STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	315195		02/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUTUMN LAKE HEALTHCARE AT BERKELEY HEIGHTS	35 COTTAGE STREET BERKELEY HEIGHTS, NJ 07922

(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: 2/1/22 Census: 81 Sample: 5 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.			
F 885 SS=E	Reporting-Residents,Representatives&Families CFR(s): 483.80(g)(3)(i)-(iii) §483.80(g) COVID-19 reporting. The facility must— §483.80(g)(3) Inform residents, their representatives, and families of those residing in facilities by 5 p.m. the next calendar day following the occurrence of either a single confirmed infection of COVID-19, or three or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other. This information must— (i) Not include personally identifiable information; (ii) Include information on mitigating actions implemented to prevent or reduce the risk of transmission, including if normal operations of the facility will be altered; and (iii) Include any cumulative updates for residents, their representatives, and families at least weekly or by 5 p.m. the next calendar day following the	F 885		2/18/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/09/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 885	Continued From page 1 subsequent occurrence of either: each time a confirmed infection of COVID-19 is identified, or whenever three or more residents or staff with new onset of respiratory symptoms occur within 72 hours of each other. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documents, it was determined that the facility failed to provide documented evidence reflecting that residents and their representatives were informed of newly confirmed COVID-19 diagnoses occurring amongst residents and staff in the facility by 5 PM the next calendar day. This deficient practice was identified for 10 of 14 dates (12/23/21, 12/25/21, 12/28/21, 12/29/21, 12/30/21, 1/7/22, 1/12/22, 1/15/22, 1/18/22, and 1/21/22) in which a resident or staff tested positive for COVID-19. The evidence was as follows: During entrance conference on 1/28/22 at 9:27 AM, the Licensed Nursing Home Administrator (LNHA) in the presence of the Infection Preventionist/Registered Nurse (IP/RN), informed the surveyor that he was responsible for sending notifications to resident representatives regarding the facility's COVID-19 status. The LNHA stated that an automated phone message was sent to representatives two times a week. At this time, the surveyor requested a copy of all resident representative COVID-19 facility status notifications. On 1/28/22 at 11:30 AM, the surveyor interviewed a Resident Representative (RR) who stated that the resident had been at the facility since the	F 885	Corrective Action: The Regional Administrator (LNHA) In serviced the Administrator and the Director of Nursing (DON)on the facility policy and regulations to inform residents, their representative, and families by 5 pm the day after a new occurrence of a single confirmed infection of COVID 19. Identification of at-risk Residents. All residents in the facility are potentially at risk for the deficient practice. Systemic changes: The Regional LNHA in-serviced the LNHA and the DON regarding the regulations that the Robo calls need to be sent out at 5 pm the next day following identification of a COVID positive case. The Administrator will audit all calls on a weekly basis to ensure compliance Quality Assurance: The LNHA/designee and QAPI team will review the calls monthly to ensure that the facility is compliance.	

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F 885	Continued From page 2 beginning of January, and he/she had received two automated phone messages from the facility regarding their COVID-19 status. The RR stated that the message did not specify how many COVID-19 cases there were in the building, just that the numbers were declining and that some residents' rooms would be changed. On 1/28/22 at 11:35 AM, the LNHA provided the surveyor with copies of [redacted] COVID-19 family notifications dated [redacted] The LNHA confirmed at this time that these were all the notifications sent by the facility to the resident's representatives for their current outbreak. A review of the facility's COVID-19 outbreak line list indicated that the following dates were opportunities in which notification of residents and their representatives were to be informed of the new COVID-19 status by 5 PM the next calendar day. The line list reflected the following: 1. On 12/23/21, one staff member tested positive for COVID-19. 2. On 12/25/21, two staff members tested positive for COVID-19. 3. On 12/28/21, two staff members and four residents tested positive for COVID-19. 4. On 12/29/21, one staff member tested positive for COVID-19. 5. On 12/30/21, three staff members and two residents tested positive for COVID-19. 6. On 1/7/22, one staff member tested positive for COVID-19. 7. On 1/12/22, two residents tested positive for COVID-19. 8. On 1/15/22, one staff member tested positive for COVID-19.	F 885		

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F 885	Continued From page 3 9. On 1/18/22, three residents tested positive for COVID-19. 10. On 1/21/22, one staff member tested positive for COVID-19. A review of the facility's "Outbreak Response Plan" dated September 2020, included for communication and notification that the facility will inform residents, their representatives and families of the residents by 5 PM the next calendar day following the subsequent occurrence of either: each time a single confirmed infection of COVID-19 is identified, or whenever three or more residents or staff with new onset of respiratory symptoms occur within 72 hours of each other.... On 1/28/22 at 1:12 PM, the surveyor in the presence of the Director of Nursing, Regional Director of Nursing, and the IP/RN addressed these findings.	F 885		
F 886 SS=F	NJAC 8:39-5.1 (a) 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:	F 886		2/18/22

