STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315087	A. BUILDING _____ B. WING _____	01/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT KING JAMES	**1040 ROUTE 36 ATLANTIC HIGHLANDS, NJ 07716**

(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 STANDARD SURVEY: 01/08/21 CENSUS: 95 SAMPLE SIZE: 22 The facility is not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for long term care facilities.	F 000		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 761		1/26/21

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

Electronically Signed | 01/25/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 761	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to properly store and label medications in 2 of 3 medication storage rooms and 4 of 6 medication carts inspected. The deficient practice was evidenced by the following. On 01/04/21 at 10:00 AM, in the presence of the Licensed Practice Nurse #1 (LPN #1), surveyor #1 observed and reviewed the inventory of Medication Cart 2B on Bayside Unit/Station 3. At this time, surveyor #1 observed an open bottle of Benadryl 5mg (a medication used to treat allergies) which revealed an open date of 01/16/20. The expiration date was "rubbed off." When asked by surveyor #1, LPN #1 was unable to read what the expiration date was. Surveyor #1 asked the Assistant Director of Nursing (ADON) who was also present, to read and state the expiration date. The ADON could not read and state the date. The ADON then disposed of the Benadryl in a secure container used to neutralize and inactivate medications. The observation and review of Medication Cart [redacted] continued and Surveyor #1 observed a box containing a vial of [redacted] (a medication used to [redacted]). The vial revealed an expiration date of [redacted] The box containing the vial reflected an open date of [redacted] and an expiration date of 01/03/21, which was 42 days after opening. Surveyor #1 asked the LPN to clarify the expiration date, and the LPN #1 confirmed it expired yesterday and said Resident [redacted] received the medication. The observation and review of Medication Cart	F 761	ID PREFIX TAG: F761 SS=E HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE: Medications that were opened without a date or expired were disposed of immediately. Medicated Topical products were removed from the medication drawer. Insulin pen was destroyed as per facility protocols. The lock box was serviced the same day. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: Upon review of the patient medical records, no other residents were affected. WHAT MEASURES WILL BE PUT INTO PLACE	

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F 761	Continued From page 2 2B continued and surveyor #1 observed an unopened container of Medi-Honey (a topical gel used to treat wounds, burns, and damaged skin). When asked by the surveyor if the Medi-Honey was supposed to be in the medication cart, LPN #1 replied that she did not keep external medications on the medication cart. She further stated that, "it must have slipped in there somehow." On 01/04/20 at 10:17 AM, in the presence of the Unit Manager (UM), the surveyor observed and reviewed the medication room and refrigerator on Rivers Edge Unit/Station 2. Within the refrigerator, the surveyor observed a multi-dose vial of the Influenza Vaccine with an opened date of 10/13/20. The surveyor asked the UM how long the vial was to be used once opened. The UM replied, "30 days." The surveyor observed the manufacturer specifications stated to discard the vial 28 days after opening. Surveyor #1 observed in the medication room, on this same unit, an unsecured cabinet above the counter which contained two boxes of Heparin Lock Pre-Filled syringes (used to prevent blood from clotting within intravenous tubes). Box #1 held 23 syringes and reflected an expiration date of 03/31/20. Box #2 held 12 Heparin Lock Pre-Filled Syringes and reflected an expiration date of 02/29/20. At this time, the surveyor asked the UM if any residents had intravenous (IV) catheters on Unit 2. UM replied that no one on the unit had an IV. The surveyor then asked how often the medication room stock is checked. The UM replied it is checked monthly, if not two times a month. The UM concluded the response by	F 761	OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: DON and ADON will in-service licensed nursing staff (RN, LPN) in r/t drugs and biologicals that must have required storage, labeling, checking of vials inside container match box and expiration dates. Education also included only those licensed should have access to the medication rooms and/or supplies. Nurses were reminded to report locks not working properly so that repair can be initiated. HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE: The Unit Manager and/or designee will conduct a biweekly medication cart and med room inspection. Results of the observations will be reviewed during the center□s Quality Assurance Performance Improvement (QAPI) committee monthly, for three months. Upon review, if further action is needed, revisions to the plan	

