STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315056	A. BUILDING _____ B. WING _____	01/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JERSEY SHORE POST ACUTE REHABILITATION AND NURSING	101 WALNUT STREET NEPTUNE, NJ 07753

(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: 1/28/2021 Census: 54 Sample: 5 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 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 886 SS=F	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of	F 886		2/18/21

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

Electronically Signed | 02/11/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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JERSEY SHORE POST ACUTE REHABILITATION AND NURSING	101 WALNUT STREET NEPTUNE, NJ 07753

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F 886	Continued From page 1 asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results.	F 886		

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F 886	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on interview and review of facility documentation, it was determined that the facility failed to test staff for Coronavirus Disease 2019 (COVID-19) at a frequency based on the COVID-19 Activity Level Index (CALI) Weekly Report. This deficient practice was identified for 3 of 3 staff members, who had worked on 3 of 3 units, which were reviewed for testing as evidenced by the following: On 1/28/21 at 9:30 AM, the surveyor met with the Assistant Director of Nursing (ADON)/Infection Preventionist (IP) in the conference room. The ADON/IP stated that staff were tested for COVID-19 at a frequency of once per week. The surveyor requested the facility ' s testing plan, testing schedule, county positivity rate, and three staff ' s most recent two COVID-19 test results. A review of the staff ' s most recent two COVID-19 test results for the three staff reviewed reflected the following: 1. A Executive Order 26, 4.b. tested Executive Order 26, 4.b. for Executive Order 26, 4.b. on Executive Order 26, and Executive Order 26, 4.b.. 2. A Minimum Data Set Executive Order 26, 4.b. Executive Order 26, 4.b. on Executive Order 26, and Executive Order 26, 4.b.. 3. The Executive Order 26, 4.b. tested Executive Order 26, 4.b. for Executive Order 26, 4.b. on Executive Order 26, and Executive Order 26, 4.b.. During an interview with the surveyor on 1/28/21 at 12:36 PM, the ADON/IP provided the facility ' s testing schedule with the county positivity rate and stated staff were tested weekly in the facility on either Tuesday or Wednesday. The ADON/IP further noted that the facility ' s county positivity	F 886	On 1/28/21 A bi-weekly schedule was immediately put in place for employee Covid-19 testing by the The ADON/IP and DON. The regional nurse consultant Immediately completed an in-service with the IP/ADON, DON, regarding Covid-19 staff testing frequency based on the Covid-19 Activity Level Index (CALI)weekly report. Residents have the potential to be affected by this alleged deficient practice. All staff will be tested for Covid-19 bi weekly when the COVID-19 Activity Level Index (CALI) is 10% or greater, to prevent the potential spread of COVID-19 to current residents. All staff were In-serviced by the DON or infection preventionist as to the New Jersey executive directive No. 20-026 revised 1/6/21, which requires a facility to test staff bi- weekly when the COVID activity level index (CALI) is 10% or greater. The DON or Administrator will audit staff Covid-19 testing monthly x 3 to evaluate the frequency of testing according to requirements of the weekly COVID-19 Activity Level Index (CALI) report. The findings of these audits will be reported to the monthly Quality Assurance Committee for review and to determine the need for further action.	

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	315056	A. BUILDING _____ B. WING _____	01/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JERSEY SHORE POST ACUTE REHABILITATION AND NURSING	101 WALNUT STREET NEPTUNE, NJ 07753

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F 886	Continued From page 3	F 886		

rate was 11.3% but was unsure of the CALI Weekly Report positivity rate. The surveyor reviewed the three staff members ' COVID-19 test results, and the ADON/IP acknowledged the staff were tested once per week.

Review of the facility ' s testing schedule, undated, included "Staff: Tuesday/Weds" and "Staff - Weekly."

A review of the CALI Weekly Report for the week ending January 23, 2021, included a percent positivity rate of 11.15% for the Central East region where the facility was located.

During a follow-up interview with the surveyor on 1/28/21 at 12:47 PM, the ADON/IP stated the facility should have tested staff twice per week based on the CALI Weekly Report, and the IP was responsible for checking the CALI Weekly Report to determine testing frequency.

Review of the facility ' s Coronavirus (COVID-19) Policy, revised 12/16/20, included, "Testing of Staff and Patients is to be completed as per current CDC/Federal, State, and/or local guidance."

Review of the New Jersey Department of Health Executive Directive No. 20-026, revised 1/6/21, included, "Continued testing of staff as follows: ... Routine testing should be based on the extent of the virus in the community, therefore facilities should use the regional positivity rate reported in the COVID-19 Activity Level Index (CALI) Weekly Report in the prior week, as the trigger for staff testing frequency as follows: ... Regional CALI Level: High/Very High - Regional Percent Positivity Rate in the past week: >10% - Minimum

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F 886	Continued From page 4 Testing Frequency: Twice a Week." NJAC 8:39-5.1(a); 19.1(a)	F 886		

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
315056 (Y1)	A. Building B. Wing (Y2)	3/4/2021 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
JERSEY SHORE POST ACUTE REHABILITATION AND NURSING	101 WALNUT STREET NEPTUNE, NJ 07753

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 F0886 Reg. # 483.80 (h)(1)-(6) LSC	Correction Completed 03/04/2021	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	
1/28/2021	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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
315056 Y1	A. Building B. Wing Y2	3/4/2021 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
JERSEY SHORE POST ACUTE REHABILITATION AND NURSING	101 WALNUT STREET NEPTUNE, NJ 07753

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REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
1/28/2021	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO