] treatment hours. 2. All residents have the potential to be affected by this deficient practice of failing to ensure that medication administration times are scheduled to accommodate a resident□s [redacted] times. 3. The DON will in-service all nurses regarding reviewing resident [redacted] schedules to ensure medication is plotted for administration times while resident is in the facility. 4. The DON or designee will monitor all dialysis resident□s MAR and physician orders weekly for one month to ensure that new medication orders continue to be reflected in the MAR and given while the resident is physically in the facility. All findings will be reported at the next quarterly quality assurance meeting.	

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management of care, dated [redacted], revealed the resident had a Brief Interview for Mental Status of [redacted] which indicated that the resident was [redacted]. Further review of the MDS revealed the resident received hemodialysis.

Review of the resident's [redacted] Physician's Order Form revealed a physician's order (PO) for [redacted] milligrams (mg) orally three times daily for [redacted] (used to [redacted] in patients who are on [redacted].

The resident's [redacted] Medication Administration Record (MAR) review included the aforementioned PO for [redacted]. The MAR reflected that from [redacted] to [redacted] nurses' signatures on the medication administration time slotted for 7:30 AM, which indicated that the medication was administered to the resident, including on [redacted] days when the resident was not in the facility. [redacted] was documented as administered at 7:30 AM on the following [redacted] days:

11/02/21-Tuesday
11/04/21-Thursday
11/06/21-Saturday
11/09/21-Tuesday
11/11/21-Thursday
11/13/21-Saturday
11/16/21- Tuesday
11/18/21-Thursday
11/20/21-Saturday
11/23/21-Tuesday
11/25/21-Thursday
11/27/21-Saturday
11/30/21-Tuesday

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Review of the resident's [redacted] MAR included the aforementioned PO for [redacted]. The MAR reflected that nurses' signatures on the medication administration time slotted for 7:30 AM, which indicated that the medication was administered to Resident #44, including on [redacted] days, when the resident was not in the facility. [redacted] was documented as administered at 7:30 AM on the following [redacted] days:

12/02/21-Tuesday
12/07/21-Tuesday
12/11/21- Saturday
12/14/21-Tuesday
12/16/21-Thursday
12/18/21-Saturday

During an interview with the surveyor on 12/20/21 at 11:32 AM, the Licensed Practical Nurse (LPN) responsible for providing care for Resident #44 stated the resident leaves the facility for [redacted] at 5:15 AM on Tuesdays, Thursdays, and Saturdays. The LPN added that the resident would not leave for [redacted] unless the resident received his/her medications and that the nurses administered the resident's medication at 5:00 AM. The LPN could not speak to how the nurse administered the [redacted] at 7:30 AM if the resident was at [redacted] at that time.

On Monday, 12/20/21, at 11:35 AM, the surveyor observed Resident #44 sitting in a wheelchair in their room. The resident stated, "I am supposed to get my medications before I go to [redacted], but it depends on the nurse." The resident further stated that on [redacted] days, they leave the facility at 5:30 AM and gets back to the facility around

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F 698	Continued From page 30 12:00 PM During an interview with the surveyor on 12/21/21 at 10:21 AM, in the presence of the survey team, the Regional Nurse acknowledged the surveyor findings regarding Resident #44 and the [redacted] being scheduled at 7:30 AM on [redacted] days (Tuesdays, Thursdays, and Saturdays) when the resident was not in the facility. The Regional Nurse further stated that the resident's [redacted] level was [redacted] on [redacted] but went down to [redacted] on [redacted], indicating no adverse outcome. During a follow-up interview with the surveyor on 12/21/21 at 11:37 AM, the LPN stated that on [redacted] days, when the resident is not in the facility, she could not administer the [redacted] at 7:30 AM. The LPN further stated that she would circle her initials on the MAR and document that the medication was not administered on the back of the MAR. The LPN then acknowledged that the PO for [redacted] should have been changed to include a schedule for [redacted] days and [redacted] days to administer the medication as ordered. The LPN added that she could not speak for the other nurses' signatures for the 7:30 AM dose of [redacted] and whether the medication was administered since the resident goes to [redacted] at 5:00 AM on Tuesday, Thursday, and Saturday. Review of the facility's "Administering Medications/SJEC" policy, revised December 2021, reflected that medications must be administered in accordance with orders, including any required time frame." Review of the facility's undated [redacted] Policy	F 698		

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F 698	Continued From page 31 did not address the administration of medication on [redacted] days. NJAC 8:39-11.2 (b), 27.1 (a)	F 698		
F 712 SS=D	Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4) §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure the frequency of physician visits for 1 of 22 residents reviewed (Resident #91). The evidence was as follows: On 12/13/21 at 10:04 AM, the surveyor observed Resident #91 in bed, awake and alert. The	F 712	F712 1. Resident #91 was immediately evaluated by the Nurse Practitioner (NP). The resident was assessed and reflected on the physician progress note. 2. All residents have the potential to be affected by this deficient practice of failing	2/28/22

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F 712	Continued From page 32 surveyor attempted to interview the resident, but the resident did not answer any of the surveyor's questions. On 12/14/21 at 09:14 AM, the surveyor returned to the room of Resident #91 and observed the resident lying in bed, awake and alert, with the head of the bed elevated. Resident #91 had their eyes opened. The resident stated, "everything was okay." The surveyor reviewed the medical records for Resident #91. The resident's Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included [redacted] The quarterly Minimum Data Set (MDS) dated [redacted] revealed that the brief interview for mental status (BIMS) score could not be obtained, so staff assessed the resident's cognition level. Which indicated that the resident had a [redacted] and [redacted]. A review of the annual MDS dated [redacted] revealed that the BIMS score could not be obtained, so staff assessed the resident's cognition level, which indicated that the resident had a [redacted] The surveyor reviewed the Medical Provider's documentation which revealed the following:	F 712	to ensure the frequency of physician visits. 3. The NP and MD will be in-serviced by the Administrator regarding the frequency of evaluation required for each resident as it pertains to their clinical status. Emphasis will be placed to ensure that documentation is provided as a record of assessment regardless of in-person or telehealth physician visit. 4. The DON or designee will review five resident medical records for 1 month to ensure physicians and/or NP are evaluating residents according to the residents clinical status and time frames required for assessment. All findings will be reported at the next quarterly quality assurance meeting.	

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The surveyor reviewed a completed Medical History and Physical Exam (H&P) dated [redacted]

The Physicians Notes (PN) review reflected that the Nurse Practitioner (NP) evaluated the resident on [redacted], and [redacted] There was no evidence that the resident was seen by an Attending Physician (MD) or the NP from [redacted] through [redacted]

The surveyor attempted to review any other H&P records in the resident's medical record. There was an H&P with the Attending Physician's name on the top and was dated [redacted], but it was incomplete.

A review of the Resident #91 physician's order summary report (POS) dated [redacted] revealed no evidence that the Attending Physician or NP had made a visit or signed their name to indicate they had made a visit during the time frame.

The surveyor continued to review the progress notes for Resident #91.

A review of the clinical notes dated [redacted] at 11:45 PM written by a Registered Nurse (RN) revealed that Resident #91 was admitted to an acute care hospital with a diagnosis of [redacted] and a [redacted].

A review of the clinical notes dated [redacted] at 3:40 PM written by a Licensed Practical Nurse (LPN) revealed Resident #91 was readmitted from an acute care hospital at 8:20 AM. The notes revealed that medications were verified by the attending physician and faxed to the pharmacy.

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A follow-up clinical note dated [redacted] during the 3 PM-11 PM evening shift written by an LPN revealed Resident # 91 was awake, alert, and oriented to self, received all their medications, had a good appetite for dinner. The note included the resident's vital signs.

There were no Clinical Notes written by the Attending Physician or the Nurse Practitioner (NP) upon the resident's readmission from the acute care hospital on [redacted] to document an in-person physician visit or a tele-health physician visit.

A review of the Occupational Therapy (OT) Evaluation and Plan of Treatment completed [redacted] certified that Resident #91 was to receive OT from [redacted] until [redacted].

