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New Jersey Department of Health

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING: |  | (X3) DATE SURVEY<br>COMPLETED  |  |  |  |  |  |  |  |
|---|---|---|--|--|--------------------------------|--|--|--|--|--|--|--|
|   | 061201  |   | B. WING                                  |  | 11/10/2020                     |  |  |  |  |  |  |  |
| NAME OF P   | ROVIDER OR SUPPLIER   | STREET AL   | DDRESS, CITY, ST                         | DRESS, CITY, STATE, ZIP CODE   |                                |  |  |  |  |  |  |  |
| AMBOY CARE CENTER 1 LINDBERG AVENUE                 |   |   |  |  |                                |  |  |  |  |  |  |  |
| PERTH AMBOY, NJ 08861                               |   |   |  |  |                                |  |  |  |  |  |  |  |
| (X4) ID<br>PREFIX<br>TAG                            | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  |   | ID<br>PREFIX<br>TAG                      | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPF<br>DEFICIENCY)  | BE COMPLETE                    |  |  |  |  |  |  |  |
| S1305   | 1305 8:39-19.1(b) Mandatory Infection Control and Sanitation  (b) Responsibility for the infection prevention and control program shall be assigned to an employee who is designated as the infection control coordinator, with education, training, completed course work, or experience in infection control or epidemiology; or services shall be provided by contract. If the services are provided by contract, the facility shall designate an on-site employee to implement, coordinate, and ensure compliance with infection control policies and procedures.  This REQUIREMENT is not met as evidenced by: |   | S1305                                    | Tag 1305   | 12/16/20                       |  |  |  |  |  |  |  |
|   | pertinent facility document that the facility failed to Directive No. 20-026 Commissioner in resp. Pandemic by failing to Infection Preventionis control training requirements. The deficient practice following:  On 11/10/20 at from 8 surveyors conducted the facility's Licensed Administrator (LNHA) Assistant Director of 1 Regional Director. At conference the Regio  | was evidenced by the s:45 AM to 9:40 AM the an entrance conference with |  | 1. The facility contracted an Infection Preventionist. Completed courses incl CDC/Train Infection Preventionist, QS COVID-19 Management Staff and COVID-19 Frontline Staff, QSEP Infection Control. These courses well exceed 2 hours of training. The facility's Region Director has also completed all above courses and will consult along with the Infection Preventionist.  2. All residents have the potential to be affected by this deficient practice whe facility's Outbreak Plan to have an Infection Preventionist direct and serv leader in infection surveillance.  3.An in-service was done by the Region | etion  5 al  e  e  n the  e as |  |  |  |  |  |  |  |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Electronically Signed 11/20/20

STATE FORM 6899 Y9L511 If continuation sheet 1 of 3

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:                      | ` '                                   | (X2) MULTIPLE CONSTRUCTION  |                            |  |  |  |  |
|--|--|---|---------------------------------------|---|----------------------------|--|--|--|--|
| ANDILAN  | OF CONNECTION  | IDENTIFICATION NOMBER.  | A. BUILDING:                          |   | COMPLETED                  |  |  |  |  |
|  |  | 061201  | B. WING                               |   | 11/10/2020                 |  |  |  |  |
| NAME OF P  | ROVIDER OR SUPPLIER  | STREET AD   | DRESS, CITY, STA                      | ATE, ZIP CODE   |                            |  |  |  |  |
| 1 LINDBERG AVENUE                                |  |   |                                       |   |                            |  |  |  |  |
| AMBOY C  | ARE CENTER   |   | MBOY, NJ 088                          | 61  |                            |  |  |  |  |
| (X4) ID  | SUMMARY ST   | ATEMENT OF DEFICIENCIES   | ID PROVIDER'S PLAN OF CORRECTION (X5) |   |                            |  |  |  |  |
| PREFIX<br>TAG                                    | •  | MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPL |                                       | BE COMPLETE   |                            |  |  |  |  |
| S1305  | Continued From page 1  |   | S1305                                 |   |                            |  |  |  |  |
|  | The surveyor requested evidence of infection control training for the ADON/IP.                         |   |                                       | Director with the Administrator to ensuthat the Outbreak Plan was being follows per directives. | ak Plan was being followed |  |  |  |  |
|  |  | 00 , the Regional Director  |                                       |   |                            |  |  |  |  |
|  |  | ertificates for infection control                                       |                                       | 4. The Outbreak Plan will be reviewed   |                            |  |  |  |  |
|  |  | led 25 hours, but it had the  |                                       | the Quality Assurance meeting to ensure   |                            |  |  |  |  |
|  |  | Director on the certificates  |                                       | all directives are being met x 2 quarte   | rs.                        |  |  |  |  |
|  | and not the ADON/IP. The Regional Director stated that she oversees multiple facilities and the        |   |                                       |   |                            |  |  |  |  |
|  | ADON/IP had recently started working at the  |   |                                       |   |                            |  |  |  |  |
|  | facility. The Regional Director confirmed that the   |   |                                       |   |                            |  |  |  |  |
|  | ADON/IP performed the infection control  |   |                                       |   |                            |  |  |  |  |
|  | in-service educations to staff and not her, but  |   |                                       |   |                            |  |  |  |  |
|  | added that the ADON/IP was also a Nurse  |   |                                       |   |                            |  |  |  |  |
|  | Practitioner by background. The surveyors asked  |   |                                       |   |                            |  |  |  |  |
|  | for any additional certificates for infection control completed by part time or full time staff at the |   |                                       |   |                            |  |  |  |  |
|  | facility. The Regional Director stated that the  |   |                                       |   |                            |  |  |  |  |
|  | ADON had not taken the infection control   |   |                                       |   |                            |  |  |  |  |
|  | education series to her knowledge.   |   |                                       |   |                            |  |  |  |  |
|  | At 12:10 PM, the surveyors interviewed the   |   |                                       |   |                            |  |  |  |  |
|  | ADON/IP who stated that she started working at   |   |                                       |   |                            |  |  |  |  |
|  |  | 20 and she took a 3.5 hour infection control in long term               |                                       |   |                            |  |  |  |  |
|  |  | not have any other formal   |                                       |   |                            |  |  |  |  |
|  |  | ing. She stated that this was   |                                       |   |                            |  |  |  |  |
|  |  | vith the IP role and that while   |                                       |   |                            |  |  |  |  |
|  | -  | ctitioner by background, she  |                                       |   |                            |  |  |  |  |
|  |  | tion in infection control. The  |                                       |   |                            |  |  |  |  |
|  | -  | e surveyors with the course   |                                       |   |                            |  |  |  |  |
|  | T  | for Centers for Medicare  |                                       |   |                            |  |  |  |  |
|  | and Medicaid Service COVID-19 Training for   | ` , •   |                                       |   |                            |  |  |  |  |
|  | _  | 0/24/2020. The ADON/IP  |                                       |   |                            |  |  |  |  |
|  | _  | as the only formal IP training  |                                       |   |                            |  |  |  |  |
|  | •  | ole thus far and she further  |                                       |   |                            |  |  |  |  |
|  |  | ne was responsible for  |                                       |   |                            |  |  |  |  |
| providing all in-service training's for staff on |  |   |                                       |   |                            |  |  |  |  |
|  | -  | nad not yet completed the   |                                       |   |                            |  |  |  |  |
|  |  | ase Control and Prevention  |                                       |   |                            |  |  |  |  |

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|--|--|---|--|-------------------------------|--------------------------|--|--|--|--|--|--|
|  | 061201   | B. WING                                 |  | 11/10/2020                    |                          |  |  |  |  |  |  |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE   |  |   |  |                               |                          |  |  |  |  |  |  |
| AMBOY CARE CENTER 1 LINDBERG AVENUE PERTH AMBOY, NJ 08861  |  |   |  |                               |                          |  |  |  |  |  |  |
| PREFIX (EACH DEFICIENCY MU   | MENT OF DEFICIENCIES<br>IST BE PRECEDED BY FULL<br>IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG                     | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROPI<br>DEFICIENCY) | BE                            | (X5)<br>COMPLETE<br>DATE |  |  |  |  |  |  |
| S1305 Continued From page 2 (CDC) Nursing Home Information Training Course.  A review of the facility's Continued that the will "direct the facility's pleffortsserve as the lead surveillanceand will per Infection Prevention and healthcare facilities carin suspected or confirmed I including COVID-19. | Outbreak Plan updated Infection Preventionist anning and response der" in infection riodically review specific Control guidance for g for residents with | \$1305                                  |  |                               |                          |  |  |  |  |  |  |