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F 886	Continued From page 4 (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 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	F 886		

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F 886	Continued From page 5 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. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of pertinent facility documentation, it was determined that the failed to a.) test staff for COVID-19 at a frequency based on the Centers for Disease Control and Prevention's (CDC) level of community transmission and b.) identify and test a partially vaccinated staff member. This deficient practice was identified for 10 of 10 sampled unvaccinated staff members (Staff #1, #2, #3, #4, #5, #6, #7, #8, #9, & #10) and 1 of 1 partially vaccinated staff member (Staff #10). Findings include: Reference: CMS QSO-20-38-NH dated revised 9/10/21, "Routine testing of unvaccinated staff should be based on the extent of the virus in the community. Fully vaccinated staff do not have to be routinely tested. Facilities should use their community transmission level as the trigger for testing frequency. Reports of COVID-19 level of community transmission are available on the CDC COVID-19 Integrated County View site:https://covid.cdc.gov/covid-data-tracker/#county-view." "Table 2: Routine testing Intervals by County COVID-19 Level of Community Transmission... Level of COVID-19 Community Transmission High Minimum testing Frequency of	F 886	Corrective Action: The Infection Control Preventionist (IP) and The Director of Nursing (DON) reviewed the records of the identified staff for the deficient practice. The DON reviewed the regulations and policy regarding testing frequency with the IP. The IP will in-service the staff regarding testing frequency, and the days of the week testing will be done. On testing day, the IP will print out a current employee roster by department, all tested employees will be highlighted, and the employee testing log updated. The employees that missed their testing day will be excluded from work until tested negative before returning to work. Identified Resident at Risk: All residents in the facility are potentially at risk for the deficient practice. Systemic change: The DON reviewed the regulations regarding testing frequency based on the community transmission level. The IP will print out reports of COVID 19 level of transmission from the Center for	

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F 886	Continued From page 6 Unvaccinated Staff twice a week." During entrance conference on 1/28/22 at 9:27 AM, the Infection Preventionist/Registered Nurse (IP/RN) in the presence of the Licensed Nursing Home Administrator (LNHA) and survey team, stated that the facility was currently only testing unvaccinated COVID-19 staff one time per week with a rapid antigen COVID-19 test (test done with the results known in fifteen minutes). The IP/RN stated that she was testing staff twice a week, but since there were only two unvaccinated staff members (Staff #1 and Staff #2) that needed to be tested, she only tested them one time per week. The IP/RN stated that Staff #2 has been out of the facility since last week on medical leave. The IP/RN stated that additional unvaccinated staff members were unable to be tested at this time due to recent COVID-19 positive results. At this time, the surveyor requested the facility's testing log from December through present day, the facility's staff COVID-19 vaccination status list, and the facility's staff COVID-19 outbreak line list. A review of the facility's staff outbreak line list indicated that the facility had six COVID-19 unvaccinated employees who tested positive for COVID-19 from 12/23/21 through 1/7/22. This included: Staff #3 (tested positive 12/23/21) Staff #4 (tested positive 12/25/21) Staff #5 (tested positive 12/27/21) Staff #6 (tested positive 12/28/21) Staff #7 (tested positive 12/29/21) Staff #8 (tested positive 1/7/22) On 1/28/21 at 11:45 AM, the IP/RN provided the	F 886	Disease Control and prevention (CDC) website as well the Local Health Department website. The Facility will continue to follow the CDC and Center for Medicare and Medicaid Services (CMS) guidance based on testing and testing frequency. The IP will in -service the facility staff on the testing frequency. Failure or refusal to test will result in removal from the work schedule until tested negative before returning to work. The IP will make each Department supervisor aware of any employee in their department needed to be excluded from work for missing testing day. Quality Assurance: The IP/Designee will do an audit of the testing log 2 X weekly for 4 weeks and then weekly. The DON will do a weekly random audit of the testing log for 4 weeks, then monthly. Any issues found from the monitoring will be addressed immediately and reported to the Administrator as well as the Quality Assurance Committee/QAPI monthly for any further education or systemic changes until compliance is met.	