During an interview with the surveyor on 12/14/21 at 11:08 AM, LPN #5 stated that the Attending Physician or Nurse Practitioner (NP) should do a readmission assessment when residents were readmitted to the facility and write a clinical/medical progress note.

During an interview with the surveyor on 12/16/21 at 12:39 PM, the NP stated she was the NP for the Attending Physician caring for Resident #91. The NP further stated that when a resident was readmitted to the facility, the nurses would notify the Attending Physician of the readmission after an acute hospital stay. The Attending Physician or NP would then complete a readmission note, including a full assessment of the resident. The NP further stated she was on-site at the facility every Thursday and would see residents that had an issue and would need to be seen and that she

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would see the residents in [redacted]) monthly. In the presence of the NP, the surveyor reviewed the blank readmission H&P assessment dated [redacted], and the last Physician note dated [redacted].

In an interview with the surveyor on 12/16/21 at 01:54 PM, the NP stated that her paperwork showed she was in the facility on [redacted]. She wrote on her paperwork that the resident was not in his room. She was told by a staff member that the resident was in the hospital. Upon request, the NP provided a copy of her paperwork. The NP further confirmed Resident #91 was not in the hospital on [redacted], as they were readmitted on [redacted]. The NP admitted to the surveyor, "It was missed."

During an interview with the surveyor on 12/16/21 at 2:15 PM, the NP stated that when a resident was readmission on the [redacted] unit, the readmission assessment by the Attending Physician or NP should be completed within five (5) days of readmission. If a resident was readmitted to the [redacted] Unit [redacted] a readmission assessment should be completed within 48 hours and assessed by the Attending Physician or NP weekly. The surveyor reviewed with the NP that the resident was receiving therapy until [redacted] which indicated that the resident was admitted as a [redacted] resident. There was no documented evidence that the Attending Physician or NP was seen from [redacted] upon readmission until [redacted] when the surveyor had inquired.

On 12/21/21 at 10:34 AM, the surveyor interviewed the Regional Registered Nurse in the presence of the survey team, the Director of

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Nursing (DON), and the Licensed Nursing Home Administrator (LNHA). The Regional Registered Nurse stated that the Attending Physician's group makes in-person visits every Tuesday, in the [redacted] section of the facility, the Nurse Practitioner makes the rounds. She elaborated that when the resident was re-admitted back to the facility on [redacted], the resident was placed back into their room on the [redacted] unit. Therefore, was not seen by the Attending Physician weekly. She added that the resident was seen by the same Attending Physician while admitted to the hospital and acknowledged that having the same Attending Physician see the resident during the hospitalization does not exempt the Attending Physician from making a visit upon the resident's return to the facility, in accordance with required timeframes. No additional documents were provided to reveal that the Attending Physician or the NP made a visit to the resident from [redacted] unti[redacted] during the surveyor inquiry. The Regional Registered Nurse confirmed that the resident had no complications upon readmission to the facility.

A review of the facility's policy titled "Admission and Readmission Policy," with a reviewed date of 01/01/21, revealed that the physician will see the resident within 24 hours of admission to the facility.

A review of a Physician Services policy reviewed 8/6/21 included that "all skilled patients must be seen by the attending physician or his alternate at least every thirty (30) days, and it must be documented in the patient's medical record. All subacute residents must be seen by the attending physician or [redacted] alternates at least weekly. At the time of each visit, progress notes on each patient

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seen must be written by the attending physician."

NJAC 8:39-23.2(b), 23.2(d)

Based on observation, interview, and record review, it was determined that the facility failed to ensure the frequency of physician visits for 1 of 22 residents reviewed (Resident #91).

The evidence was as follows:

On 12/13/21 at 10:04 AM, the surveyor observed Resident #91 in bed, awake and alert. The surveyor attempted to interview the resident, but the resident did not answer any of the surveyor's questions.

On 12/14/21 at 09:14 AM, the surveyor returned to the room of Resident #91 and observed the resident lying in bed, awake and alert, with the head of bed elevated. Resident #91 had his/her eyes opened. The resident stated, "everything was okay."

The surveyor reviewed the medical records for Resident #91.

A review of the resident's Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included [redacted].

A review of the quarterly Minimum Data Set (MDS) dated [redacted] revealed that the brief

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interview for mental status (BIMS) score could not be obtained, so staff assessed the resident's cognition level, which indicated that the resident had a [redacted].

A review of the annual MDS dated [redacted] revealed that the BIMS score could not be obtained, so staff assessed the resident's cognition level, which indicated that the resident had a [redacted]

The surveyor reviewed the Medical Provider's documentation which revealed the following:

The surveyor reviewed that there was a completed Medical History and Physical Exam (H&P) dated [redacted]

A review of the Physicians Notes (PN) reflected that the Nurse Practitioner (NP) evaluated the resident on [redacted] and [redacted]. There was no evidence that the resident was seen by an Attending Physician (MD) or the NP from [redacted] through [redacted]

The surveyor attempted to review any other H&P records in the resident's medical record. The surveyor reviewed that there was an H&P with the Attending Physician's name on the top and was dated [redacted], but it was not completed.

A review of the Resident #91 physician's order summary report (POS) dated [redacted] revealed no evidence that the Attending Physician or NP had made a visit or signed their name to indicate they had made a visit during the time frame.

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The surveyor continued to review the progress notes for Resident #91.

A review of the clinical notes dated [redacted] at 11:45 PM written by a Registered Nurse (RN), revealed that Resident #91 was admitted to an acute care hospital with a diagnosis of [redacted] in the [redacted] and a [redacted].

A review of the clinical notes dated [redacted] at 3:40 PM written by a Licensed Practical Nurse (LPN), revealed Resident #91 was readmitted from an acute care hospital at 8:20 AM. The notes revealed that medications were verified by the attending physician and faxed to the pharmacy.

A follow-up clinical note dated [redacted] during the 3 PM-11 PM evening shift written by an LPN, revealed Resident # 91 was awake, alert and oriented to self, received all his/her medications, had a good appetite for dinner. The note included the resident's vital signs.

There were no Clinical Notes written by the Attending Physician or the Nurse Practitioner upon the resident's readmission from the acute care hospital on [redacted] to document an in-person physician visit or a tele-health physician visit.

A review of the Occupational Therapy (OT) Evaluation and Plan of Treatment completed [redacted] certified that Resident #91 was to receive OT from [redacted] until [redacted].

During an interview with the surveyor on 12/14/21 at 11:08 AM, the LPN #5 stated that the attending

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F 712	Continued From page 40 MD or NP should do a readmission assessment when residents were readmitted to the facility and write a clinical/medical progress note. During an interview with the surveyor on 12/16/21 at 12:39 PM, the NP stated she was the NP for the attending MD for Resident #91. The NP further stated that when a resident was readmitted to the facility, the nurses would notify the Attending Physician of the readmission after an acute hospital stay. The MD or NP would then complete a readmission note which would include a full assessment on the resident. The NP further stated she was on-site at the facility every Thursday and would see residents that had an issue and would need to be seen. She stated that she would see the residents in [redacted] monthly. The surveyor reviewed with the NP the blank readmission H&P assessment dated [redacted] and last Physician note dated [redacted] During a follow up interview with the surveyor on 12/16/21 at 01:54 PM, the NP stated that her paperwork showed she was in the facility on [redacted] and she wrote on her paperwork that the resident was not in his room and a staff member told her that that the resident was in the hospital. The NP provided a copy of her paperwork. The NP further confirmed Resident #91 was not in the hospital on [redacted], as he/she was readmitted on [redacted] The NP admitted to the surveyor, "It was missed." During an interview with the surveyor on 12/16/21 at 2:15 PM, the NP stated that when a resident was a readmission on [redacted] unit, the readmission assessment by the MD or NP should be completed within five (5) days of readmission,	F 712		

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and if a resident was readmitted to [redacted] Unit [redacted]), then readmission assessment should be completed within 48 hours and then assessed by the MD or NP on a weekly basis. The surveyor reviewed with the NP that the resident was receiving therapy until [redacted] which indicated that the resident was admitted as a [redacted] resident, but there was no documented evidence that the MD or NP was seen from [redacted] upon readmission until [redacted] when the surveyor had inquired.