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F 761	Continued From page 3 stating, "But that cabinet is obviously frequently missed." At this time, the Unit Secretary (US) entered the medication room doorway and gave a single key to the UM. The US stated that LPN #1 told him to give the key to the UM. The UM said that it was the key to the medication room. Surveyor #1 asked LPN #1 and the UM if the US should have the key to the medication room. They both responded, "No." On 01/04/21 10:41 AM, surveyor #2 inspected Medication Cart 2A on the Rivers Edge Unit/Station 2 in the presence of LPN #2. Surveyor #2 observed in the top drawer of the medication cart, a bottle of Nystatin Powder (a topical skin treatment for irritations). Surveyor #2 asked LPN #2 if the Nystatin bottle was to be kept in the top drawer with internal medications. She replied that it should not have been there. Surveyor #2 further observed a bottle of Naproxen Sodium tablets (a medication used as a pain reliever) with an open date of 04/29/20. Surveyor #2 observed that the manufacturer expiration on the bottle was 12/20. LPN #2 confirmed that it was expired. Surveyor #2 observed the metal lock box used to secure controlled substance medications in a drawer of the medication cart. Surveyor #2 in the presence of LPN #2 noted that the metal lockbox was unsecure. LPN #2 stated that the box should be locked. At this time, Surveyor #2 observed a used tube of Executive Order 26, 4.b. Executive Order 26, 4.b.) prescribed to Resident #68 located in the bottom drawer of the medication cart. Surveyor #2 asked	F 761	will be completed. Time Frame: 1/26/2021	

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F 761	Continued From page 4 LPN #2 if the cream should have been in the medication cart. She replied that the topical creams should have been in the treatment cart. The surveyor then observed various insulin pens (medications used to Executive Order 26, 4.b.) in a drawer of the medication cart. Surveyor #2 observed a Executive Order 26, 4.b. stored in a plastic bag prescribed to Resident #88 that was unopened and unlabeled. The pharmacy sticker on the plastic bag reflected that the Executive Order 26, 4.b. Executive must be refrigerated until opened. LPN #2 confirmed that the Executive Order 26, 4 was unopened and should have been refrigerated. Surveyor #2 observed Executive Order 26, 4.b. (a medication used to Executive Order 26, 4.b.) contained in a plastic bag prescribed to Resident #83. Surveyor #2 observed one pen dated opened on Executive Order 26, 4.b. the second pen dated opened on Executive Order 26, 4.b.. Surveyor #2 observed both pens reflected an expiration date of Executive Order 26, 4.b.. On 01/04/21 at 11:54, surveyor #2 inspected Medication Cart 1 on Executive Order 26, 4.b. in the presence of LPN #3. Surveyor #2 observed a Executive Order 26, 4.b. Executive Order 26, 4.b. prescribed to Resident #73. Surveyor #2 observed that the Executive Order 26, 4.b. package that contained the device was opened but did not have an open date on it. LPN #3 confirmed there was no date. Surveyor #2 further observed a Executive Order 26, 4.b. (a medication used to treat Executive Order 26, 4.b.) prescribed to Resident #85. The expiration date written on the pen was Executive Order 26, 4. Surveyor #2 observed a box containing a vial of	F 761		

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F 761	Continued From page 5 Executive Order 26, 4.b. (a medication used to treat Executive Order 26, 4.b.) that contained a pharmacy label which indicated the medication was prescribed to Resident #85. Surveyor #2 observed the vial in the box had a pharmacy label prescribing the vial to Resident #53 with an expiration date of Executive Order 26, 4. On 01/04/21 at 11:58 AM, Surveyor #1 observed the second medication cart on Rivers Edge Unit/Station 2 in the presence of LPN #2. Surveyor #1 observed an opened, 90 tablet container of Cetirizine 10mg (a medication used to treat allergy symptoms) that expired on 08/20. LPN #2 disposed of the medication in a secure container used to neutralize and inactivate medications. Surveyor #1 further observed an opened, 130 tablet container of Vitamin B-12 100mcg reflecting an expiration date of 11/20. LPN #2 disposed of the medication in a secure container used to neutralize and inactivate medications. Surveyor #1 then observed a 100 capsule container of Poly Iron that expired on 08/20. LPN #2 disposed of the medication in a secure container used to neutralize and inactivate medications. On 01/04/21 at 12:10 PM, surveyor #1 observed the medication room on the Bayside Unit/Station 3 in the presence of the ADON. Surveyor #1 observed a box of Heparin Lock Pre-Filled syringes (a medication used to prevent blood from clotting within intravenous tubes) reflecting an expiration date of 10/31/20. On 01/07/21 at 12:10 PM, in the presence of the Registered Nurse (RN), surveyor #2 conducted a follow-up observation and review medication cart 2A on Rivers Edge Unit/Station 2. Surveyor #2	F 761		

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F 761	Continued From page 6	F 761		

observed the metal lock box used to secure controlled substance medications. Surveyor #2 in the presence of the RN noted that the metal lockbox was unsecure.

