STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315251	A. BUILDING _____ B. WING _____	12/07/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARTWYCK AT OAK TREE	2048 OAK TREE ROAD EDISON, NJ 08820

(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: 12/7/2020 Census: 96 Sample: 7 A COVID-19 Focused Infection Control Survey was conducted by the New Jersey Department of Health. The facility was found not to be in compliance with 42 CFR §483.80 infection control regulations and has implemented 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 §483.70(e) and following	F 880		12/8/20

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

Electronically Signed | 12/11/2020

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F 880	Continued From page 1 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 infection.	F 880		

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F 880	Continued From page 2 §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 ensure that appropriate infection control practices were followed by staff to prevent the spread of COVID-19. This deficient practice was identified for 1 of 7 staff members observed on 2 of 2 nursing units, and was evidenced by the following: On 12/7/2020 at 9:00 AM, the survey team conducted an entrance conference with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON). The DON stated that the facility currently had two COVID-19 positive residents who resided on a designated section on the [redacted] floor. She added that those residents had a designated nurse and a designated Certified Nursing Aide (CNA) who only cared for the two residents. The DON stated that the remaining 94 residents in the building were on a fourteen-day quarantine for possible exposure to COVID-19 from staff members who tested positive for COVID-19. The DON stated that they placed all residents on a transmission-based precautions (TBP) to be cautious. She added that all staff members were required to don full Personal Protective Equipment (PPE; items worn to protect the wearer from contracting infectious agents) which included an N95 (respirator) mask with a surgical mask covering, eye protection, disposable gown,	F 880	F880 1) C.N.A.#1 and the RN were both immediately re-educated and counseled on the policy and procedure for proper use of PPE supplies and hand hygiene. C.N.A.#1 received competency testing for donning/doffing PPEs and hand hygiene. Residents in rooms [redacted] and [redacted] were immediately placed on extended quarantine precautions for 14 days from this date. 2) All residents on C.N.A. #1□s assignment were identified and placed on extended quarantine precautions for 14 days from this date. All facility residents who are not currently COVID(+) or COVID Recovered within the last 90 days were retested via PCR Nasal Swab for COVID19. 3) All facility staff were re-educated to: - Wear N95 covered by a surgical mask and goggles or face shield at all time on the patient care units, as per the policy in facility Pandemic Plan. - Change the surgical mask after providing care for a resident on quarantine precautions. - The purpose and guidelines of the Quarantine Precautions, including the signage used to identify residents on quarantine precautions, hand-hygiene and	

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F 880	Continued From page 3 and gloves prior to entering any resident's room. Staff were expected to doff (remove) the gown and gloves prior to exiting the room and perform hand hygiene with soap and water or an alcohol-based hand rub (ABHR). The DON stated that all staff on the two nursing units were supposed to wear N95 mask throughout the units. The DON stated that all residents were tested for COVID-19 on a weekly basis and that staff were currently getting the COVID-19 rapid antigen testing trial every other day since 11/30/2020. She added that previous to 11/30/20, staff were routinely tested weekly. At 11:00 AM, the surveyor entered the [redacted]-floor nursing unit and observed in all [redacted] wings, that TBP signs and PPE bins were located outside each resident room door. The surveyor observed that outside each resident room was an ABHR dispenser mounted to the wall. At 11:05 AM, the surveyor interviewed CNA #1 who stated that the cautionary signs on the residents' room doors were there to notify staff of residents' TBP status and to show the type of PPE staff should don when providing care to residents. The surveyor observed that CNA#1 wore only a surgical mask and goggles and not the N95 mask and gown. When questioned, CNA#1 stated that she wore N95 mask earlier, and that she removed it because she needed a break because N95 mask was uncomfortable. At that time, CNA #1 proceeded into resident room [redacted] with no observed hand hygiene, and wearing only surgical mask and goggles. CNA#1 did not don gloves or gown.	F 880	PPE required to enter a room with quarantine precautions, removal of PPE and hand-hygiene prior to exiting a quarantine precautions room. 4) The following systemic changes have been initiated: Each Charge Nurse, or designee, will conduct a Nursing Team Huddle on each nursing unit at the beginning of every shift to - communicate PPE requirements in effect for that day - visually inspect all nursing team members on the unit to confirm N95, surgical mask and goggles/face shield are properly donned - review quarantine and isolation precautions, including signage and requirements Team Huddle participants must sign the Huddle form at every shift to indicate participation in the Huddle and understanding of the information presented. The form is to be collected at the end of the 11-7 shift and audited by the 11-7 Supervisor to ensure all nursing Team Members that were on the schedule for that day participated in the Huddle. Any missing signatures will be communicated to the Facility Educator to address those team members directly. All Team Members who have been out of work for more than 5 days must report to the Nursing Supervisor upon return to work to be re-educated regarding updates to the facility Pandemic Plan, including Phase of Opening and associated	