On 12/21/21 at 10:34 AM, the surveyor interviewed the Regional Registered Nurse in the presence of the survey team, the Director of Nursing (DON) and the Licensed Nursing Home Administrator (LNHA). The Regional Registered Nurse stated that the Attending Physician's group make in-person visits every Tuesday, and in the [redacted] section of the facility the Nurse Practitioner makes the rounds. She elaborated that when the resident was re-admitted back to the facility on [redacted], he/she was placed back into their room on the [redacted] unit, and therefore was not seen by the Attending Physician weekly like other residents that are admitted for [redacted] rehab. She added that the resident was seen by the same Attending Physician while admitted in the hospital. She acknowledged that having the same Attending Physician see the resident during a hospitalization was not an exception to not making a visit upon the resident's return to the facility in accordance with required timeframes. No additional documents were provided to reveal that the Attending Physician or the NP made a visit to the resident from [redacted] until [redacted] during surveyor inquiry. The Regional Registered Nurse confirmed that the resident had no

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F 712	Continued From page 42 complications upon readmission to the facility. A review of the facility's policy titled "Admission and Readmission Policy", with a reviewed date of 01/01/21, revealed that the resident will be seen by the physician within 24 hours of admission to the facility. A review of a Physician Services policy reviewed 8/6/21 included that "all skilled patients must be seen by the attending physician or his alternate at least every thirty (30) days, and it must be documented in the patient's medical record. All sub acute residents must be seen by the attending physician or his alternates at least weekly. At the time of each visit, progress notes on each patient seen must be written by the attending physician." NJAC 8:39-23.2(b), 23.2(d)	F 712		
F 835 SS=K	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 interviews, medical record review, and other pertinent facility documentation, it was determined that the facility's Licensed Nursing Home Administrator (LNHA) failed to ensure that the facility was in compliance with the following regulatory requirements, which affected the safety of all residents in the facility. The LNHA	F 835	F835 1. All unvaccinated residents and partially unvaccinated residents who were identified on CNA #1, CNA #2, CNA #3, and LPN #1 assignments were immediately transferred to the [redacted] unit	3/1/22

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F 835	Continued From page 43 failed to a.) oversee the Infection Preventionist (IP) and Assistant Director of Nursing (ADON) to ensure that the facility followed their Outbreak Response Plan, b.) maintain compliance with Regulation F880, and c.) ensure the implementation of Transmission Based Precautions (TBP) in accordance with CDC guidance. This affected 11 unvaccinated residents with a known exposure to COVID-19, which are considered, according to CDC, as PUI (persons under investigation), for [redacted] units [redacted] and [redacted] Units). Refer to F880K as it pertains to the facility's failure to ensure the implementation of Infection Control Practices and Precautions during an identified COVID-19 outbreak. During the Standard Survey conducted on 12/30/21, the surveyors identified deficient practices concerning Infection Control related to the identification of residents who had been exposed to staff members with known COVID-19 positive test results; and timely implementation of TBP for these residents. These deficient practices were identified on [redacted] nursing units [redacted] and [redacted] Units). This deficient practice was evidenced by the following: A review of the Administrator.s job description provided by the facility revealed the following: Position Summary: "This position is responsible to establish and maintain systems that are efficient and effective to operate the nursing home in a manner to safely meet residents' needs in accordance with federal, state and local	F 835	and placed on Transmission Based Precautions (TBP). The Administrator, Infection Preventionist (IP) as well as the Assistant Director of Nursing (ADON) were immediately in-serviced on 12/9/2021 by the Corporate Director on the policy and procedure for placing unvaccinated residents and/or partially vaccinated residents on TBP and timely testing staff and residents after exposure to an employee who test positive for COVID-19 in order to expeditiously cohort as necessary. Additional in-service consisted of initiating contact tracing once an employee or resident has been identified with a positive COVID-19 test result. A Root Cause Analysis (RCA) was initiated by the Administrator to determine the cause of the event. All staff assigned to residents with exposure to staff who test positive for COVID-19 were notified. 2. All residents have the potential to be affected by this deficient practice when the Administrator fails to ensure that the facility is in compliance with overseeing the Infection Preventionist (IP) and Assistant Director of Nursing (ADON) in following their Outbreak Response Plan, maintaining compliance with Infection Prevention and Control, and ensuring the implementation of Transmission Based Precautions (TBP) in accordance with CDC guidelines. 3. The Administrator will review and in-service all staff regarding all state and federal guidelines pertaining to COVID-19, facility policies to ensure that policies	

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F 835	Continued From page 44 regulations. Also, develop and maintain systems that are effective and efficient to operate the facility in a financially sound manner." Responsibilities/Accountabilities included: "Develop, maintain and implement operational policies and procedure to meet residents' need in compliance with federal, state and local requirements; Develop and enforce a monitoring program to assure compliance with federal, state and local requirements; Prepare reports for, and attend meetings with the governing body regarding the total activities of the nursing home, as well as governmental developments, which effects health care;Establish systems to enforce the facility policies and procedures; Interpret all federal, state and local regulations for the facility staff; Establish systems to ensure compliance with all federal, state and local regulation." On 12/10/21 at 12:27 PM, the facility's LNHA was notified that an Immediate Jeopardy (IJ) situation was identified related to his failure to oversee the Infection Preventionist (IP) and Assistant Director of Nursing (ADON) to ensure that the facility followed their Outbreak Response Plan, maintain compliance with Regulation F880, and ensure the implementation of Transmission Based Precautions (TBP) in accordance with CDC guidance for a period of [redacted]. On 12/10/21, the facility's removal plan was accepted. The non-compliance remained on [redacted]2/10/2021 for actual harm that is not immediate jeopardy based on the following: The gfacility's removal plan included the	F 835	compliment all mandated requirements, IP audit tool from the New Jersey Department of Health allowing provisions to protect residents, staff, and visitors from acquiring or transmitting COVID-19 and any other associated infections or communicable diseases, requirements for COVID-19 testing of staff and residents that are fully vaccinated and non-vaccinated during an outbreak, weekly or bi-weekly testing which is dependent on the county level and exposure rate. Additional review and in-servicing will consist of cohorting processes, ensuring contact tracing and risk assessments are completed, environmental controls remain in place and the emergency operations plan remains updated and followed. 4. The Administrator or designee will monitor weekly for one month the cohorting process and contact tracing as new staff and/or residents test positive for COVID-19 and that the facility□s policy and procedures and CDC guidelines are followed during this process as each incident occurs. All findings will be reviewed at the Quality Assurance meeting x 4 quarters.	

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follwoing:

- Review all state and federal guidelines pertaining to Covid-19
- Review facility policies to ensure we are aligned with all mandated regulations
- Review the infection preventionist audit tool from the New Jersey Department of Health (NJDOH) that will allow us to provide an environment that protects residents, staff, and visitors from acquiring or transmitting Covid-19 and any other associated infections or communicable diseases.
- Review the requirements for Covid-19 testing of staff and residents that are fully vaccinated and non-vaccinated during an outbreak, weekly or bi-weekly testing depending on the county levels, and exposure
- Quarantine timeframes and who needs to be quarantined and who does not
- Review the Co-horting process
- Ensure all contact tracing and risk assessments are being completed
- Address environmental controls that includes isolation rooms, plastic barriers, sanitation stations, specialized EPA disinfectants, appropriate infectious disease, and special areas for contaminated waste
- Review our emergency operations plan, we will maintain a supply of personal protective equipment (PPE), including moisture-barrier gowns, face masks/goggles, assorted sizes of disposable N95 respirators or higher, surgical masks, approved disinfectants, and gloves to meet to requirements of a 30-day supply.

The admissions department will provide the administration with a log on each resident's start and end date on TBP. The administrator will round the unit daily and ensure all necessary PPE

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supplies are in place. The administrator will conduct competency on each employee on the unit to ensure they are in compliance. Effectively immediately, on 12-10-2021 at 3:45 PM, the Regional Director will be re-educating the LNHA on all areas listed above, meet with the LNHA weekly, and expect him to demonstrate return competency in all areas. All findings will be reviewed during our QAPI meeting.

A review of the facility's Outbreak Plan, revised on 09/10/21, indicated that testing would begin immediately upon identifying a single new case of COVID-19 infection in any staff or residents. The policy further instructed to refer to the CDC guidance "Interim Infection Prevention and Control Recommendations to prevent SARS-CoV-2 Spread in Nursing Homes." for further information on contact tracing and broad-based testing. Under the "Cohort Policy" section, the policy indicated that Cohort 2 consisted of both symptomatic and asymptomatic residents who test negative for COVID-19 with an identified exposure to someone who is positive, regardless of vaccination status. The policy further indicated that exposed individuals would be quarantined for 14 days from the last exposure date, regardless of negative test results.

During an interview with the surveyors on 12/09/21 at 11:01 AM, the ADON stated that the facility was currently in a COVID-19 outbreak which started [redacted]. There were no positive residents in the facility, and six staff members tested positive for COVID-19. One positive staff member was a nurse who worked on Thursday, [redacted], went on vacation, and then tested positive during vacation. One CNA tested positive before her shift and was sent home, but the

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ADON did not provide the date at that time. A second CNA worked on the 11 PM-7 AM shift on [redacted] and felt sick during the shift with flu-like symptoms. The CNA went home, tested on Wednesday, and called out of work with a positive COVID-19 result on Friday, [redacted]. The ADON stated that the facility completed two rounds of rapid testing, and no residents exhibited signs/symptoms of COVID-19. As a result, they did not initiate TBP for any exposed residents. At that time, the ADON provided the team with a Resident & Staff Outbreak Line List (Line List) dated [redacted].

The surveyors reviewed the Line list, which revealed the following:

1. The facility became aware on [redacted] that CNA #1, who last worked on [redacted], tested positive for COVID-19 on [redacted]. Once the facility became aware on [redacted] that CNA#1 tested positive and was experiencing symptoms following her shift on [redacted], the facility did not identify possible exposed residents and did not implement TBP.

2. The facility became aware on [redacted] that LPN #1 tested positive for COVID-19. Once the facility became aware on [redacted] that LPN #1 tested positive, the facility did not identify possible exposed residents and did not implement TBP.

3. The facility became aware on [redacted] that CNA #2 tested positive for COVID-19. Once the facility became aware on [redacted] that CNA#2 tested positive, the facility did not identify possible exposed residents and did not implement TBP.

4. The facility became aware on [redacted] that

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CNA #3 tested positive for COVID-19. Once the facility became aware on [redacted] that CNA #3 tested positive, the facility did not identify possible exposed residents and did not implement TBP.

During an interview with the survey team on 12/09/2021 at 12:35 PM, the Infection Preventionist (IP) confirmed that the identified residents on CNA #1's assignment were not vaccinated for COVID-19. The IP further stated that the process for contact tracing of a positive employee included looking back 48 hours prior to the positive test to identify residents and staff who had contact with the positive employee for greater than 15 minutes. The IP then stated that all residents and staff, regardless of vaccination status, undergo two rounds of testing for COVID-19.

During the same interview with the survey team, the ADON stated that on Friday, [redacted], CNA #1 notified the facility that she became symptomatic after her 11 PM - 7 AM shift on Monday, [redacted], took a COVID-19 test on Wednesday, [redacted] and received a positive COVID-19 test result on Friday, [redacted]. The ADON further stated that residents who are unvaccinated and identified as exposed to someone with COVID-19 were monitored for signs and symptoms of COVID-19 and that staff performed hand hygiene and wore surgical masks when caring for those residents. The ADON also stated that TBP were not implemented for the unvaccinated, exposed residents.

During the same interview with the survey team, the IP explained that new admission and re-admission residents are placed on PUI

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isolation for 14 days due to their unknown exposure status to COVID-19. The IP further stated the importance of placing residents on Persons Under Investigation (PUI) isolation is because "you can still test positive and shed the virus within 14 days" of exposure.

During an interview with the survey team on 12/09/2021 at 2:29 PM, the IP confirmed that the identified residents on CNA #2 and CNA #3's assignments were not fully vaccinated for COVID-19

During an interview with the surveyor on 12/10/21 at 12:27 PM, the LNHA stated that he thought this tag would be included in the F880. The LNHA did not comment on his job responsibilities related to this deficient practice.

During an interview with the survey team on 12/16/2021 at 11:45 AM, the IP stated that residents who have been exposed to COVID-19, regardless of vaccination status, are placed on PUI isolation for 14 days and that the required Personal Protective Equipment (PPE) for those rooms included an N95 mask, eye protection, a gown, and gloves. The IP further stated that when an employee tests positive for COVID-19, contact tracing is performed to identify residents who had contact with the employee up to 48 hours prior to the positive test result so that non-vaccinated, exposed residents can be placed on PUI isolation. The IP added that it is important to wear the correct PPE to protect the residents and staff from COVID-19.

Review of the CDC's "Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes," dated

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F 835	Continued From page 50 09/10/2021, included unvaccinated residents who have had close contact with someone with SARS-CoV-2 infection, should be placed in quarantine for 14 days after their exposure, even if viral testing is negative. Healthcare Professionals (HCP) caring for them should use full PPE (gowns, gloves, eye protection, and N95 or higher-level respirator). If testing of close contacts reveals additional HCP or residents with SARS-CoV-2 infection, contact tracing should be continued to identify residents with close contact to the newly identified individual(s) with SARS-CoV-2 infection. The guidelines further included that unvaccinated residents should generally be restricted to their rooms, even if testing is negative, and cared for by HCP using an N95 or higher-level respirator, eye protection (goggles or a face shield that covers the front and sides of the face), gloves and gown. The resident should not participate in group activities. NJAC 8:39-27.1 (a)	F 835		
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. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention	F 880		5/26/22

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F 880	Continued From page 51	F 880		

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 contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed

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F 880	Continued From page 52 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, record review, and review of other facility documentation, it was determined that the facility failed to appropriately identify residents exposed to COVID-19 as Persons Under Investigation (PUI) for the COVID-19 virus; and as a result, failed to implement Transmission Based Precautions (TBP) in a timely manner to prevent the transmission of COVID-19. This deficient practice was identified for 11 of 11 residents (Residents #10, #11, #25, #48, #51, #60, #63, #65, #73, #84, and #94) who were exposed to four known COVID-19 positive staff members on [redacted] nursing units ([redacted] Unit and [redacted] Unit) during a Standard Survey on 12/09/21. The facility's failure to identify residents exposed to COVID-19 positive staff and implement strategies to prevent the spread of COVID-19 posed a serious and immediate threat to the safety and wellbeing of all non-ill residents (residents who were negative for COVID-19).	F 880	F880 1. All unvaccinated residents and partially unvaccinated residents who were identified on CNA #1, CNA #2, CNA #3, and LPN #1 assignments were immediately transferred to the GH unit and placed on Transmission Based Precautions (TBP). The Infection Preventionist (IP) as well as the Assistant Director of Nursing (ADON) were immediately in-serviced on 12/9/2021 by the Corporate Director on the policy and procedure for placing unvaccinated residents and/or partially vaccinated residents on TBP. A Root Cause Analysis (RCA) was initiated by the Administrator to determine the cause of the event. Need for increased monitoring and IP rounds, need for appropriate hand hygiene standards and need for appropriate PPE standards. All staff assigned to residents with exposure to staff who test positive for	

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F 880	Continued From page 53 This resulted in an Immediate Jeopardy (IJ) situation that began on [redacted] when the facility was notified of the confirmed COVID-19 positive CNA #1. The facility Administration was notified of the IJ on [redacted] at 6:22 PM. The immediacy was removed on [redacted], based on an acceptable Removal Plan that was implemented by the facility and verified by the surveyors during the Standard Survey conducted on 12/10/2021. The non-compliance remained on 12/10/2021 for actual harm that is not immediate jeopardy based on the following: The evidence was as follows: During an interview with the surveyor on 12/09/21 at 8:30 AM, the Assistant Director of Nursing (ADON) stated there were no COVID-19 positive cases in the facility. The ADON further stated there were three units, A-B, C-D, and G-H, and the required Personal Protective Equipment (PPE) for the [redacted] and [redacted] Units was a surgical mask. The [redacted] Unit included long-term care residents, new admissions, and readmissions. The ADON stated that two residents on the [redacted] Unit were recently admitted and considered PUI. The required PPE in the hallways of the [redacted] Unit were surgical masks, and staff dons an N95 mask, gown, gloves, and eye protection prior to entering a PUI room. During a follow-up interview with the ADON on 12/09/21 at 11:01 AM, the ADON stated that the facility was currently in a COVID-19 outbreak which started [redacted]. There were no positive residents in the facility, and six staff members tested positive for	F 880	COVID-19 were notified. All residents, resident representatives, and staff were notified. All contact tracing was completed to include the unvaccinated and partially vaccinated residents and the daily assignment sheets for CNA #1, CNA #2, CNA #3, and LPN #1. All residents on [redacted] and [redacted] unit were tested [redacted] All facility staff were tested on [redacted] CNA #6, CNA #7, LPN #2, LPN #4, LPN #5, LPN #6, LPN #7, facility Social Worker, and housekeeper were immediately in-serviced regarding the appropriate Personal Protective Equipment (PPE) that is to be donned and doffed during facility COVID-19 outbreak and when in close contact with residents exposed to COVID-19. LPN #2 was immediately in-serviced regarding proper hand washing procedure. The Hand Washing Policy and Procedure was revised to reflect that lathering of hands with soap should occur outside the stream of water. A new full time IP was hired on January 12, 2022 and approved. 2. All unvaccinated or partially vaccinated residents have the potential to be affected by this deficient practice when exposed to staff members who test positive for COVID-19 virus and are not placed on TBP. All unvaccinated or partially vaccinated residents have the potential to be affected by the deficient practice of staff failing to don and doff PPE during facility COVID-19 outbreak and when in close contact with employees exposed to COVID-19.	

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F 880	Continued From page 54 COVID-19. One positive staff member was a nurse who worked on Thursday, [redacted], went on vacation, and then tested positive during vacation. One CNA tested positive before her shift and was sent home, but the ADON did not provide the date at that time. A second CNA worked on the 11 PM-7 AM shift on [redacted] and felt sick during the shift with flu-like symptoms. The CNA went home, tested on Wednesday, and called out of work with a positive COVID-19 result on Friday, [redacted]. The ADON stated that the facility completed two rounds of rapid testing, and no residents exhibited signs/symptoms of COVID-19. As a result, the facility did not initiate TBP for any exposed residents. At that time, the ADON provided the team with a Resident & Staff Outbreak Line List (Line List) dated [redacted] The surveyors reviewed the Line list, which revealed the following: 1. The facility became aware on [redacted] that a Certified Nursing Assistant #1 (CNA), who last worked on [redacted], tested positive for COVID-19 on [redacted]. Once the facility became aware on [redacted] that CNA #1 tested positive and was experiencing symptoms following her shift on [redacted], the facility did not identify possible exposed residents and did not implement TBP. 2. The facility became aware on 1[redacted] that a Licensed Practical Nurse #1 (LPN) tested positive for COVID-19. Once the facility became aware on [redacted] that LPN #1 tested positive, the facility did not identify possible exposed residents and did not implement TBP.	F 880	3. The Administrator, ADON, and IP will review the facilities Infection Control and Managing Infections Policy and Procedures; the IP will in-service all staff regarding policies related to COVID-19. A Root-Cause Analysis (RCA) was completed with all top-line (Administrator, DON) and front-line staff and determined that line staff required additional increase attention and monitoring after being educated to ensure compliance. Directed in-service training videos and modules were completed. Module 1,4 and 5 were completed by Topline Staff and Infection Preventions, Module 6a,6b and 7 were completed by all staff. Videos "Keep Covid Out!", "Clean Hands", "Closely Monitor Residents" and " Use PPE Correctly For Covid-19" were watched by Frontline staff. Long term care self assessment completed. The IP will in-service all staff regarding the appropriate time frames of applying and removing PPE. The IP will in-service all staff on the revised Hand Washing Policy and Procedure. The IP will also conduct hand washing and PPE application and removal competencies with all staff. 4. The Administrator, IP, ADON will review all staff COVID-19 test results daily for four quarters to ensure that any unvaccinated residents or partially vaccinated residents who have exposure to these employees are placed on TBP immediately. The IP will complete employee hand washing and PPE competencies on five staff members weekly for four quarters. All findings will	

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F 880	Continued From page 55 3. The facility became aware on [redacted] that CNA #2 tested positive for COVID-19. Once the facility became aware on [redacted] that CNA #2 tested positive, the facility did not identify possible exposed residents and did not implement TBP. 4. The facility became aware on [redacted] that CNA #3 tested positive for COVID-19. Once the facility became aware on [redacted] that CNA #3 tested positive, the facility did not identify possible exposed residents and did not implement TBP. The surveyors reviewed the Line List, COVID-19 Contact Tracing Forms (Contact Tracing Form), staff assignments, and vaccination status of the staff and residents provided by the facility. 1. CNA #1: Review of the staff vaccination status revealed that CNA #1 was fully vaccinated. Review of the Line List indicated that the facility became aware on [redacted] that a CNA #1 tested positive for COVID-19 on [redacted]. The Line List reflected, "Saff [Staff] called in facility on [redacted] stated that started to feel sick on [redacted] after her shift. Went to get tested at [redacted]] on [redacted] PCR [Polymerase Chain Reaction] test result resived [received] positive on [redacted] Called the facility to notify of results. Last day of work [redacted]. Quratined [quarantined] for 14 days at home. Fully vaccinated." Once the facility became aware on [redacted] that CNA #1 tested positive and was experiencing symptoms following her shift on [redacted], the facility completed a Contact Tracing Form dated [redacted], which reflected that CNA #1 "Came into contact with the following for longer than a combined total of 15 minutes throughout the shift	F 880	be reviewed at the Quality Assurance meeting x 4 quarters.	

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at closer than 6 feet in the last 24 hours:

Assignment #3. [indecipherable]." The Contact Tracing Form further revealed "Testing Dates and Results: [redacted] PCR test at Rite Aid results received on [redacted] + [positive]" with an "Outcome: Quarantine at home." At that time, the facility did not identify possible exposed residents on CNA #1's assignment and implement TBP.

The surveyors reviewed CNA #1's 11 PM - 7 AM assignments on the [redacted] Unit and identified that on [redacted], CNA #1 was assigned to provide care for 15 residents, two of which were unvaccinated (Residents #51 and #84). The [redacted] assignment reflected that CNA #1 was assigned to provide care for [redacted] residents, [redacted] of which were unvaccinated (Residents #10 and #51).

On 12/10/21 at 8:30 AM, the ADON provided a "revised" Contact Tracing Form dated [redacted] which revealed that on [redacted], CNA #1 was "in contact with two unvaccinated residents [Residents #10 and #51], and 2 half vaccinated residents [#47 and #102]." The Contact Tracing form further reflected an "Outcome: quarantine at home x 14 days. Residents in contact placed on TBP x 14 days."

The surveyors reviewed CNA #1's 11 PM - 7 AM assignment on the [redacted] Unit dated [redacted] and confirmed that CNA #1 was assigned to provide care for Residents #47, #51, #84, and #102. The surveyors further reviewed CNA #1's 11 PM - 7 AM assignment on the [redacted] Unit dated [redacted] and confirmed that CNA #1 was assigned to provide

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care for Residents #10 and #51.