During an interview with surveyor #2 on 01/07/20 at 12:30 PM, the UM stated the Pharmacy worked on the metal lock box but he was informed it was not locking again.

During an interview with surveyor #2 on 01/07/20 at 01:30 PM, the Director of Nursing (DON) stated that the Pharmacy arrived at the facility to repair the box on 01/06/21. The DON informed surveyor #2 that the Pharmacy sent an individual to repair the lock box.

Surveyor #1 asked when the last time the consultant Pharmacist was in the facility for inspection. The DON stated that the last time was in March of 2020 because of COVID-19. He further stated that the Unit Managers were supposed to be performing unit inspections in the absence of the consultant pharmacist.

The facility's "Medication Storage in the Facility" policy with an effective date of February, 2019 revealed under "Procedures" part B: "Only licensed nurses, pharmacy personnel and those lawfully authorized to administer medications (such as medication aides) are permitted to access medications Medication rooms, carts, and medication supplies are locked when not attended by person with authorized access."

The policy further revealed under "Procedures" part D: "Orally administered medications are stored separately from externally used medications and treatments. Ophthalmics should

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F 761	Continued From page 7	F 761		

be stored separately. Injectable medications should be stored separately."

The policy further revealed under "Procedures" part H: "Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from inventory, disposed of according to procedures for medication disposal (See IE: DISPOSAL OF MEDICATIONS AND MEDICATION-RELATED SUPPLIES), and reordered from the pharmacy (See IC3: ORDERING AND RECEIVING NON-CONTROLLED MEDICATIONS FROM THE DISPENSING PHARMACY), if a current order exists."

The policy further revealed under "Temperature" part D: "Medications requiring refrigeration are kept in a refrigerator at temperatures between 35°F (2°C) and 46°F (8°C) with a thermometer to allow temperature monitoring. All other medications should be stored in accordance with the manufacturer label and instructions ..."
The facility's undated "Drug Storage Requirements" reflected under Insulin Vials: "Lantus (Insulin Glargine) Refrigerate (until 1st Use)."

The facility's policy "Labeling of Medication Containers" revised April 2019, reflected in part 3: "Labels for individual resident medications include all necessary information, such as": ...(h) "The expiration date when applicable." Part 4 reveals "Labels for stock medications include all necessary information, such as:" ...(c.) "The expiration date when applicable."

Upon review of the facility's email from the

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F 761	Continued From page 8 Pharmacy provider revealed that on Wednesday (01/06/21) the Narc Box Lock on a Medcart from Station 2 now functions appropriately. Upon review of a document titled, "Unit Inspection" dated 03/11/20 revealed that the consultant pharmacy performed an inspection of the building. NJAC 8:39-29.4	F 761		
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 accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include,	F 880		4/21/21

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F 880	Continued From page 9 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. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.	F 880		

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F 880	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility policies and procedures it was determined that the facility failed to don all of the required Personal Protective Equipment (PPE) when entering the room of persons under investigation (PUI) for Covid-19 infection. This was found on 1 of 1 units designated by the facility as a 14 day quarantine for new/re- admissions. The deficient practice was evidenced by the following: On 01/04/21 at 11:00 AM, the surveyor asked the Director of Nursing (DON) what PPE was required on the units. The DON stated the green units required a mask and goggles or face shield, the yellow zone, which he stated was the 14 day quarantine unit for residents who were admitted/re-admitted, required goggles or face shield and a mask but in the rooms we were required to wear full PPE which consisted of an N95 mask, gown, gloves, goggles or face shield. 1. The surveyor observed the noon meal distribution on the [redacted] on 01/04/2021 at 1:01 PM. Staff distributed all trays to residents in their rooms. Staff entered rooms, after knocking, wearing respirator masks and face shield or goggles, placed the trays on the overbed tables, and left the rooms. Staff did not don gowns when entering the resident rooms. Staff did use handsanitizer between deliveries. The surveyor observed residents who required staff assistance with meals. The staff donned gowns before entering the rooms for those residents who required assistance with eating.	F 880	ID PREFIX TAG: F880 SS=D HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO HAVE BEEN AFFECTED BY THE PRACTICE: No Residents were affected by the practice cited HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents in the yellow zone have the potential to be affected. WHAT MEASURES WILL BE PUT INTO PLACE OR WHAT SYSTEMIC CHANGES WILL BE MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: DON and ADON will in-service staff as to why deficiency took place and putting measures into place that practice will not happen again. As staff was confused as	