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F 886	Continued From page 7 surveyor with a copy of the facility's COVID-19 testing log with an initial testing date of 12/6/21. The log included four pages. At this time, the surveyor asked the IP/RN in the presence of the Director of Nursing (DON) if this was every staff test from December until present. The IP/RN confirmed that the log was all the rapid antigen test results completed on the unvaccinated staff members. The IP/RN also confirmed that she was only currently testing staff for the past few weeks one time per week. A review of the facility's COVID-19 rapid antigen test log revealed the following: Staff #1: week of 12/26/21 through 1/1/22 tested on 12/27/21 only. Staff #2: week of 12/5/21 through 12/11/21 tested on 12/7/21 only; no testing for the weeks of 12/12/21 through 12/18/21; week of 12/26/21 through 1/1/22 tested only on 12/27/21; the week of 1/2/22 through 1/8/22 tested on 1/3/22 only; the week of 1/9/21 through 1/15/22 tested only on 1/10/22; the week of 1/16/22 through 1/22/22 tested only on 1/18/22; and no testing was documented for the week of 1/16/22 through 1/22/22. Staff #3: week of 12/12/21 through 12/17/21 tested on 12/17/21 only. Staff #4: week of 12/5/21 through 12/11/21 no testing for the week; the week of 12/19/21 through 12/25/21 no testing. Staff #5: week of 12/19/21 through 12/25/21 tested on 12/20/22 only. Staff #6: week of 12/19/21 through 12/25/21 no testing. Staff #7: began work at the facility on 12/27/21 no COVID-19 testing until 12/29/21 (positive). Staff #8: week of 12/19/21 through 12/25/21 no	F 886		

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F 886	Continued From page 8 testing; week of 12/26/21 through 1/1/22 testing on 12/27/21 only; week of 1/2/22 through 1/8/22 testing only 1/3/22. A review of the CDC's COVID-19 Community Level indicated that from 12/4/21 through present, the facility's community transmission level was high. On 2/1/22 at 9:30 AM, the surveyor interviewed the DON and IP/RN regarding the facility's COVID-19 testing. The IP/RN stated that she was responsible for testing and ensuring all unvaccinated staff were tested for COVID-19. The IP/RN stated that the facility's corporation informed them that they had to test all unvaccinated staff twice a week but could not speak to why staff had to be tested twice a week. The IP/RN stated that she changed unvaccinated staff testing to one time per week but could not speak to if anyone instructed her to do so. The IP/RN also stated that newly vaccinated staff were not required to test after two weeks past their second dose of the vaccine. A review of the facility's employee COVID-19 vaccine status log revealed that Staff #9 received their second dosage of the COVID-19 vaccine on 12/18/21. A review of the corresponding COVID-19 staff testing log revealed that Staff #9's last COVID-19 test was on 12/15/21. A further review of the facility's employee COVID-19 vaccine status log revealed that Staff #10 received their first dose of the COVID-19 vaccine on 1/6/22.	F 886		

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F 886	Continued From page 9 A review of the corresponding COVID-19 staff testing log revealed that Staff #10 was not tested. On 2/1/22 at 2:05 PM, the DON informed the surveyor that Staff #10 was newly hired to the facility with a start date of 1/2/22. On 2/1/22 at 2:37 PM, the surveyor in the presence of the LNHA, DON, IP/RN, and survey team addressed these findings. No additional information was provided. A review of the facility's "Outbreak Response Plan" dated September 2020, included testing in accordance with CDC, CMS (Centers form Medicare & Medicaid Services), Federal and State Regulations, the Facility will conduct expansive and extensive facility wide testing for COVID-19...	F 886		
F 887 SS=E	NJAC 8:39-5.1(a); 19.1(a) COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side	F 887		2/18/22

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F 887	Continued From page 10 effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident or resident representative, has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; Note: States that are not subject to the Interim Final Rule - 6 [CMS-3415-IFC], must comply with requirements of 483.80(d)(3)(v) that apply to staff under IFC-5 [CMS-3414-IFC] and (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following:	F 887		

