STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315223	A. BUILDING _____ B. WING _____	06/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON CONTINUING CARE	1059 EDINBURG ROAD HAMILTON, NJ 08690

(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: 06/09/21 Census: 103 Sample: 6 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	F 880		7/6/21

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

Electronically Signed | 06/18/2021

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

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F 880	Continued From page 1 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 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	F 880		

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F 880	Continued From page 2 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 review of pertinent facility documentation, it was determined that the facility failed to follow their policy for Personal Protective Equipment usage and hand hygiene to prevent the possible spread of infection during a COVID-19 focused survey. This deficient practice was identified for one staff member on Executive Ord nursing units (Executive Order 26, 4.b.), and 1 of 1 resident reviewed for transmission-based precautions (Resident #6) as evidenced by the following: The surveyor interviewed the MDS (Minimum Data Set) (an assessment used to direct care) Coordinator on Executive Order 26, 4.b. The MDS Coordinator stated that the facility entered Phase Zero of a COVID-19 Outbreak on Executive Order 2 after two staff members and one resident Executive Order 26, 4.b. Executive Order 26, 4.b. She further stated that all staff were required to wear Personal Protective Equipment (PPE) (garments or equipment used to protect the body from injury or infection) throughout the building. She explained that on the nursing units that were designated for Persons Under Investigation (PUI) for exposure or signs and symptoms of COVID-19, or with confirmed COVID-19, staff were required to wear an N-95 respirator mask (filters at least 95% of airborne particles), eye goggles or face shield, gown, and gloves when they entered a resident room. She stated that an N-95 respirator mask and eye goggles or face shield were required to be worn	F 880	DISCLAIMER STATEMENT Preparation and/or execution of the Plan of Correction does not constitute admission or agreement of the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of federal and state law. The Plan of Correction represents the facility's credible allegation of compliance as of July 6, 2021. Plan of Correction Date: July 6, 2021 -One, actions taken for the (1) resident identified: 1. Resident Execu - The resident had no adverse reaction from not following the Personal Protective Equipment (PPE) and hand wash protocol. Resident care plan was reviewed. The resident was on close monitoring for signs and symptoms of communicable disease for 14 days and testing for COVID-19 was performed bi-weekly. Resident Execu is symptom-free and did not develop any communicable	

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F 880	Continued From page 3 when in the hallway or common areas of the affected units Executive Order 26, 4.b. [redacted]. She noted that the areas of the building that were designated as green zones (no suspected or confirmed cases of COVID-19) were the Executive Order 26, 4.b. and the Executive [redacted], where staff were required to wear an N-95 respirator mask at all times. At 11:26 AM, during the tour of the Executive Order 26, 4.b. of Executive Order 26, 4.b., the surveyor observed a Stop Corona Virus Sign on the wall outside of Resident #6's room, which indicated that staff must wear the following PPE before entering the PUI room: gown, N95 or KN95 Mask, goggles or face shield and gloves. The surveyor observed the Certified Nursing Assistant (CNA), who wore an N95 respirator mask and goggles but did not wear a gown or gloves as she removed linens from the bed in Resident #6's room. The CNA placed the soiled linens inside of a plastic bag after removal. She then exited the room without washing her hands or using hand sanitizer located on top of a three-bin PPE cart located outside the resident's room. She then lifted the plastic protective covering from a linen cart in the hallway and accessed the cart to obtain additional bed linens. The surveyor observed the CNA as she returned to Resident #6's room. The CNA did not perform hand hygiene or donn a gown or gloves before entering the room and placing clean linens on the bed.	F 880	disease. Nursing Administration in-serviced and reinforced all staff about the PPE and handwash/hand hygiene protocol. Also, the importance of following the PPE and handwash/hand hygiene protocol every single time to prevent the transmission of communicable disease. -Two, identification of other residents who have the potential to be affected: Currently, all the residents in building can potentially be affected by not following the PPE and handwash/hand hygiene protocol is enforced. -Three, system changes and measures that will be made: 1. All staff will be in-serviced and reinforced by nursing administration in the following areas: -The importance of preventing the communicable disease by donning PPE upon entry of isolation/patient under investigation (PUI) room with an N-95 or KN-95 mask, goggles or face shield, gown, gloves, and the doffing of PPE and hand hygiene upon exit. -The importance of hand-washing hygiene on completion of any task when hands are contaminated. 2. Weekly, nursing unit managers will perform competencies with the staff for donning of PPE upon entry of an isolation/PUI room with an N-95 or KN-95	