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F 880	Continued From page 11 The surveyor interviewed the Registered Nurse Unit Manager (RNUM) on 01/04/2021 at 1:10 PM. She stated when staff is not having direct contact with a resident, a gown is not required. 2. On 01/05/21 at 10:15 AM, the surveyor interviewed a Licensed Practical Nurse (LPN) and the Unit Secretary (US) about the required PPE for entering the resident rooms on the yellow zone. The LPN and the US said gowns and gloves were only required for direct resident care. They added that if the surveyor wanted to wear a gown that would have been fine. On 1/06/21 at 10:39 AM, the surveyor entered the [redacted]. The surveyor approached the room of Resident #394. The call light was on. There was a sign on the wall outside of the room that had a picture of a stop sign and it read the following: "Special Droplet/Contact Precautions In addition to Standard Precautions Only essential personnel should enter this room If you have questions ask nursing staff Everyone must: including visitors, doctors, and staff Clean hands when entering and leaving the room Wear mask (Fit tested N-95 or higher required when performing aerosol-generating procedures) Wear eye protection (face shield or goggles) Gown and glove at the door" Additionally, there was a sign posted on the wall outside of the room which had a picture of a mask, gloves, gown, and goggles. At 10:41 AM, the surveyor observed the Unit	F 880	to signage on door didn't correlate will in-servicing done with staff in r/t yellow zone PPE and alignment with our PPE Optimization protocols, specifically Prioritization of Gown Use with door signage not matching protocols HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR, I.E., WHAT QUALITY ASSURANCE PROGRAM WILL BE PUT INTO PLACE: Monitoring observations will be done by DON or Designee and will be completed on the yellow zone once per day for two months, three times per week for one month, and once per week for one month focused on the appropriate use of PPE by all staff Observation audits will be documented and education sessions completed as necessary. Results of the audits will be forwarded to the QA Committee monthly for 3 months for tracking, trending, performance and updating as necessary. Ongoing in-services and monitoring will occur and be reported hereafter to QAPI team quarterly As per DPOC/Directive In-Service Training-	

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	315087	A. BUILDING _____ B. WING _____	01/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT KING JAMES	**1040 ROUTE 36 ATLANTIC HIGHLANDS, NJ 07716**

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F 880	Continued From page 12 Manager (UM) enter the resident's room with goggles and a KN95 mask, no gown or gloves. The UM closed the door behind her. Just then the Social Worker (SW) arrived, she donned a gown, had mask and goggles, no gloves. She was about to enter the room. The surveyor asked her what the reason was for visiting the resident. The SW said the resident did not want to go to [redacted] so she was going to speak with the resident. The UM then came out of room only wearing the KN95 mask and goggles, no gown or gloves. The resident was sitting in the wheelchair next to the bed wearing a mask. The resident did not want to go to [redacted] unless it was on a stretcher. The UM said she would call for a stretcher. The surveyor then asked the UM what PPE was required when entering the rooms of residents on the unit. The UM said a mask and goggles or face shield. She further stated they only had to put on a gown and gloves if providing direct patient care, and stated she did not touch the resident or the resident's environment. She said if she were to touch the resident or the resident's environment she would don gloves and a gown. She said the gowns were hanging in the hall and the gloves were in each resident's room. The UM went back into the room of Resident #394. After a few minutes the UM came out of the room of resident #394 and went into the room of Resident #94 wearing the KN95 mask and goggles and no gown or gloves, to answer the call light. The UM closed the door behind her. After a few minutes the UM came out of the room. The surveyor had observed bins with lids in the hallway after every other room. The surveyor asked the UM what the bins were for. The UM	F 880	Videos viewed by staff: Nursing Home Infection Preventionist Training Course - Module 1 (Topline Staff including Infection Preventionist) Keep COVID-19 Out- (Front Line Staff) Use PPE Correctly for COVID-19 RCA has been completed as to why event occurred with plan and evaluated to prevent.	

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said they were to place used gowns. She stated "One and done" she explained that they wear a gown once for direct contact with a resident and then they put it in one of those bins.

The UM then donned a gown, that she retrieved from a rack in the hallway which held cloth gowns on hangers, and once again, entered the room of Resident #94, closing the door behind her. The UM came out of the room about five minutes later took off the gown in the doorway, balled it up, carried it to the bin with the lid and dropped it in. The UM then used hand sanitizer. The UM said she donned the gown because the resident needed something that required close contact.

On 01/06/21 at 1:11 PM, the surveyor interviewed the Infection Preventionist (IP) and asked about the yellow zone. The IP stated "The yellow zone is for new admissions that come in from the hospital, they are in a room alone, and on quarantine for 14 days. The residents on that unit are swabbed [for Covid-19] on the day of admission, then day 6, 12, and 14. On the 14th day if the resident tests negative they are transferred onto the green zone [Covid-19 negative]. We require the most recent Covid-19 test from the hospital when they are admitted."

The surveyor asked the IP if residents on quarantine were permitted out of their room. The IP said they were not. The surveyor asked where the residents did therapy. The IP said in their room. The surveyor asked what kind of isolation was instituted for residents on the yellow zone. The IP said Contact/Droplet precautions. The surveyor asked the IP what PPE the staff were supposed to wear when they entered the rooms of residents on the yellow zone. The IP stated

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"Goggles or face shield, and an N95 mask, they use the gown if providing direct care, and they wear gloves as well, if they are providing direct care or coming into contact with the resident's environment. If staff enters the room the resident puts on the mask."

On 01/07/21 at 9:40 AM, the surveyor reviewed the facility's policy and procedure for "Isolation-Categories of Transmission-Based Precautions." Under Contact Precautions, number 4 read: "Staff and visitors will wear gloves (clean, non-sterile) when entering the room." Number 5 read "Staff and visitors will wear a disposable gown upon entering the room and remove before leaving the room and avoid touching potentially contaminated surfaces with clothing after gown is removed." Under Droplet Precautions, number 4 read: "Gloves, gown, and goggles should be worn if there is risk of spraying respiratory secretions."

The IP had provided an additional policy and procedure which the surveyor also reviewed, it was titled "Yellow Zone PPE Use." Under Gown Use-Disposable or washable it read:
"A gown is worn upon entering the patient's room for the purpose of high contact care activities (defined by CDC)* and for environmental cleaning. To optimize gown supply, a brief encounter with no contact such as delivering a tray or delivering oral medications does not require a gown.
Gown use in the Yellow zone is "one and done"
Gowns ARE NOT worn for the care of more than one resident
One staff member does not wear a gown previously worn by another.
If there are 2 patients cohorted together in one

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room; a separate, single use gown is worn for the care of each patient.
No gowns are to be worn in the hallway; no double gowning.
Under Gloves, it read:
Always use clean gloves for each patient, procedure, and encounter performing hand hygiene after removing gloves.
*The CDC describes high contact patient care activities as those that provide opportunities for transfer of pathogens to other patients and staff via the soiled clothing of healthcare providers such as: Dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use, wound care."

On 01/07/21 at 1:00 PM, the survey team spoke with the DON and the Administrator about the concern with the staff on the [redacted] not wearing full PPE when entering the rooms of the residents. The surveyor reminded the DON what he said on 01/04/21 when asked what PPE was required on the units. The DON stated "Well for you guys for interviewing you are going to be in the room more than 10 minutes so you have to wear full PPE but for the staff if they are going in briefly to give medication or to talk to the resident then just the mask and goggles or face shield is fine." The surveyor asked for the literature from the CDC that they used to create their policy for the yellow zone.