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F 887	Continued From page 11 (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to a.) implement their COVID-19 vaccination policy and b.) maintain an accurate staff COVID-19 vaccination status log. This deficient practice was identified for 6 of 6 staff members (Staff #1, #2, #3, #4, #5, & #6) reviewed and 2 out of 2 staff COVID-19 vaccination logs reviewed. The findings were as follows: During entrance conference on 1/28/22 at 9:27 AM, the Infection Preventionist/Registered Nurse (IP/RN) in the presence of the Licensed Nursing Home Administrator (LNHA) and survey team, stated that the facility was tracking COVID-19 vaccination status of the facility staff. The IP/RN stated that the facility had only four staff members that were unvaccinated; three had religious exemptions and one staff member was currently out of the facility on medical leave. At this time, the surveyor requested a copy of the facility's COVID-19 staff vaccination record. On 1/28/22 at 10:20 AM, the IP/RN provided the surveyor with a copy of the facility's employee COVID-19 vaccination log. The log provided	F 887	Corrective Action: The Infection Control Preventionist (IP) and the Director of Nursing reviewed records of the identified employees for the deficient practice. All other employees' records were reviewed for vaccination status, no irregularity found. The staff will be in-serviced by the IP on the regulation regarding COVID 19 vaccine available to the facility, resident, and staff. Prior to vaccine administration, education will be provided to the staff regarding the benefits and risks associated with the vaccines. Consents and declination forms will be kept in the employee medical records. The IP will maintain an updated employee vaccination log which will include dates of administration and as well as proof of vaccination. Identification of the at-Risk Residents: All residents in the facility are potentially at risk for the deficient practice. Systemic Changes: The staff will be in-serviced by the IP on the regulation and facility policy regarding vaccinations. The Ip will maintain an up-to-date staff vaccination record which will include the	

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	315195		02/01/2022

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F 887	Continued From page 12 included ninety-three employee names. Out of the ninety-three employees; there were twenty employees with the vaccine brand, but no dates received; there were five employees that yes was indicated with no vaccine brand or dates received; and there were three employees with a blank status. At this time, the IP/RN stated that she asked staff to bring in their vaccine cards, but some staff had not brought their cards in. The IP/RN stated that she would provide the surveyor with a more updated COVID-19 vaccination list. On 1/28/22 at 11:45 AM, the IP/RN provided the surveyor with an updated employee COVID-19 vaccination log. This log provided included ninety-eight employees. Out of the ninety-eight employees; there were four employees with the vaccine brand name with no dates received; there were three employees with one dose received date and no second dose date; and there was one employee with a second dose date but no first dose date. A review of the facility's COVID-19 Staff Symptoms Line List, included five additional staff members (Staff #1, Staff #2, Staff #3, Staff #4, Staff #5) that unvaccinated was indicated. A review of the facility's employee COVID-19 vaccination log, did not include Staff #1, Staff #2, Staff #3, Staff #4, and Staff #5. On 1/31/22 at 9:48 AM, the surveyor via telephone requested the Director of Nursing (DON) to provide Staff #1, Staff #2, Staff #3, Staff #4, and Staff #5's COVID-19 vaccine cards. On 1/31//22 at 11:41 AM, the DON emailed a response that Staff #1, Staff #3, and Staff #5	F 887	vaccine type, date of administration, exemptions, and proof of vaccination cards. the facility will continue to Follow the recommendations from the Center for Disease Prevention and Control (CDC)and Center for Medicare and Medicaid Services (CMS). Quality Assurance: The DON/ designee will audit the employee vaccination log weekly for 4 weeks and then monthly. Any issues found from the audit/monitoring will be addressed immediately and reported to the Administrator as well as the Quality Assurance Committee/QAPI monthly for any further education or systemic changes until compliance is met.	

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F 887	Continued From page 13 were unvaccinated. The DON provided COVID-19 vaccine cards for Staff #2 and Staff #4. On 2/1/22 at 10:13 AM, the surveyor interviewed the LNHA who stated that if a staff member was not vaccinated and had no vaccine exemption, they could not work at the facility. At this time, the LNHA provided the surveyor with two additional religious exemptions for Staff #1 and Staff #5. The LNHA stated that both staff members worked in therapy. On 2/1/22 at 1:00 PM, the surveyor reviewed the facility's employee COVID-19 vaccination log with the DON. The surveyor showed the DON the blank documentation as well as Staff #1, Staff #2, Staff #3, Staff #4, and Staff #5 were not included on the log. The surveyor asked the DON for additional vaccine information for Staff #6. On 2/1/22 at 2:05 PM, the DON stated that Staff #6 was vaccinated and worked the night shift. The DON stated that Staff #6 was going to provide the facility with their vaccine card tonight. On 2/1/22 at 2:37 AM, the IP/RN in the presence of the LNHA, DON, and survey team, stated that she had not included any therapy staff on the facility's employee COVID-19 vaccination log since they were contracted employees. A review of the facility's undated "COVID-19 Co-Worker Vaccination Policy" included that: All co-workers are required to show proof of first dose or single dose of COVID-19 vaccination...Co-workers are required to provide proof of vaccination to their local human resources department by December 5, 2021.	F 887		

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F 887	Continued From page 14 Documentation received must include date of immunization and maker...Human Resources will maintain the confidential records of COVID vaccinations for co-workers. This will then be placed in your individual medical file/record. NJAC 8:39-5.1(a)	F 887		