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F 880	Continued From page 4 The surveyor noticed outside the door to room [redacted], a quarantine TBP sign which indicated that prior to entering the room, staff should wash or sanitize their hands and don gown, gloves, eye protection, and a N95 mask covered with a surgical mask. There was a PPE bin located directly outside the door to room [redacted] which contained gowns, gloves, surgical masks, and germicidal bleach wipes. The surveyor also observed an ABHR dispenser that was mounted on the wall outside the room. There were two residents in room [redacted]. The surveyor stood outside room [redacted] and observed CNA#1 as she exited the residents' bathroom, carrying a blue plastic garbage bag that contained unidentifiable materials. CNA #1 placed the garbage bag into a covered linen bin and rolled the bin down the hallway to outside of room [redacted]. The surveyor did not observe CNA#1 perform hand hygiene after handling the plastic bag and the linen bin. CNA #1 then proceeded into room [redacted], while still wearing the same surgical mask and goggles, no gown, no gloves. The surveyor observed outside the door to room [redacted], a quarantine TBP sign, a PPE bin, and ABHR mounted on the wall. CNA #1 went into the residents' bathroom, and exited the bathroom wiping her hands with a disposable towel. She proceeded to the resident's dresser and moved around the resident's belongings which was on the dresser. CNA#1 then went over to Resident #1 and picked their water cup, went to the bathroom with the water cup and then brought the cup back to the resident. CNA#1 then went back into the bathroom and came out with a water basin and placed the basin on the resident's tray table. She then closed the resident's privacy curtains blocking the surveyor's	F 880	restrictions in place, PPE requirements, Quarantine/Isolation precautions, and COVID unit locations. The Return to Work education will be documented and signed by the Team Member and filed with the Facility Educator. The Infection Preventionist, or designee, will observe for compliance with PPEs and hand hygiene daily for one month then monthly thereafter, during Infection Control rounding. Non-compliance will be addressed immediately with the Team Member and reported to Director of Nursing and Facility Educator for further corrective action as warranted. Documentation from the Team Huddles, the Return-to-Work Education and the Infection Preventionist Compliance observations will be reviewed monthly at the Nursing Professional Practice meeting to monitor compliance and identify trends. Results will be reported to QA committee on a quarterly basis. Preparation and/or execution of this Plan of Correction does not constitute admission/agreement of the provider of the truth of the facts alleged or conclusions set forth in any statement of deficiencies. This Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal or State Law.	

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F 880	Continued From page 5 view of the resident. CNA#1 then went to Resident#1's closet, removed some clothing and placed the clothing on the bed and then walked out of the room with no observed hand hygiene. From room [redacted], CNA #1 walked into room [redacted] with no observed hand hygiene or donning of new PPE. The surveyor observed quarantine TBP sign, PPE bin, and ABHR dispenser mounted to the wall outside the door of room [redacted]. The surveyor observed CNA#1 as she moved resident's belongings on the dresser. She then picked a pair of gloves from a box on the resident's dresser and left the room with the gloves. The surveyor did not observe CNA#1 perform hand hygiene. At 11:21 AM, CNA #1 walked back into room [redacted] and donned the gloves she picked from room [redacted]. She did not perform hand hygiene. The surveyor observed the CNA#1 move sheets around the Resident#1's bed. At this time, the surveyor interviewed a unit Registered Nurse (RN) who was outside of room [redacted] preparing medications. The RN confirmed that CNA #1 was performing direct care on Resident #1. The surveyor asked the RN if CNA #1 should be wearing full PPE to perform care on Resident #1. The RN stated that CNA #1 should be wearing full PPE, and confirmed that CNA#1 was not wearing a gown. The RN did not stop CNA#1 but rather continued to prepare medications for residents. The surveyor then asked the RN if she should stop CNA#1 from performing care and have her don full PPE. The RN agreed and then went to CNA#1 and informed her to don full PPE. In the presence of the surveyor, CNA #1 stated to	F 880		

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F 880	Continued From page 6 the RN that she was unaware that she needed to wear a gown to perform care for Resident #1. CNA #1 then exited room [redacted] wearing a pair of gloves and proceeded to a PPE bin across the hall from room [redacted]. With the same gloves she wore when she exited room [redacted], CNA#1 pulled out a gown from the PPE drawer, and donned the gown. When interviewed regarding CNA#1's reaching into the bin for a gown while wearing the same glove she wore in room [redacted], both the RN and CNA #1 did not respond. CNA#1 then removed the gloves, performed hand hygiene and proceeded back into the room [redacted] and donned new gloves. At 11:33 AM, the surveyor interviewed CNA #1 again. She stated that nurses were supposed to inform CNAs as to what PPE to wear in residents' rooms and that she was supposed to don PPE prior to entering the room and doffed the PPE prior to exiting the room and to perform hand hygiene. At 11:40 AM, the surveyor interviewed the third-floor Licensed Practical Nurse/Charge Nurse (LPN/CN) who stated that staff were aware of what PPE to don prior to entering a room based on the sign outside the resident's door. She added that the sign indicated what type of TBP the resident was on, and what type of PPE that staff are to don. The LPN/CN stated that staff were informed of this when the signs first went up and were also informed of any changes every morning. The LPN/CN stated that staff received their N95 mask each morning when they entered the unit and that staff knew to report to the supervisor if they did not have a N95 mask. At 11:45 AM, the surveyor interviewed the RN	F 880		

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F 880	Continued From page 7	F 880		

again. She stated that staff were aware of what PPE to don prior to entering a room based on the sign outside the door. The RN stated that staff donned full PPE - gown, gloves, eye protection, N95 mask, and a surgical mask prior to entering a resident's room. The RN stated that she should have stopped CNA#1 immediately and have her don full PPE including N95 mask before continuing with performing care.

At 12:20 PM, the surveyor interviewed the in-service Educator/Infection Preventionist (IE/IP) who stated that staff were educated on TBP and donning/doffing of PPE at the start of the current outbreak which started on 11/16/2020. The IE/IP stated that CNA #1 was out of the facility on vacation for two weeks in November and returned to work on 11/23/2020.

At 12:21 PM, the DON stated that facility's protocol when a staff member was out of the facility on vacation, was to first test the staff member for COVID-19 prior to returning to work. Then educate the staff on any changes that have occurred in the facility since the last time they worked. The DON stated that the IE/IP and the nursing supervisors oversaw all education and made sure that all staff were updated with education. Review of in-service education for CNA #1 reflected that she was last educated on infection control practices on 10/22/2020. The IE/IP stated that CNA #1 would have been verbally educated on anything she missed upon returning to work.
The IE/IP stated that the CNA was a fulltime staff member who worked on the long-term care nursing unit and not with COVID-19 positive residents. Review of assignment sheet showed that CNA#1 did not work with covid-19 positive

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F 880	Continued From page 8	F 880		

residents.
At this time, the LNHA confirmed that CNA #1 should have been verbally informed of any facility changes upon return to the facility from vacation. The LNHA stated that both the Nursing Supervisor and the Charge Nurse should be educating staff daily and performing rounds to ensure that staff were adhering to TBP.

At 1:10 PM, the surveyor interviewed CNA #1 again who confirmed that she was out of the facility for a few weeks in November. CNA#1 stated that she was educated by the LPN/CN and was told to wear PPE according to any TBP signs on residents' doors. CNA#1 could not provide a reason as to why she had not donned full PPE prior to entering the TBP rooms earlier.

At 1:22 PM, the surveyor interviewed the RN/NS who stated that he educated staff on infection control every morning during morning meetings. The RN/NS stated that he reminded staff on a daily basis that they needed to don full PPE which included a N95 mask. The RN/NS stated that the facility had a large supply of PPE and so there should have been no reason why staff were not donning full PPE.

A review of the Face Sheet (an admission record) reflected that the Resident #1 was [redacted]

A review of the [redacted] Physician's Order Sheet (POS) indicated that the resident had a physician's order (PO) dated [redacted] for [redacted]

A review of the most recent quarterly Minimum

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F 880	Continued From page 9 Data Set (MDS), a tool used to facilitate the management of care, dated [redacted], reflected that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted] which indicated a [redacted]. A review of the resident's COVID-19 test results reflected that the resident tested negative for COVID-19 on Executive Order 26, 4.b. [redacted]. The surveyor reviewed CNA #1's COVID-19 tests, which indicated that CNA#1 tested negative for COVID-19 on Executive Order 26, 4.b.. At 2:22 PM, the surveyor interviewed Resident #1 who stated that staff donned eye protection, mask, gown, and gloves when entering his/her room. The resident was unsure the exact date that staff started donning the full PPE but stated that staff wore PPE because of the "germs" in the building. At 2:35 PM, the DON informed the survey team that the CNA#1 should have been aware of the PPE to don from the morning meeting. The DON acknowledged that CNA#1 should have worn a N95 mask on that floor, donned full PPE prior to entering rooms of residents on TBP, and performed hand hygiene prior to entering and exiting the rooms. The DON stated that the RN should have stopped CNA #1 immediately from performing care on Resident #1 without donning full PPE. At 3:00 PM, the DON stated that all the residents on the [redacted] units were placed on TBP for possible exposure to a staff member that tested positive for COVID-19	F 880		

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F 880	Continued From page 10 on 11/23/2020. The DON stated that the second staff member on the [redacted] who tested positive for covid-19 on [redacted] from rapid response antigen test was retested with follow-up PCR test (a diagnostic test that detects the active virus) and that the staff member tested negative. At 3:45 PM, the survey team addressed their concerns with the LNHA, DON, IE/IP, and the IP who all acknowledged their concerns. A review of the facility's policy labeled: Hackensack Meridian Nursing and Rehabilitation Managing Outbreaks policy dated revised date 3/2020 included to provide in-service education to all staff on all shifts. The policy also included that signs will be posted at the entrance to the facility and outside of resident's room that will include precaution and reinforce hand hygiene. A review of the facility policy labeled: Hackensack Meridian Nursing and Rehabilitation COVID-19 Strict Isolation Precautions and Discontinuance of Isolation policy dated updated 5/23/2020 included that the use of N95 respirator masks will be used upon entering the room of a COVID-19 suspect cases or persons under investigation for COVID-19. A review of the Linen Services Related to Infection Control policy dated retrieved 3/5/2020 included that staff perform hand hygiene each time after handling solid linen. N.J.A.C 8:39-19.4	F 880		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315251 Y1	A. Building B. Wing Y2	12/21/2020 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HARTWYCK AT OAK TREE	2048 OAK TREE ROAD EDISON, NJ 08820

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 12/21/2020	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
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	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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	
12/7/2020	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO