STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315293	A. BUILDING _____ B. WING _____	02/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT WHITING	3000 HILLTOP ROAD WHITING, NJ 08759

(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	F 000		

Survey date: 2/10/2021

Census: 113

Sample: 17 (12 staff and 5 residents)

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.

COVID-19 (Coronavirus Disease 2019) is a disease caused by the coronavirus SARS-CoV-2. COVID-19 is thought to spread mainly from person to person via respiratory droplets produced when an infected person coughs, sneezes talks or yells. Covid-19 is a transmissible virulent virus that is known to be deadly and could cause the liklihood of serious harm, impairment or death.

Based on observation, interview, medical record review and review of other pertinent facility documentation, it was determined that the facility failed to implement mitigation strategies to prevent the transmission of COVID-19 by not appropriately identifying residents exposed to COVID-19 as persons under investigation (PUI) for the virus and not implementing appropriate PPE according to Centers for Disease (CDC) guidelines and facility Outbreak Plan.

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

Electronically Signed | 03/01/2021

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F 000	Continued From page 1 The facility's failure to adequately identify the Covid-19 exposed cohort resident group and institute necessary TBP and PPE and appropriately identify the unit as a PUI unit, posed a serious and immediate threat to the safety and wellbeing of all non-ill residents residing in the facility. After consultation with the office it was determined that an Immediate Jeopardy (IJ) situation was identified on 02/10/2020 at 04:32 PM. The facility provided an acceptable IJ Removal Plan on 02/11/2021 at 12:02 PM. The IJ removal plan was verified on-site on 2/12/21.	F 000		
F 880 SS=L	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	F 880		4/29/21

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F 880	Continued From page 2	F 880		

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, 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

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F 880	Continued From page 3 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, medical record review and review of other pertinent facility documentation, it was determined that the facility failed to implement mitigation strategies to prevent the transmission of COVID-19 by not appropriately identifying residents exposed to COVID-19 as persons under investigation (PUI) for the virus; and failed to implement appropriate Transmission Based Precautions (TBP) according to Centers for Disease (CDC) guidelines and the facility's Outbreak Plan for those residents exposed to Covid-19 positive Health Care Personnel (HCP). This deficient practice was identified for 4 of 4 staff members who provided care to residents on 2 of 2 Long-Term Care (LTC) Units. These units were the [redacted] unit) and [redacted] (Long Term Care). Both units were considered a well, non-ill, non-Covid-19 units. The deficient practice was evidenced by the following: Part 1 On [redacted], the facility became aware that one staff member, a Certified Nursing Assistant (CNA #1) was confirmed positive for Covid-19 with a rapid test and was immediately sent home. According to the facility contact tracing, CNA #1 worked on the Long-Term Care [redacted] Unit (well, non Covid unit) on [redacted] and provided direct	F 880	COMPLETE CARE AT WHITING PLAN OF CORRECTION: This plan of correction constitutes our written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was cited correctly. This plan of correction is submitted to meet requirements established by state and federal law CORRECTIVE ACTIONS: ¿ The residents in the [redacted] unit) and [redacted] (Long Term Care) Units were identified as PUI□s under Cohort Level #2 (COVID- 19 Negative, Exposed). Facility immediately implemented CDC guidelines on Care for PUI□s as per CDC guidance. Residents were closely observed and monitored for COVID-19 symptoms. All residents remained asymptomatic. ¿ In addition, all residents on the [redacted] ([redacted] unit) and [redacted] (Long Term Care) were tested once weekly x eight weeks with negative results, beginning on Dec 28, 2020. This testing schedule will continue for residents on a bi-weekly basis. CALI reports will be checked by IP	