2. LPN #1's staff vaccination status review revealed that LPN #1 was unvaccinated.

Review of the Line List indicated that the facility became aware on [redacted] that LPN #1 tested positive for COVID-19. The Line List reflected, "Employee last day worked on [redacted] and went on vacation. Anticipated to return to work on [redacted] Called facility stated that she started to feel sick, [redacted] rapid tested Positive on [redacted] while been on vacation. Employee staying home quarantine."

Once the facility became aware that LPN #1 tested positive, the facility completed a Contact Tracing Form dated [redacted], which reflected that LPN #1 "Came into contact with the following for longer than a combined total of 15 minutes throughout the shift at closer than 6 feet in the last 24 hours: No contact with residents." The Contact Tracing Form further revealed "Testing Dates and Results: employee rapid test on [redacted] on vacation. Vacation days [redacted]-[redacted]" with an "Outcome: quarantine at home x 14 days. Notified job of possible rapid test. Did not return to work." At that time, the facility did not identify possible exposed residents on LPN #1's assignment and implement TBP.

The surveyors reviewed LPN #1's 7 AM - 3 PM and 3 PM - 11 PM assignments on the [redacted] Unit. They identified that on [redacted], LPN #1 was assigned to provide care for [redacted] residents, [redacted] of which were unvaccinated (Residents #11, #60, and #94) and one partially vaccinated resident receiving one (1) dose of a two-dose series (Resident #63).

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F 880	Continued From page 58 On 12/10/21 at 8:30 AM, the ADON provided further information that Resident #11 was fully vaccinated. On 12/10/21 at 8:30 AM, the ADON provided a "revised" Contact Tracing Form dated [redacted], which revealed that on [redacted] LPN #1 also "had contact on [redacted] with [redacted] unvaccinated residents [Residents #60 and #94]. One half vaccinated resident [Resident #63]." The "revised" Contact Tracing Form further reflected that "Resident half vaccinated and unvaccinated placed on PUI + [and] TBP x14 days." The surveyors reviewed LPN #1's 7 AM - 3 PM and 3 PM - 11 PM assignments on the [redacted] Unit dated [redacted] and confirmed that LPN#1 was assigned to provide care for Residents #60, #63, and #94. 3. Review of CNA #2's staff vaccination status revealed that CNA #2 was unvaccinated. Review of the Line List indicated that the facility became aware on [redacted] that a CNA #2 tested positive for COVID-19. The Line List reflected, "Employee was rapid test before her shift on [redacted] positive COVID-19. Send home imidiatly [immediately], no s/s [signs/symptoms] reported by employee, no direct contact was made with residents. Last day at work [redacted]" Once the facility became aware on [redacted] that CNA #2 tested positive, the facility completed a Contact Tracing Form dated [redacted], which reflected that CNA #2 "Came into contact with the following for longer than a combined total of 15 minutes throughout the shift at closer than 6 feet in the last 24 hours: Non [none] sent home before	F 880		

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providing care to Residents." The Contact Tracing Form further revealed "Testing Dates and Results: Rapid test [redacted] with an "Outcome: sent home to quarantine x 14 days." At that time, the facility did not identify possible exposed residents on CNA #2's assignment and implement TBP.

The surveyors reviewed CNA #2's 3 PM - 11 PM assignment on the [redacted] Unit. They noted that on [redacted], CNA #2 was assigned to provide care for [redacted] residents, [redacted] of which were unvaccinated (Residents #25 and #73) and one partially vaccinated resident receiving one (1) dose of a two-dose series (Resident #65).

On 12/10/21 at 8:30 AM, the ADON provided a "revised" Contact Tracing Form dated [redacted] for CNA #2, which revealed that on [redacted] "Employee was in contact with the following Residents on [redacted]: [Residents #25 and #73] unvaccinated and 1 [one] half vaccinate [vaccinated] [Resident #65]." The contact Tracing Form further reflected that "Residents in contact with employee placed on TBP x14 days."

The surveyors reviewed CNA #2's 3 PM - 11 PM assignment on the [redacted] Unit dated 1[redacted] and confirmed that CNA #2 was assigned to provide care for Residents #25, #65, and #73.

4. Review of CNA #3's staff vaccination status revealed that CNA #3 was unvaccinated.

Review of the Line List indicated that the facility became aware on [redacted] that a CNA #3 tested positive for COVID-19. The Line List reflected, "Emplyee [Employee] rapid tested Positive before the sift [shift] on [redacted] Rapid test is positive. Sent

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F 880	Continued From page 60 home imiditaly [immediately] to quarantine. Last day off work before testing on [redacted]" Once the facility became aware on [redacted] that CNA #3 tested positive, the facility completed a Contact Tracing Form dated [redacted], which reflected that CNA #3 "Came into contact with the following for longer than a combined total of 15 minutes throughout the shift at closer than 6 feet in the last 24 hours: N/A [not applicable]." The Contact Tracing form further revealed "Testing Dates and Results: [redacted] rapid test + [positive]" with an "Outcome: employee sent home immediately, quarantine x 14 days." At that time, the facility did not identify possible exposed residents on CNA #3's assignment and implement TBP. The surveyors reviewed CNA #3's 7 AM - 3 PM assignment on the [redacted] Unit and noted that on [redacted], CNA #3 was assigned to provide care for [redacted] residents, [redacted] of which was unvaccinated (Resident #48). On 12/10/21 at 8:30 AM, the ADON provided a "revised" Contact Tracing Form dated [redacted] which revealed that on [redacted], CNA #3 "Employee was in contact with unvaccinated Resident on [redacted] [Resident #48]." The Contact Tracing Form further reflected that "Resident in contact with + [positive] employee placed on TBP x14 days." During an interview with the survey team on 12/09/2021 at 12:35 PM, the Infection Preventionist (IP) confirmed that the identified residents on CNA #1's assignment were not vaccinated for COVID-19. The IP further stated that the process for contact tracing of a positive	F 880		

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employee included looking back 48 hours prior to the positive test to identify residents and staff who had contact with the positive employee for greater than 15 minutes. The IP then stated that all residents and staff, regardless of vaccination status, undergo two rounds of testing for COVID-19.

During the same interview with the survey team, the ADON stated that on Friday, [redacted], CNA #1 notified the facility that she became symptomatic after her 11 PM - 7 AM shift on Monday, [redacted] took a COVID-19 test on Wednesday, [redacted], and received a positive COVID-19 test result on Friday, [redacted] The ADON further stated that residents who are unvaccinated and identified as exposed to someone with COVID-19 are monitored for signs and symptoms of COVID-19 and that staff perform hand hygiene and wear surgical masks when caring for those residents. The ADON also stated that TBP were not implemented for the unvaccinated, exposed residents.

During the same interview with the survey team, the IP explained that new admission and readmission residents are placed on PUI isolation for 14 days due to their unknown exposure status to COVID-19. The IP further stated the importance of placing residents on PUI isolation is because "you can still test positive and shed the virus within 14 days" of exposure.

During an interview with the survey team on 12/09/2021 at 2:29 PM, the IP confirmed that the identified residents on CNA #2's and CNA #3's assignments were not fully vaccinated for COVID-19

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During an interview with the survey team on 12/16/2021 at 11:45 AM, the IP stated that residents who have been exposed to COVID-19, regardless of vaccination status, are placed on PUI isolation for 14 days and that the required Personal Protective Equipment (PPE) for those rooms included an N95 mask, eye protection, a gown, and gloves. The IP further stated that when an employee tests positive for COVID-19, contact tracing is performed to identify residents who had contact with the employee up to 48 hours prior to the positive test result so that non-vaccinated, exposed residents can be placed on PUI isolation. The IP added that it is important to wear the correct PPE to protect the residents and staff from COVID-19.

A review of the facility's Outbreak Plan, revised 09/10/21, included the following:

Testing of staff and Residents during an Outbreak investigation:
A. Upon identification of a single new case of COVID-19 infection in any staff or residents, testing should begin immediately. Facilities have an option to perform outbreak testing through two approaches, contact tracing or broad based (e.g., facility wide) testing. For further information on contact tracing and broad-based testing, see CDC guidance "Interim Infection Prevention and Control Recommendations to prevent SARS-CoV-2 Spread in Nursing Homes."

Cohort Policy:
1. Cohort 1- COVID-19 Positive. This cohort consists of both symptomatic and asymptomatic patients/residents who tested positive for COVID-19, regardless of c\vaccination status.
2. Cohort 2- COVID-19 Negative; Exposed. This

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cohort consists of symptomatic and asymptomatic patients/residents who test negative for COVID-19 with an identified exposure (i.e., close contact) to someone who is positive, regardless of vaccination status. Exposed individuals should be quarantined 14 days from last exposure, regardless of negative test results.
3. Cohort 3- COVID-19 Negative/ Not exposed. This cohort consists of patients/residents who test negative for COVID-19 with no COVID-19 like symptoms and are thought to have no know exposures.
4. Cohort 4-New admissions or Readmissions Observation:
This cohort consists of all new and readmitted patients/residents from the community or other healthcare facilities who are not fully vaccinated.

Review of the CDC's "Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes," dated 09/10/2021, included unvaccinated residents who have had close contact with someone with SARS-CoV-2 infection should be placed in quarantine for 14 days after their exposure, even if viral testing is negative. Healthcare Professionals (HCP) caring for them should use full PPE (gowns, gloves, eye protection, and N95 or higher-level respirator. If testing of close contacts reveals additional HCP or residents with SARS-CoV-2 infection, contact tracing should be continued to identify residents with close contact to the newly identified individual(s) with SARS-CoV-2 infection.
The guidelines further included that unvaccinated residents should generally be restricted to their rooms, even if testing is negative, and cared for by HCP using an N95 or higher-level respirator,

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eye protection (goggles or a face shield that covers the front and sides of the face), gloves and gown. They should not participate in group activities.

NJAC 8:39-27.1 (a)

F880 continues at a lower s/s based on the following:

Based on observation, interview, record review, and review of facility documents, it was determined that the facility failed to a.) implement personal protective equipment according to the New Jersey Department of Health (NJ DOH) and Centers for Disease Control and Prevention (CDC) guidelines to minimize the potential spread of infection to residents on [redacted] units ([redacted] Unit, [redacted] Unit, and [redacted] Unit) and b.) minimize the potential spread of infection to residents for 1 of 3 nurses observed during medication pass on [redacted] of [redacted] units ([redacted] Unit).

This deficient practice was evidenced by the following:

1. Upon entrance into the facility on 12/09/21, the ADON stated that the required PPE for the PUI rooms were full PPE, which consisted of an N95 mask (respirator), eye protection, gown, and gloves, and the required PPE for non-PUI rooms was a surgical mask. The ADON further stated that eye protection was not required in non-PUI rooms.

On 12/13/21, from 8:33 AM to 9:10 AM, Surveyor #2 observed the LPN #2, on the [redacted] Unit, prepare and administer medications to two

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residents (Resident #76 and Resident #13) without donning eye protection.

On 12/13/21, from 8:50 AM to 9:22 AM, Surveyor #1 observed LPN #7 on the [redacted] Unit, prepare and administer medications to three residents (Resident #5, Resident #30, and Resident #56) without donning eye protection.

On 12/13/21 at 9:55 AM, Surveyor #3 observed a staff member talking with a resident while on the [redacted] unit. The staff member's PPE consisted of an N95 mask without eye protection.

On 12/13/21 at 9:55 AM, Surveyor #4 observed a CNA in the hallway of the [redacted] unit, within 6 feet of a resident, wearing only a surgical mask with no eye protection. Surveyor #4 also observed a housekeeper sweeping the floor around the nurses' station and hallway near room numbers 15-23, wearing only a surgical mask without eye protection.

On 12/13/21 at 9:57 AM, Surveyor #4 observed a CNA enter a resident's room wearing only a surgical face mask, without eye protection.

On 12/13/21 at 10:00 AM, Surveyor #4 observed two therapists, one wearing only a surgical mask and the other wearing an N-95 mask, both without eye protection, performing direct care with the resident. One therapist applied a surgical mask on the resident while the other therapist assisted the resident by putting their shoes on their feet. At 10:06 AM, the surveyor then observed the same two therapists using handheld assistance, ambulating the resident with a walker in the hallway.

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F 880	Continued From page 66 On 12/13/2021 at 12:40 PM, Surveyor #5 observed the Social Worker (SW) enter a PUI room on the [redacted] unit wearing a surgical mask under her N95 mask, a gown, and gloves. The SW did not don eye protection prior to entering the PUI room. During an interview with Surveyor #5 on 12/13/2021 at 12:43 PM, the Social Worker (SW) stated that the resident in the PUI room was in isolation for being exposed to a COVID-19 positive person. The SW further stated that the required PPE for the PUI room consisted of an N95 mask, a gown, and gloves. When asked if eye protection was required in the PUI room, the SW responded, "I don't believe so." The SW further stated that she was unsure of the correct order of donning the surgical mask and N95 mask and that she wore the surgical mask underneath the N95 for comfort. The SW then stated that the importance of wearing the correct PPE in the PUI room was to protect herself and the resident from spreading or contracting COVID-19. On 12/14/21, from 8:55 AM to 9:02 AM, Surveyor #1 observed LPN #3 on the [redacted] Unit prepare and administer medications to one resident (Resident #88) without donning eye protection. On 12/14/21 from 9:13 AM and 9:35 AM, Surveyor #1 observed LPN #3 and LPN#4 complete the [redacted] treatment for Resident #52 without donning eye protection. On 12/14/21 at 09:19 AM, Surveyor #4 observed all staff members on the [redacted] unit wearing only surgical face masks without eye protection.	F 880		

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F 880	Continued From page 67 On 12/14/21 at 9:25 AM, Surveyor #3 observed LPN #6 pushing a medication cart down the hall on the [redacted] unit. LPN #6's PPE consisted of an N95 mask with no eye protection. During an interview with Surveyor #3 on 12/14/2021 at 9:28 AM, LPN #6 stated the required PPE on the [redacted] unit was an N95 mask. LPN #6 further stated that she would don the required PPE when entering a PUI room. LPN #6 added the required PPE for the PUI room consisted of an N95 mask, a gown, and gloves. When asked if eye protection was required on the [redacted] unit, LPN #6 stated that staff donned eye protection prior to entering the PUI room. LPN #6 further stated that eye protection was not required while on the [redacted] unit. During an interview with Surveyor #1 on 12/16/21 at 9:33 AM, LPN #5 stated that she currently worked as an agency nurse at the facility and previously worked full time at the facility, on and off for nine years. LPN #5 stated that no residents on the [redacted] Unit had symptoms, were exposed to, or had an active case of COVID-19. The required PPE for the [redacted] Unit was a surgical mask, and the staff do not have to wear eye protection. The agency provided PPE education. During an interview with Surveyor #2 on 12/16/21 at 9:42 AM, CNA #4 on the [redacted] Unit responded to the surveyor's question about the type of PPE that should be worn while care is rendered to residents. CNA #4 stated it is necessary to wear a gown, gloves, face mask, and goggles when there is a sign on the door and a storage container next to the room. The sign usually indicates to see the nurse because there are transmission-based precautions. In such cases,	F 880		

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CNA #4 indicated all the previously mentioned articles of PPE should be worn, in addition to an N-95 face mask. If there is no sign and no transmission-based precautions in place, CNA #4 stated it was necessary to always wear a face mask, knock on the door to enter the room and wear the face mask and a pair of gloves while rendering care to residents. CNA #4 further stated PPE training was most recently conducted with staff last month by an individual who was no longer employed at the facility.

During an interview with Surveyor #2 on 12/16/21 at 9:50 AM, LPN #4 on the same Unit addressed the surveyor's question regarding the type of PPE that should be worn while care is rendered to residents. LPN #4 advised the surveyor that it was always necessary to wear gloves, a mask and perform hand hygiene to render care. LPN #4 stated that staff did not don or doff PPE on this Unit, specifically mentioning that no gowns or booties (shoe coverings) were used on the [redacted] Unit. In cases where staff is irrigating a wound, they would be expected to wear a face shield or goggles. LPN #4 further clarified that the type of mask to be worn on the Unit should be a surgical mask. PPE training was most recently conducted with staff during the past week or so by the Regional Nurse/Infection Preventionist.

During an interview with Surveyor #5 on 12/16/21 at 9:52 AM, CNA #5 for the [redacted] Unit stated that residents on the Unit were under "quarantine isolation" and that the required PPE consisted of an N95 mask with a surgical mask over it, eye protection, a gown, and gloves. CNA #5 further stated that PPE is donned prior to entering the isolation room and removed prior to exiting the room.

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During a follow-up interview with Surveyor #5 on 12/16/2021 at 9:56 AM, LPN #6 stated the residents on the Unit were on PUI isolation and that the required PPE consisted of an N95 mask, surgical mask, eye protection, a gown, and gloves. LPN #6 further stated that PPE is donned prior to entering the PUI room and removed prior to exiting the room. LPN #6 added that the importance of wearing the correct PPE was for infection control.

During an interview with Surveyor #4 on 12/16/21 at 10:26 AM, CNA #6 stated she was the CNA for the [redacted] Unit and only needed to wear a surgical face mask without eye protection on this Unit. CNA #6 further stated that the Unit did not have any COVID-19 positive residents on the Unit. If a resident has a sign on the door indicating isolation, staff was educated to wear a gown, gloves, mask, and face shield prior to entering the isolation room.

During an interview with Surveyor #4 on 12/16/21 at 10:29 AM, the housekeeper stated she was responsible for cleaning rooms on the [redacted] unit. The housekeeper further stated that the PPE required on this Unit was only a surgical face mask, without eye protection. If a resident was positive for COVID-19 or PUI, she would need to wear full PPE, which included a mask, gloves, gown, and face shield prior to entering the resident's rooms.

During an interview with Surveyor #1 on 12/16/21 at 10:39 AM, CNA #7 stated that she worked at the facility for four years and was a permanent CNA on the [redacted] Unit. CNA #7 further stated that the required PPE on this Unit was a surgical

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mask and gloves when giving care and reviewed daily PPE education.

During an interview with Surveyor #5, in the presence of the survey team, on 12/16/2021 at 11:45 AM, the IP stated that the required PPE for the PUI rooms consisted of an N95 mask, eye protection, a gown, and gloves. The IP further stated that staff should don their N95 masks and then a surgical mask over them, so that staff can discard the surgical mask between rooms. When asked about the current NJ DOH COVID-19 Activity Level Index (CALI) Score and the CDC COVID Data Tracker County Transmission Rate, the IP was unsure of the CALI Score but stated the County Transmission Rate was high or substantial. The IP then noted that the facility utilized PPE according to "the regulations" to determine what PPE was required throughout the facility. The IP added that it is important to wear the correct PPE to protect the residents and staff from COVID-19.

On 12/16/2021 at 12:45 PM, the IP followed up with Surveyor #5 and the survey team to provide the CALI Score for the Southeast region of NJ (where the facility is located), which indicated the current activity level was high. The IP also provided the CDC COVID Data Tracker for Cumberland county (where the facility is located), which indicated the transmission rate was high.

Review of the NJDOH Executive Directive 20-026 included, "Facilities shall implement universal eye protection, in addition to source control and other infection prevention and control measures, for all staff and for compassionate care or essential caregiver visitors unable to maintain social distancing when the NJDOH CALI Level is Very

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High/High or Moderate."

Review of the CDC's Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic guidelines, dated 09/10/2021, included, "If SARS-CoV-2 infection is not suspected in a patient presenting for care (based on symptom and exposure history), HCP [healthcare professionals] working in facilities located in counties with substantial or high transmission should also use PPE as described below: ... Eye protection (i.e., goggles or a face shield that covers the front and sides of the face) should be worn during all patient care encounters."

Review of the CDC's How to Properly Put on and Take off a Disposable Respirator guideline included, "Do not allow facial hair, hair, jewelry, glasses, clothing, or anything else to prevent proper placement or come between your face and the respirator."

2. On 12/13/21 at 8:58 AM, Surveyor #2 observed LPN #2, upon completion of administering medications to a resident, enter the bathroom of a second resident. There were no paper towels present in the wall dispenser, so the LPN asked a staff member to replace a large roll of paper towels within the dispenser. The LPN then wet her hands, briefly lathered them with soap, and placed both hands under the stream of water while applying friction to her hands. The entire process lasted 12 seconds. Afterward, the LPN prepared medications and administered them to the second resident.

During an interview with Surveyor #2 on 12/13/21

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at 10:00 AM, LPN #2 described the handwashing process. The LPN explained it was necessary to turn the water on for warmth, use soap, and rub hands, including between the fingers. When asked about the length of time-related to handwashing, LPN #2 stated she sings the "Happy Birthday" song to herself to know how long to wash and added that the process should take longer than two seconds. She further stated that she probably washes her hands for 60 seconds and that the facility policy indicates that handwashing is longer than 30 seconds.

During an interview with Surveyor #2 on 12/16/21 at 12:06 PM, the IP described the facility's handwashing procedure to the survey team. She stated that handwashing occurs with soap and water, followed by lathering the hands and scrubbing them for 20 seconds. The hands are held in a downward manner, and scrubbing should include the area under the nails, so the dirt goes down the drain. The lathering process occurs outside the stream of water because otherwise, "there is no point." At this time, the surveyor questioned the wording on the facility's policy, which indicated that hands should be lathered under the stream of water. The IP then stated lathering could occur under the stream of water and referenced CDC guidelines, which indicated to lather for 20 seconds. The IP then stated she could not remember whether lathering of the hands should occur outside or under the stream of water but acknowledged that if the entire handwashing process occurred for a total of 12 seconds, such a practice would be considered problematic because the process was not long enough. The IP then stated she would like to investigate matters further and follow up with the survey team.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315061	A. BUILDING _____ B. WING _____	12/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTH JERSEY EXTENDED CARE	99 MANHEIM AVENUE BRIDGETON, NJ 08302

(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 73	F 880		

During an interview with Surveyor #2 and the survey team on 12/16/21 at 12:34 PM, the IP stated it is necessary to scrub hands outside the stream of water per CDC guidelines and referenced a poster to that effect. She further stated that the posters are displayed "everywhere" and that she understood there was a need to look at the facility's policy regarding handwashing further.

A review of the facility's "Handwashing/Hand Hygiene" policy reviewed 8/17/21 revealed handwashing included vigorously lathering the hands with soap and rubbing them together, creating friction to all surfaces, for a minimum of 20 seconds under a moderate stream of water, with water at a comfortable temperature.

Review of the facility's "Hand Hygiene How-To" poster provided by the IP, who stated that the poster was obtained online from the CDC website, revealed it is necessary to "rub the hands for at least 20 seconds to get rid of bacteria." It included the following steps, both in words and depicted in pictures:

1. Wet (picture of two hands under a faucet of running water)
2. Soap (picture of two hands under a soap dispenser)
3. Wash 20 Seconds (picture of hands being rubbed together)
4. Rinse (picture of hands under a stream of running water)
5. Dry (picture of one hand drying the other with a paper towel, with a roll of paper towels in the background)
6. Turn off water with paper towel (picture of a

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SOUTH JERSEY EXTENDED CARE	99 MANHEIM AVENUE BRIDGETON, NJ 08302

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F 880	Continued From page 74 faucet and hand turning a nob, using a paper towel). Review of LPN #2's "Hand Washing Skills Evaluation," undated, indicated to, "Rub hands together vigorously to create lather, wash all areas of hands including fingernails by rubbing against palm of the opposite hand for at least 20-30 seconds. Keep fingertips pointed down." NJAC 8:39 - 19.4(a)(1)	F 880		