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F 880	Continued From page 4 The surveyor interviewed the CNA at 11:27 AM, who acknowledged that she was not supposed to be in any resident room on the unit without a gown, gloves, N95 respirator mask, and face shield. She said that she had a gown and gloves on and doffed them after Resident #6 [redacted] She stated that she initially intended to exit the room and instead made a mistake after noticing that the bed was dirty and began to remove the soiled sheets without first donning gloves or a gown. The CNA further stated that she could have potentially contaminated the linen cart since she did not wash her hands after she doffed her gown and gloves and handled soiled linens before accessing the linen cart. The CNA stated that she would ensure that the linen cart was removed from use to prevent the potential spread of infection. The surveyor interviewed the Licensed Practical Nurse (LPN) at 11:39 AM, assigned to Resident #6. The LPN said that the CNA was required to wear an N95 respirator mask, goggles/face shield, gown, and gloves when entering the resident's room. She stated that the CNA must wash her hands or use hand sanitizer after she doffed her gown and gloves before leaving the room. She further noted that if the CNA did not wash her hands after she doffed her gown and gloves and handled soiled linens, and then accessed the linen cart, it was now considered to be contaminated. The surveyor interviewed the Unit Manager at 11:47 AM, who also stated that the CNA was required to wear an N95 respirator mask, gown, and goggles/face shield when she entered the	F 880	mask, goggles or face shield, gown and gloves. Doffing of all PPE and hand hygiene upon exit of isolation room. Hand-washing hygiene competencies will be done with staff by unit managers. 3. The Director of Nursing or her designee will review infection prevention audits done by unit managers and address the issues in real time and on a regular basis. 4. Monthly, the Director of Nursing and the Infection Preventionist will review the audits done by the nursing unit managers. Analysis will be conducted with discussion at the facility's quarterly Quality Assurance and Performance Improvement meeting. Information will be used for staff education and development. Four, monitoring mechanisms to assure compliance: 1. As part of the daily monitoring the Director of Nursing or her designee with nursing unit managers, and nursing supervisors will observe the staff for donning of PPE upon entry and doffing of PPE upon exit of an isolation/PUI room as well as handwashing hygiene protocols on a daily basis. 2. As part of the facility's Quality Assurance and Performance Improvement Program (QUAPI) a route cause analysis (RCA) will be done on the topic of the failed use of PPE upon entry to PUI/isolation resident room, and failed	

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F 880	Continued From page 5 room on the PUI unit. She noted that gloves were required if resident care was rendered. She said that the CNA should have washed her hands after she doffed her gown and gloves and handled resident linens. She stated that the CNA was required to gown up before she entered Resident #6's room. She said that the CNA informed her of what happened and the linens in the linen cart were discarded, and a replacement linen cart was ordered to prevent the potential spread of infection. The surveyor interviewed the Assistant Director of Nursing (ADON)/Infection Preventionist at 2:19 PM. The ADON stated that the CNA was only required to wear a gown and gloves if she was in direct contact with a resident or within six feet of a resident housed on the PUI Unit. She further stated that since Resident #6 was on Executive Order 26, 4.b. [redacted] the CNA was required to wash her hands after she was in contact with soiled linens within the resident's room. She stated that there was a possibility that the CNA may have contaminated the linen cart, which could transmit the spread of infection. The surveyor reviewed the facility policy "COVID-19 Transmission-Based Precautions: Droplet, Universal Mask, and Contact Precautions" (Revised 11/11/2020), which revealed the following: Gloves and Hand Washing: Gloves will be worn upon entering the resident's	F 880	action of hand hygiene after any task performed in a resident room where hands are contaminated. The evaluation of the RCA will be brought to the facility's quarterly QUAPI meeting for discussion. The outcome of the discussion will be brought back to front line staff for education and development. Issues will be discussed and addressed on an as needed basis in real-time. 3. RCA was completed and staff was interviewed as to why the policy was not followed. The employee stated that she forgot, due to being nervous about the survey and wanted the room to be neat. 4. All Topline and Frontline staff viewed the video on Keep Covid 19 Out, clean hands video, use of PPE video. CDC Module one was viewed by Topline staff. Infection Control preventionist viewed all CDC modules. In summary of the plan of correction, the steps are listed above. We have taken corrective actions with staff education and monitoring.	

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F 880	Continued From page 6 room and while providing care. ...Gloves will be removed before leaving the resident's room, and hands will be washed. After gloves removed and hand [sic.] washed in accordance with the hand-washing policy, hands should not touch potentially contaminated environmental surfaces or items before leaving the room. Gowns: Staff should wear a gown when entering the resident's room if staff anticipates that: Clothing will have contact with infectious body fluids, environmental surfaces, or items in the resident's room. ... staff should not permit clothing to contact potentially contaminated [sic.] environmental surfaces after removing a gown. NJAC 8:39-19.4 (n)	F 880		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
315223		8/4/2021

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON CONTINUING CARE	1059 EDINBURG ROAD HAMILTON, NJ 08690

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0880 Reg. # 483.80(a)(1)(2)(4)(e)(f) LSC	Correction Completed 07/06/2021	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
6/2/2021

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