STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315357	A. BUILDING _____ B. WING _____	11/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALARIS HEALTH AT CEDAR GROVE	110 GROVE AVE CEDAR GROVE, NJ 07009

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Survey Date: 11/4/20 Census: 130 A COVID-19 Focused Infection Control Survey was conducted by the New Jersey Department of Health. The facility was found to be not in compliance with 42 CFR §483.80 infection control regulations as it relates to the implementation of the CMS and Centers for Disease Control and Prevention (CDC) recommended practices for COVID-19.	F 000		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to	F 880		11/10/20

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

Electronically Signed | 11/12/2020

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315357	A. BUILDING _____ B. WING _____	11/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALARIS HEALTH AT CEDAR GROVE	**110 GROVE AVE CEDAR GROVE, NJ 07009**

(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 1 §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 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	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315357	A. BUILDING _____ B. WING _____	11/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALARIS HEALTH AT CEDAR GROVE	110 GROVE AVE CEDAR GROVE, NJ 07009

(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 2 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, and record review it was determined that the facility staff failed to adhere to accepted standards of infection control practices for the use of the required personal protective equipment (PPE) and to sanitize the area that was used for COVID-19 specimen collection to mitigate the spread of COVID-19 for 1 of 1 staff observed during staff testing. This deficient practice was evidenced by the following: According to the U.S. Centers for Disease Control and Prevention (CDC) guidelines, Performing Facility-wide SARS-CoV-2 Testing in Nursing Homes updated 5/19/2020 included guidelines to "PPE for swabbing" The guideline specified that, "HCP (healthcare personnel) in the room or specimen collection area should wear an N95 or higher-level respirator (or facemask if a respirator is not available) and eye protection. A single pair of gloves and a gown should also be worn for specimen collection or if contact with contaminated surfaces is anticipated." According to the U.S. CDC's "Interim Infection Prevention and Control Recommendations for HCP During the Coronavirus Disease 2019 (COVID-19) Pandemic" updated 11/4/20	F 880	The IPN was immediately re-in-serviced by DON that complete "PPE for swabbing" for COVID-19 nasopharyngeal swab collection,(mask, gown, face shield, gloves), should be worn for specimen collection or if contact with contaminated surfaces is anticipated. The IPN was immediately re-in-serviced by DON to clean and disinfect all procedure room surfaces. The IPN disinfected the surface of the table used for the COVID-19 nasopharyngeal collection. All staff and residents have the potential to be affected. All nursing managers assigned to do the swab testing were re-in-serviced by DON and completed the competency evaluation on complete "PPE for swabbing" and cleaning and disinfecting procedure room surfaces immediately after swabbing. DON/ADON will observe the nurse manager doing the swabbing weekly on 2-3 residents/staff and randomly with proper use of full PPE and cleaning and disinfecting procedure room surfaces immediately.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315357	A. BUILDING _____ B. WING _____	11/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALARIS HEALTH AT CEDAR GROVE	110 GROVE AVE CEDAR GROVE, NJ 07009

(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 3 guidelines to "Collection of Diagnostic Respiratory Specimens" specified that, "Clean and disinfect procedure room surfaces promptly as described in the section on environmental infection control ....Ensure that environmental cleaning and disinfection procedures are followed consistently and correctly." On 11/4/2020 at 8:35 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) in the presence of the survey team. The LNHA stated that the facility had a current COVID-19 outbreak in which 5 staff members had tested positive for COVID-19 during weekly testing on 10/22/20. On that same date and time, the LNHA stated that staff was being tested for COVID-19 weekly every Wednesday and it was the Infection Preventionist Nurse (IPN) responsibility to collect the specimen. On 11/4/2020 at 11:12 AM, during COVID-19 nasopharyngeal (back of the nose and throat) swab collection the IPN did not wear a complete PPE only a KN95 mask. During this procedure the Director of Maintenance (DoM) was asked by the IPN to blew his nose in a piece of tissue paper before collecting a specimen. At that time, the DoM was not wearing a mask and was within six feet of the IPN. On that same date and time after completing the specimen collection, the IPN left the room without sanitizing the table that had been used for specimen collection. During an interview on 11/4/2020 at 11:23 AM,	F 880	DON/ADON will audit testing procedure weekly for the next quarter, and report any variance findings and resolution to the Administrator weekly for the next quarter. Results of these audits will be reported quarterly at the QA meeting for the next quarter.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315357	A. BUILDING _____ B. WING _____	11/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALARIS HEALTH AT CEDAR GROVE	**110 GROVE AVE CEDAR GROVE, NJ 07009**

(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 4 the IPN stated that "I should have worn the full PPE when I asked the DoM to blow his nos." That PPE would have included in addition to the mask; a gown, face shield, and gloves. She further stated that she should sanitize the table after use for infection control. At 12:35 PM, the LNHA stated that the facility had no guidelines for a step to step COVID-19 swab specimen collection procedure. At 12:52 PM, surveyors met with the LNHA, Vice President for Operations, and the Regional Nurse and were made aware of the above concerns. There was no additional information provided by the facility. NJAC 8:39-27.1	F 880		