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F 880	Continued From page 4 care to [redacted] residents that resided on that unit. On [redacted], the facility became aware that a second staff member (CNA #2) was confirmed positive for Covid-19 from a Covid-19 test that was collected on [redacted]. According to the facility contact tracing, CNA #2 last worked on the LTC [redacted] Unit (well, non Covid unit) on [redacted] and provided direct care to 24 residents that resided on that unit. On [redacted] a third staff member (CNA #3) had a test for Covid-19 and was confirmed positive on [redacted] by a rapid Covid-19 test. According to the facility contact tracing, CNA #3 worked on the LTC [redacted] and [redacted] Units (well, non Covid units) on [redacted] and [redacted] and provided direct care to the residents that resided on that unit. According to the employee assignment sheet dated [redacted], CNA #3 provided direct care to [redacted] residents. On [redacted], CNA #3 provided direct care to [redacted] residents. On [redacted], CNA #3 provided direct care to [redacted] residents and on [redacted], CNA #3 provided direct care to [redacted] residents. On [redacted], the facility became aware that a fourth staff member (CNA #4) was confirmed positive for Covid-19. According to the facility contact tracing, CNA #4 last worked on the Long-Term Care (LTC) [redacted] Unit (well, non Covid) on [redacted] and provided direct care to [redacted] residents that resided on that unit. On 02/09/2021 at 9:15 AM, Surveyor #1 and Surveyor #2 interviewed the corporate Regional Director of Nursing (RD), the Licensed Nursing Home Administrator (LNHA) and Director of Nursing (DON) who all stated that when CNAs	F 880	Nurse weekly to adjust testing amount to ensure that no residents show any signs or symptoms. ¿ Transmission-based Precautions (TBP) were immediately initiated in both units. o Signage to indicate that [redacted] ([redacted] and [redacted] (Long Term Care) Units were placed on Transmission-Based Precautions were put in place. o Personal Protective Equipment (PPE) bins containing the necessary PPE□s to don for TBP (such as gowns, gloves, face shields/goggles, KN95/N95 masks as available) were stocked and made readily available in the [redacted] and [redacted] Units. ¿ All staff were immediately notified that residents in the [redacted] unit) and [redacted] (Long Term Care) were on Transmission-Based Precautions. Emphasized the need to follow all CDC guidelines. ¿ RN #1 and CNA #2 were counselled regarding following appropriate infection control protocols related to donning (applying) and doffing (removing) appropriate PPE on a unit identified as Persons under Investigation (PUI), in accordance to facility protocols. They were also educated on the proper disposal of used gowns. ¿ The hooks for gowns were moved from the residents□ doors to inside the PUI residents□ rooms so they are no longer by the doorway or the entrance of the rooms. Each hook was also labeled properly to indicate which hook is designated to each staff member□s gown	

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F 880	Continued From page 5 #1, #2, #3 and #4 were identified as being Covid-19 positive they did not consider the residents exposed to the Covid-19 positive healthcare professionals (HCP) as Persons Under Investigation (PUI). The residents that were exposed to the Covid-19 positive HCP on the LTC [redacted] and [redacted] units were not placed on Transmission-Based Precautions (TBP) and the appropriate PPE for residents exposed to Covid positive persons was not instituted. A review of the guidance issued by the New Jersey Department of Health/Communicable Disease Services (NJDOH/CDS) titled Considerations for Cohorting COVID-19 Patients in Post-Acute Care Facilities dated revised 10/22/2020 included that Cohort 2 COVID-19 negative, exposed group consisted of both symptomatic and asymptomatic residents who tested negative for COVID-19 with an identified exposure to someone who was positive. These individuals should be quarantined for fourteen days from their last exposure, regardless of test results. The guideline further included that residents in Cohort Group 2 should be placed on TBP using COVID-19 recommended PPE consisting of an N95 mask, eye protection, gloves, and isolation gowns. A review of the guidance issued by NJDOH/CDS titled Testing in Response to a Newly Identified COVID-19 Case in Long-term Care Facilities dated 1/26/21 included that regardless of attribution of the case, all facilities should take the following steps when a new case of COVID-19 is identified in their facility. The steps included to perform a risk assessment to determine any potential exposures/or infection control breaches	F 880	(e.g. Nurse; CNA; Housekeeper). ¿ Bins for gown disposal in the hallways were removed in PUI Wing/Unit. Facility ensured that each PUI Room had a bin for gown disposal. All staff were educated on disposing contaminated gowns in the bin inside the room prior to exiting the room IDENTIFICATION OF RESIDENTS WHO HAVE THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE ¿ All residents have the potential to be affected by the same deficient practice. SYSTEMIC CHANGES TO ENSURE THAT THE DEFICIENT PRACTICE DOES NOT RECUR ¿ All staff were re-educated on the facility□s outbreak plan with an emphasis on CDC guidelines regarding exposure to a positive COVID-19 individual, as well as proper PPE and procedures to follow for Transmission-Based Precautions. The education included the different cohort levels, dedicated HCP□s (Health Care Providers) for each cohort as much as possible, and types of precautions to be used for each cohort. Education will be on-going with all new hires. ¿ COVID-19 Testing for Staff and residents will continue as per CDC guidelines and State Guidance. Currently, this is done once weekly for residents while in Outbreak and bi-weekly for all staff. IP Nurse will check the CALI (COVID-19 Activity Level Index) Weekly Report scores and adjust testing accordingly. The COVID-19 Weekly	

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F 880	Continued From page 6 at the facility. Determine any possible exposures the new case of COVID-19 (exempli gratia (e.g.) resident, healthcare personnel, essential caregiver) may have had prior to the diagnosis including contact with other known COVID-19 positive persons or those who later developed symptoms consistent with COVID-19. Identify close contact including forty-eight hours prior to symptom onset/date of specimen collection of associated case, if applicable. Close contact is identified as being within approximately six feet of a COVID-19 case for a prolonged period of time, a cumulative of fifteen minutes or more over a twenty-four hour period starting from two days before illness onset (or, for asymptomatic residents, two days prior to test specimen collection) until the time the resident is isolated. Quarantine close contacts for fourteen days from last exposure and provide care using all COVID-19 recommended PPE (N95 mask, gown, gloves, eye protection). A review of the NJDOH/CDS Guidance for COVID-19 Diagnosed and/or Exposed Healthcare Personnel dated 1/4/21 included healthcare facilities should establish a plan for how exposures in a healthcare facility will be investigated and how contact tracing will be performed. The guidance also included that when a healthcare personnel was positive for COVID-19, facilities should do their due diligence to identify and notify close contacts (fifteen cumulative minutes of exposure at a distance of less than six feet to an infected person during a twenty-four hour period). Prolonged close contact should be determined by taking the cumulative contact the potentially exposed individual had with the infected case over a twenty-four hour period from two days before the	F 880	Activity Report provides data on COVID-19 transmission risk by six regions in the State of NJ. ¿ Contact Tracing for 48 hours will be conducted promptly by the Infection Preventionist or designee whenever a Staff or resident tests positive for COVID-19. All patients/residents who were in direct contact with positive Staff or Resident (for a cumulative 15-minute period within 24 hours) will be considered as PUI□s. Transmission-based precautions will be implemented immediately for these residents, including but not limited to the use of the appropriate PPE□s. ¿ All staff were re-in-serviced on appropriate infection control protocols related to donning (applying) and doffing (removing) appropriate PPE on a unit identified as Persons under Investigation (PUI) in accordance to facility protocols. ¿ The hooks for gowns were moved from the residents□ doors to inside the PUI residents□ rooms so they are no longer by the doorway or the entrance of the rooms. Each hook was also labeled properly to indicate which hook is designated to each staff member□s gown (e.g. Nurse; CNA; Housekeeper). ¿ Bins for gown disposal in the hallways were removed in PUI Wing/Unit. Facility ensured that each PUI Room had a bin for gown disposal. All staff were educated on disposing contaminated gowns in the bin inside the room prior to exiting the room MONITORING OF CORRECTIVE ACTIONS	

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F 880	Continued From page 7 symptom onset (or positive collection date in asymptomatic infected individual) until the positive case has been effectively isolated. The guidance also included that patients who are identified as a close contact of a positive healthcare personnel at a healthcare facility should be placed on appropriate transmission-based precautions and monitored for the onset of COVID-19 until fourteen days after their last exposure. According to Centers for Disease Control Responding to Coronavirus (Covid-19) in nursing homes regardless of cohort, all staff should adhere to standard precautions and any necessary Transmission-based Precautions (TBP) according to clinical presentation and diagnoses, when caring for any patient/resident full TBP and all recommended Covid-19 PPE should be used for all patients who are: -Covid-19 positive -Covid-19 PUI -Exposed to Covid-19 Healthcare Professional (HCP) PUI -Exposed to any Covid-19 positive person The facility's failure to identify the Covid-19 exposed cohort resident group, institute necessary TBP and PPE, and appropriately identify the unit as a PUI unit posed a serious and immediate threat to the safety and wellbeing of all non-ill residents residing in the facility. After consultation with the office it was determined that an Immediate Jeopardy (IJ) situation was identified on 02/10/2020 at 04:32 PM. The facility provided an acceptable IJ Removal Plan on 02/11/2021 at 12:02 PM. The IJ removal plan was verified on-site on 2/12/21.	F 880	¿ IP Nurse/designee will audit cohort levels in the facility on a weekly basis x 6 months. Cohort Level Audit will review the resident population in each cohort and evaluate the use of proper PPE (per Cohort Level), in accordance with the facility□s Outbreak Plan and CDC Guidelines. Audit will include a review of residents under Cohort #2 and Cohort #4 (Admissions and Readmissions) to ensure that proper Transmission-Based Precautions are in place. Findings will be reported to the DON and Administrator on a weekly basis x 6 months and presented in the QAPI Committee Meeting on a quarterly basis. ¿ Infection Preventionist or designee will audit Prompt Contact Tracing of employees/residents who test positive on a weekly basis x 6 months. This is to ensure that all patients/residents who were in direct contact with positive Staff or Resident (for a cumulative 15-minute period within 24 hours) will be considered as PUI□s. Transmission-based precautions will be implemented immediately for these residents, including but not limited to the use of the appropriate PPE□s. Findings will be reported to the Administrator on a monthly basis x 6 months and presented in the QAPI Committee Meeting on a quarterly basis. ¿ The Director of Nursing/Infection Preventionist/Designee will conduct Competency Assessments on 5 Staff members per week x 6 months on the Proper Donning (putting on) and Doffing (Taking off) of Personal Protective	

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F 880	Continued From page 8 This deficient practice was evidenced by the following: On 02/09/2021 at 9:15 AM, Surveyor #1 and Surveyor #2 interviewed the Administrator, the Director of Nursing and the corporate Regional Director of Nursing who revealed that the facility followed the CDC guidelines for cohorting which was included on the facility policy implemented 03/06/2020 and updated 12/18/2020, titled, "Policy for Emergent Infectious Diseases (Covid-19) Outbreak Plan and indicated that: Cohorting means any group of individuals affected by common diseases, environmental or temporal influences, treatments, or other traits whose progress is assessed in a research study should be house together. This cohorting guideline was as follows: a) Cohort 1 - COVID-19 Positive: This cohort consists of both symptomatic and asymptomatic patients/residents who test positive for COVID-19, including any new or re-admissions known to be positive, who have not met the discontinuation of Transmission-Based Precautions criteria. If feasible, care for COVID-19 positive patients/residents on a separate closed unit. Patients/residents who test positive for COVID-19 are known to shed virus, regardless of symptoms; therefore, all positive patients/residents would be placed in this positive cohort. b) Cohort 2 - COVID-19 Negative, Exposed: This cohort consists of symptomatic and asymptomatic patients/residents who test negative for COVID-19 with an identified exposure to someone who was positive. Exposed	F 880	Equipment (PPE). Results of Competency Assessments will be reported to the Administrator on a monthly basis x 6 months and presented in the facilitys QAPI Meeting on a Quarterly basis. Module #1 of the Infection and prevention and control program. completed by all Department Heads and infection preventionist Module 6B Principles of transmission based precautions. completed by all staff Keeping Covid out Video Complete by all staff Use of Personal Protective Equipment (PPE) correctly for covid 19 Infection prevention overview. Completed by all staff CIC has been approved by the DOH effective 4/14. Self assessment has been completed including infection control piece. RCA has been completed: Facility did not place residents on TBP because facility followed the local health Dept guidance and not the state DOH and CDC COMPLETION DATE: 4/29/2021	

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F 880	Continued From page 9	F 880		

individuals should be quarantined for 14 days from last exposure, regardless of test results. All symptomatic patients/residents in this cohort should be evaluated for causes of their symptoms. Patients/residents who test negative for COVID-19 could be incubating and later test positive. To the best of their ability, long-term care facilities (LTCFs) should separate symptomatic and asymptomatic patients/residents, ideally having one group housed in private rooms. Even though symptomatic COVID-19 negative patients/residents might not be a threat to transmit COVID-19, they still may have another illness, such as influenza. Asymptomatic patients/residents should be closely monitored for symptom development.

c) Cohort 3 - COVID-19 Negative, Not Exposed:
This cohort consists of patients/residents who test negative for COVID-19 with no COVID-19 like symptoms and are thought to have no known exposures. The index of suspicion for an exposure should be low, as COVID-19 has been seen to rapidly spread throughout the post-acute care setting. In situations of widespread COVID-19, all negative persons in a facility would be considered exposed. Cohort 3 should only be created when the facility is relatively certain that patients/residents have been properly isolated from all COVID-19 positive and incubating patients/residents and HCP. Facilities may not be able to create this cohort.

d) Cohort 4 - New or Re-admissions:
This cohort consists of all persons from the community or other healthcare facilities who are newly or re-admitted. This cohort serves as an observation area where persons remain for 14 days to monitor for symptoms that may be

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compatible with COVID-19. Testing at the end of this period could be considered to increase certainty that the person is not infected. COVID-19 positive persons who have not met the discontinuation of Transmission-Based Precautions should be placed in Cohort 1 - COVID-19 Positive. Individuals who have cleared Transmission-Based Precautions and it has been <3 months after the date of symptom onset or positive viral test (for asymptomatic) of prior infection can go to cohort 3.

On 2/10/2021 at 10:14 AM, Surveyor #1 interviewed the Licensed Practical Nurse Unit Manager (LPN/UM #1) on the [redacted] Unit (LTC) who stated that if a HCP tested positive for the Covid-19 virus on the [redacted] unit then the DON would perform contact tracing to see what residents the infected HCP exposed or had direct contact with. She revealed that there were also CNA's who became infected with Covid-19 on the [redacted] Unit and that the facility did not make any changes in what PPE was required on the unit. She confirmed that the residents that were exposed to the infected HCP were not put on TBP or identified as PUI. LPN/UM #1 told the surveyors that HCP continued to wear the facility's requirement of a surgical mask and a face shield. The unit staff were observed by Surveyor #1 to be wearing a surgical mask and face shield or eye protection.

On 02/10/2021 at 10:30 AM, Surveyor #1 interviewed the LPN/UM #2 of the LTC [redacted] unit who told Surveyor #1 that this unit was a well, non-ill unit. She added that if a staff member on the [redacted] Unit was infected with the Covid-19 virus that the facility would immediately perform Covid-19 tests on the residents that had been

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exposed to the Covid positive employee and that the facility would monitor the exposed residents every shift for signs and symptoms of Covid-19. She confirmed that the facility did not implement TBP for the exposed residents but wore the facility requirements of a surgical mask and a face shield because the residents were not identified by the facility as Persons Under Investigation (PUI) for Covid-19. The unit staff were observed by Surveyor #1 to be wearing a surgical mask and face shield or other eye protection.

On 02/10/2021 at 10:40 AM, Surveyor #1 interviewed the Registered Nurse/UM for the North Unit concerning facility practice for residents who had been exposed to positive HCP. She told the surveyor that the exposed residents were not considered PUI by the facility and no TBP were implemented. She stated that the residents that had been exposed to the Covid-19 infected HCP were not considered PUI by the facility so TBP were not implemented. She added that if an employee who tests positive for Covid-19 the exposed residents would be monitored every shift for signs and symptoms of Covid-19 and vital signs were taken. There was no change to the PPE of a surgical mask and a face shield.

On 02/10/2021 at 11:30 AM, Surveyor #1 interviewed the facility Infection Preventionist (IP) who stated that residents considered PUI were new admissions, re-admissions and residents that were exposed to someone who was positive for Covid-19. She added that residents who were considered PUI were on TBP (droplet precautions) and that staff were required to wear full PPE which consist of N95 or KN95 (covered

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with a surgical mask), isolation gown, gloves, face shields or goggles.

The IP revealed that if an employee test positive for Covid-19 and had contact with residents, those exposed residents would be considered PUI and transmission-based precautions would be implemented. She added that the staff should be wearing full PPE when caring for the exposed residents because the residents would be on droplet precautions. The IP did not have any comments on why appropriate TBP were not implemented in the facility after residents were exposed to HCP who were tested positive for Covid-19.

On 02/10/2021 at 12:30 PM, the surveyors interviewed the LNHA and RD and were told that the facility followed the recommendations of the Local Health Department (LHD) who handled pandemics and that the LHD recommendations superseded what the state, CDC or what the facility Outbreak plan indicated.

On 02/10/2021 at 4:10 PM, the surveyors interviewed the LNHA and the Regional Director of Nursing who both agreed that the facility usually followed the facility cohorting policy and Disease Outbreak Plan however were given direction from the Local Health Department that residents exposed to infected Health Care Personal just needed to be monitored for signs and symptoms of Covid-19 and were not considered PUI and did not need to be put on TBP.

The surveyors received the Removal Plan on 2/11/12 at 9:56 AM via email and it was accepted.

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F 880	Continued From page 13 The implementation of the removal plan was verified with an on-site visit on 2/12/21. On 2/12/21 at 10:40 AM, the surveyors toured the [redacted] and [redacted], and [redacted] units of the facility and verified through observations, interviews with facility staff, and review of in-service education, facility documentation that the Removal Plan had been implemented. Part B: F880 remains a deficiency, at a scope and severity level of a E based on the following: On 02/10/21, it was determined that F 880 deficiency continued at an E level, for failure to ensure staff followed appropriate infection control protocols related to donning (applying) and doffing (removing) appropriate PPE on a unit identified as Persons under Investigation (PUI) in accordance to facility protocols. This deficient practice was identified for 2 of 2 nursing staff observed on 1 of 2 PUI units during a focused infection control survey conducted on 02/10/21 and was evidenced by the following: On 02/09/21 at 9:11 AM, during an entrance conference with the DON, LNHA, and Regional Director of Nursing the surveyors were told that the PUI Unit consisted of new admission/readmission residents and any residents that were exposed to Covid-19. The staff were to wear a N95 or KN95 mask covered with a surgical mask, face shield or goggles, a washable isolation gown and gloves prior to entering a PUI resident's room. Upon exiting a PUI room, the staff was to remove the gloves and discard the gloves in the room's trash can,	F 880		

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remove the washable gown and dispose of the gown in the bins located in the hallway. The staff could hang the contaminated gown on the hooks on the doorway of each resident's room if the gown was to be used again on their shift.

On 02/09/2021 at 12:06 PM, the two surveyors toured the [redacted] PUI Unit. The PUI Unit was located on the [redacted] Unit and had a plastic zippered barrier doorway with signage attached to the plastic which indicated that Standard Precautions and Droplet Precautions were to be used and the appropriate PPE was to be worn on the unit. Upon entering the PUI unit, the surveyors observed 3 tier bins containing clean PPE in the hallways outside the residents' rooms and bins in the hallway to dispose of trash and washable isolation gowns. The surveyors observed white lab coats and washable isolation gowns hung on hooks of resident's doors facing the hallway and on a set of hooks located in the hallway by the zippered doorway.

The washable isolation gowns and lab coats were layered on top of one another on the hooks near the zippered plastic barrier doorway.

On 02/09/2021 at 12:08 PM, the surveyors observed a staff member in room #114 on the PUI Unit performing care for a resident with the curtains closed. The surveyors observed the staff member exit the room without removing the contaminated washable gown she was wearing. The staff member proceeded to walk down the hallway and place a trash bag in the trash can located at the end of the hallway near the plastic barrier door. She then performed hand hygiene with hand gel and continued to walk through the hallway wearing the contaminated gown.

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The staff member identified herself as a Registered Nurse (RN#1) and was interviewed at that time. RN #1 admitted to the surveyors that she should not be wearing the contaminated gown in the hallway and that she should have removed the gown before exiting the resident's room. RN #1 then removed the gown, rolled the gown in a ball and carried the contaminated gown down the hallway and disposed of the gown in the bin located in the hallway. RN#1 stated that staff was to use one isolation gown for each resident and were to hang the contaminated gown on the hooks of each resident's room to reuse again. The surveyors observed that the 2 hooks on the resident doors were not labeled and were located on the door side facing the hallway.

RN #1 then stated that even though the hooks were not labeled to identify who the gown belonged to; she would know which gown belonged to her. RN #1 further stated that a contaminated gown was to be removed prior to exiting a PUI room, roll it with the dirty side in and the clean side outside, then dispose of the contaminated washable gown in the bin located in the hallway or the bin located by the zippered plastic doorway. When asked if the PUI Unit hallway was considered contaminated, RN #1 stated that she thought it was about 50% contaminated. RN #1 stated that the white lab coats and gowns that were layered together on the hooks located in the hallway of the PUI unit were used by doctors who came to see the residents in the PUI Unit. She explained that the doctors came and applied the gowns to examine residents and then after they were done would hang the gowns back up on the hooks. She said that they could be contaminated because they

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had been used in residents' rooms.

On 02/09/2021 at 12:15 PM, Surveyor #1 observed a staff member enter the PUI unit through the zippered barrier and take a washable isolation gown off the hook that was located just beyond the zippered barrier. The gown that the staff member took off the hook was mixed with other gowns. She applied the gown and entered a residents room. The staff member was identified as a CNA (CNA #5)

On 02/09/2021 at 12:50 PM, the surveyor interviewed CNA #5 who stated that she was assigned to the PUI Unit. She stated that she took the gown from the stack of gowns hanging on the hooks because it was her gown. She added that she knew it was her gown because it was green. She stated that she did not know that the gown was contaminated even though she wore the gown earlier in a resident's room to provide care and then hung the same gown up on a hook with other gowns to be used again.

On 02/20/21 at 10:36 AM, the surveyors interviewed the RN/UM #1 for the [redacted] Unit which contained the PUI Unit. RN/UM#1 stated that the staff were to change isolation gowns between residents. When exiting a PUI room, the contaminated gowns were to be removed prior to exiting a resident's room then placed in a plastic bag to be disposed of in the designated bins in the hallway. She further stated that she would consider the gowns /lab coats hanging on the hooks located in the hallway to be contaminated therefore the hallway would be considered contaminated.

On 02/10/21 at 11:29 AM, the surveyors

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interviewed the IP who stated that on the PUI Unit the staff were to wear a N-95 mask (covered with a surgical mask), a face shield or goggles, then don (apply) an isolation gown and gloves prior to entering a PUI resident's room. Upon exiting the PUI room, staff were to remove gloves and gown prior to exiting the room and dispose of the isolation gowns in bins located inside each PUI resident's room then perform hand hygiene.

On 02/10/21 at 03:04 PM, during an interview with the RD and IP, both stated they were unaware that the staff were disposing of the contaminated gowns in disposal bins located in the hallways of the PUI Unit. Both the RD and IP stated that bins for gown disposal should have been in each PUI room in order for staff to dispose of contaminated gowns prior to exiting the room. The RD, LNHA, DON and IP were also unaware that staff were hanging contaminated gowns on top of one another on the hooks located in the hallway near the zippered barrier and admitted that this was not the facility process.

The surveyor reviewed the education provided by the facility for RN #1 which included but not limited to the following:
-COVID-19: PPE Guidance for Use dated January 20, 2020.
-Infection Control (F880, F881, F882, F883) dated January 20,2020.
-2020 Annual education records which included hand hygiene and infection control precautions.
-Symptoms of Covid-19 vs the Flu/cold dated 11/16/20.
-Keeping Covid Out- infection prevention Overview dated 12/18/20 (which included proper use of PPE).

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The surveyor reviewed the education provided by the facility for CNA #5 which included but not limited to the following:
-COVID-19-PPE Guidance for Use dated January 20, 2021.
-2020 Annual Education record which included Infection prevention, Hand Hygiene, Covid Vs other Illnesses, PPE and Extended Use.
-Keeping Covid Out- infection prevention Overview dated 12/18/20 (which included proper use of PPE).

The facility policy implemented 03/06/2020 and updated 12/18/2020, titled, "Policy for Emergent Infectious Diseases (Covid-19) Outbreak Plan and indicated that:
-Facility would implement the isolation protocol in the care center (isolation rooms, cohorting, cancellation of group activities and social dining) as described in the center's infection prevention and control plan and/or recommended by the local, state or federal public health authorities.
-Activate quarantine interventions for residents and staff with suspected exposure as directed by local and state public health authorities and in keeping with guidance from the CDC.
-When cohorting residents the facility shall identify a minimum of three cohort groups:
a.) Individuals who are showing symptoms of Covid-19 or who have tested positive for Covid-19.
b.) Individuals who have been exposed to someone who has tested positive for Covid-19 or has shown symptoms of Covid-19 (i.e., individuals who are not themselves symptomatic, but may potentially be incubating the virus); and
c.) Individuals who are not ill and not been exposed.
d.) Facility shall assign dedicated staff to each

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cohort and allow for necessary space to do so at the onset of and outbreak.

The facility policy dated 11/10/2020 and titled, "Use of Personal Protective Equipment Utilized by Cohort" indicated that the policy serves for use of Standard, Droplet, and Contact Precautions for residents with symptoms of respiratory infection unless the suspected diagnoses requires Airborne Precautions (e.g., tuberculosis).
The policy indicated that for suspect or confirmed Covid-19 case (s) Standard and Transmission-based Precautions including use of N95 respirator or higher (or facemask, if available), gowns gloves, and eye protection is recommended.
Use of PPE by Cohort:
-Positive: N95/KN95, Protective Eye Equipment such as goggles/face shield, Gown and Gloves.
-Persons under Investigation (PUI): N95/KN95, Protective Eye Equipment such as goggles/face shield, Gown and Gloves.
-New admissions/Readmissions: N95/KN95, Protective Eye Equipment such as goggles/face shield, Gown and Gloves.
-Negative: Surgical Mask, Eye Protection

The facility policy updated 03/06/2020 and titled, "Quarantine" indicated that the facility will protect the health and wellbeing or residents and staff during infectious disease outbreaks. Quarantine is generally enacted by governmental authorities.

The facility policy updated 03/06/2020 and titled, "Respiratory Infection, Prevention and Control of" indicated that that facility follows current guidelines and recommendations for the prevention and control of respiratory infections.
The policy indicated that:

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Standard Precautions: during care of any resident, all staff should adhere to standard precautions, which are the foundation for preventing transmission of infectious agents in all healthcare settings. (Hand hygiene, gloves, and gowns)
According to this policy gowns will be worn for any resident care activity when contact with blood, body fluids, secretions (including respiratory) or excretions is anticipated. Gowns will be removed, and hand hygiene will be performed before leaving the residents room and the same gown will not be worn for care of more than one resident.
- Droplet precautions will be implemented for residents with suspected or confirmed respiratory infection for seven days after illness or until 24 hours after the resolution of fever and respiratory symptoms, whichever is longer.
-In some cases, droplet precautions may be applied longer periods based on clinical judgement.
-Residents with suspected or confirmed respiratory infection would be placed in a private room and when single room is not available, the IP will assess the risk associated with other resident placement options (e.g., cohorting or keeping the resident with an existing resident.)
-Alternative PPE would be provided such as face shields and N95 respirators.

The facility policy updated 03/06/2020 and titled, "Isolation-Categories of Transmission-Based Precautions" indicated that Droplet Precautions may be implemented for and individual documented or suspected to be infected with microorganisms transmitted by droplets.
Residents on droplet precautions will be placed in private room if possible, masks will be worn,

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F 880	Continued From page 21 gloves, gowns and goggles should be worn if there is a risk of spaying respiratory secretions. The facility policy also indicated that Standard Precautions shall be used when caring for residents at all times regardless of their suspected or confirmed infection status and droplet precautions are implemented for an individual documented or suspected to be infected with microorganisms transmitted by droplets (large particles larger than 5 microns in size) that can be generated by the individual coughing, sneezing, talking, or performance procedures such as suctioning. NJAC 8:39-19.4 (a)(b)(c)(d)	F 880		