On 01/08/21 at 9:30 AM, the surveyor reviewed the literature from the CDC that the facility used to create their policy for the [redacted]. The title of the guidance document was "Strategies for Optimizing the Supply of Isolation Gowns." It was dated 10/09/20. The top line read "Once PPE

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supplies and availability return to normal, healthcare facilities should promptly resume conventional practices."

The IP highlighted a section under "Crisis Capacity Strategies." The document defined Crisis Capacity as: "strategies that are not commensurate with standard U.S. standards of care but may need to be considered during periods of known gown shortages. Crisis capacity strategies should only be implemented after considering and implementing conventional and contingency capacity strategies. Facilities can consider crisis capacity strategies when the supply is not able to meet the facilities current or anticipated utilization rate." The context that was highlighted by the IP read: "Prioritize gowns. Gowns should be prioritized for the following activities:
During care activities where splashes and sprays are anticipated, which typically includes aerosol generating procedures.
During the following high-contact patient care activities that provide opportunities for transfer of pathogens to other patients and staff via the soiled clothing of healthcare providers, such as: Dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use, wound care."

On 01/08/21 at 9:12 AM, the Team Coordinator (TC) of the survey team interviewed the IP and asked about the Covid-19 status of residents at the facility. The IP explained that the facility did not have any Covid-19 positive residents. She further stated that if a resident was to test positive they would send the resident to their sister facility if they were asymptomatic (without symptoms) or

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to the hospital if they were symptomatic because the facility did not have a "red zone" (Covid-19 positive unit).

01/08/21 at 9:59 AM, the surveyor reviewed the amount of isolation gowns on hand. The facility used cloth isolation gowns. There were 18 residents on that unit. The laundry room had 175 clean gowns. The yellow zone had 50 gowns hanging on racks on the unit. That did not include any soiled gowns in the bins in the hallway that hadn't been picked up for laundering.

The facility also had disposable gowns in storage. There were 1100 disposable gowns plus several additional boxes of disposable and washable. The surveyor asked the Administrator for the current PPE burn rate calculation (a formula that is used to calculate the number of items the facility uses per day). The box for gowns was blank. The surveyor asked the Administrator why it was blank. She said because they have reusable gowns that they wash after use so they don't include the gowns in the burn rate calculation.

On 01/08/21 at 10:27 AM, the surveyor interviewed the housekeeper on the yellow zone and asked what PPE she used when entering the rooms and about the cleaning procedure. The housekeeper stated "When I go into a room to clean I wear a mask, KN95, goggles, gown, gloves. I put on the gown and gloves right before I enter the room, I wear all of it whether or not there is a resident in the room, I take it off in the doorway and put the gown in the designated bin outside the room. I do hand washing or sanitizer after every room, I clean high touch surfaces, twice a day in each room."

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F 880	Continued From page 18 On 01/08/21 at 11:10 AM, the surveyor spoke with the IP and asked about the differing policies for Transmission Based Precautions. She said they had a separate policy for the yellow zone (The unit for new/re-admissions where the residents are quarantined for 14 days). She said the facility's corporate Infectious Disease Doctor (IDMD) went to the facility and provided training for the staff in December 2020 and agreed that the staff only had to wear a gown and gloves for the residents on the yellow zone if providing direct care. On 01/08/21 at 11:30 AM, the surveyor spoke with the IDMD on the phone and asked about him instructing the facility's IP that the staff could enter the rooms of resident's on 14 day quarantine without gowns or gloves. The IDMD stated "It was related to PPE optimization, I did tell them that, it was anticipatory based on their burn rate and prior use. They should be using the gown and gloves for direct care. If they are going in to speak with them briefly and have no direct contact then face shield or goggles and mask is fine. It is a very low risk there because they have no covid positive residents and if they do they are sent out. We are expecting the peak to be around 01/15 so I will visit them again around that time and discuss what has been going on and how the vaccine distribution is going." NJAC 8:39-19.4 (a)	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)
315087		4/28/2021

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT KING JAMES	1040 ROUTE 36 ATLANTIC HIGHLANDS, NJ 07716

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 F0761 Reg. # 483.45(g)(h)(1)(2) LSC	Correction Completed 01/26/2021	ID Prefix F0880 Reg. # 483.80(a)(1)(2)(4)(e)(f) LSC	Correction Completed 04/21/2021	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	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	
1/8/2021	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO