STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315490	A. BUILDING _____ B. WING _____	10/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEDICAL CENTER TCU	99 ROUTE 37 WEST TOMS RIVER, NJ 08755

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F 000	INITIAL COMMENTS Survey Date: 10/27/2020 Census: 10 Sample: 10 +1 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 the U.S Centers for Disease Control and Prevention (CDC) recommended practices for COVID-19.	F 000		
F 880 SS=F	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	F 880		11/30/20

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

Electronically Signed | 11/12/2020

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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 transport linens so as to prevent the spread of

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F 880	Continued From page 2 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, record review and review of pertinent facility documents, it was determined that the facility failed to: a.) implement Transmission Based Precautions for 10 of 10 newly admitted residents as persons under investigation for COVID-19 in accordance with the U.S. Centers for Disease Control and Prevention (CDC) guidelines, b.) offer hand hygiene to residents before a lunch meal, and c.) ensure an effective strategy for contract tracing in the event a staff member tests positive for COVID-19. This deficient practice was identified during the COVID-19 Focused Infection Control survey conducted on 10/27/2020, and was evidenced by the following: 1. According to the U.S. Centers for Disease Control and Prevention (CDC) guidelines, Responding to Coronavirus (COVID-19) in Nursing Homes updated 4/30/20 included, "Create a plan for managing new admissions and readmissions whose COVID-19 status is unknown...All recommended COVID-19 PPE [personal protective equipment] should be worn during care of residents under observation, which includes use of an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e. goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown. Testing residents upon admission could identify those who are infected but otherwise without symptoms and might help	F 880	483.80(a) Plan of Correction : Transitional Care unit is a short term Rehabilitation with length of stay up to 8 days. - Root Cause Analysis was conducted with the finding of misinterpretation of the guidelines related to COVID - 19 Infection Prevention and Control in Long Term Care Facilities - CDC guidelines, "Responding to Coronavirus (COVID-19) in Nursing Homes" was reviewed by staff. - Plan on managing new admission and re-admission who's COVID status is unknown was put in place. - All residents are monitored for evidence of COVID - 19 throughout their stay and cared for using all recommended COVID -19 PPE - All residents (10 of 10) have been placed on Transmission-based precautions using PPE such as N95, eye protection, gowns and gloves. - Transmission Based Precaution signage were posted at all resident's entrance door. - PPE cart were made available outside of every room	

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F 880	Continued From page 3 direct placement... However, a single negative test upon admission does not mean that the resident was not exposed or will not become infected in the future. Newly admitted or readmitted residents should still be monitored for evidence of COVID-19 for 14 days after admission and cared for using all recommended COVID-19 PPE." On 10/27/2020 at approximately 9:05 AM, the surveyor interviewed the Director of Nursing (DON) in the presence of the survey team. The DON informed the survey team that the facility had a current census of 10 residents, and acknowledged that all 10 of 10 residents were admitted less than 14 days ago and were assigned private rooms. She stated that the facility did not currently have a COVID-19 outbreak, but recently on 10/10/20 one resident had tested positive for COVID-19 two days upon admission to the facility and had no signs and symptoms of COVID-19. She added that the resident who had tested positive for COVID-19 (Resident #11) had already been discharged back to the community and was not a current resident in the facility. The DON stated that no staff had tested positive for COVID-19 during the weekly testing in the last few months. The DON provided the surveyor a copy of the facility Census Report dated 10/27/20. The Census Report reflected that 10 of 10 residents were admitted to the facility less than nine (9) days. At 9:30 AM, two surveyors observed a Certified Nursing Aide (CNA) inside the private room of Resident #10 with the door open. The resident was sitting upright in a chair. There was no PPE	F 880	- All therapies are done inside the resident's room and doors are kept closed -Resident # 10 - Implemented Transmission-based precautions using PPE such as N95, eye protection, gowns and gloves to all staff. PPE cart and signage were placed at the room entrance door. Resident # 9- PTA was coached to wear proper PPE for transmission based precaution. All therapies are done inside the resident's room. Social distancing of 6 feet were implemented. PPE cart and signage were placed at the room entrance door. Re-education of environmental staff of proper PPE usage when changing the biohazard container inside the resident's room. Resident #6 - Housekeeper was re-educated regarding Transmission Based Precaution and proper usage of CoVID -19 required PPE. PPE cart and signage were placed at the room entrance door. Residents #2, #3 and #8 - Director of Nursing (DON) re-educated staff to offer residents hand wipe to perform hand hygiene before and after meals. -All residents are offered hand wipes before and after meals.	

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F 880	Continued From page 4 cart in proximity to the resident's room and there was no signage to indicate that the resident was on transmission-based precautions (TBP). The CNA was wearing gloves and a surgical mask (without the use of a gown or eye protection) and assisted the resident by placing his/her jacket on the resident's bed within reach of the resident, provided the resident his/her assistive device (a reacher), placed a pillow behind the resident's back for support and repositioned the resident's bedside table in front of the resident. The surveyor then observed the CNA doff the gloves and perform hand hygiene using alcohol-based hand gel (ABHG) and exit the resident's room. At 9:35 AM, the surveyor observed a Physical Therapy Assistant (PTA) wearing a surgical mask standing outside the room of Resident #9. The surveyor observed Resident #9 in a wheelchair wearing a surgical mask and the resident began self-propelling down the hallway toward the rehab gym located on the unit and across the hallway. The PTA was less than six feet from the resident and was not wearing a gown, gloves or form of appropriate eye protection. There was no sign posted outside the resident's room that indicated the resident was on transmission-based precautions or a PPE cart within close proximity of the resident's room. At 9:39 AM, the surveyor interviewed the CNA. The CNA stated that he was the only assigned CNA for all 10 of 10 residents on the unit that day. He stated that all the residents are newly admitted to the facility within eight (8) days, they were all tested upon admission to the facility, and all 10 residents had tested negative for COVID-19 upon admission. The surveyor asked if any residents on the unit were on transmission-based	F 880	-- NJDOH Healthcare Personnel (HCP) Exposure to Confirmed COVID-19 Case Risk Algorithm UPDATED 10/22/20 and Guidance for COVID-19 Diagnosed and/or Exposed Healthcare Personnel UPDATED 10/30/20 were reviewed by staff. - Consideration for Cohorting COVID-19 Patients in Post-Acute Care Facilities was reviewed to the staff. The DON or designee is designated to do contact tracing in the event of designated level of exposure from positive staff member or resident. The Director of Nursing (DON) and/or designee will conduct two (2) observational audits daily to ensure proper Transmission based precautions are being utilized, and hand hygiene is being offered before meals. Monitoring will continue until 100% compliance is achieved for three (3) consecutive months. Findings will be reported monthly to QAA and the Licensure & Accreditation Committee. - TCU Pandemic Plan update to include the look back time period when performing the contact tracing will be completed on November 30, 2020	

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precautions, and the CNA stated, "No" adding that since all residents were tested negative for COVID-19 on admission and none of them have signs or symptoms of COVID-19, or a multi-drug resistant organism (MDRO), therefore staff were not required to wear PPE upon entering the resident rooms. The CNA stated that he only had to follow standard precautions which included wearing gloves when entering each resident room. He added that in addition, all staff were mandated to wear surgical masks at all times while in the facility as and added precaution.

The surveyor continued to interview the CNA who stated that if a resident was under investigation for COVID-19, staff would have to wear a gown, gloves, an N95 respirator mask and a face shield upon entering the room and that it would get discarded after each use. He confirmed a second time that there were no residents under investigation for COVID-19 and no residents on TBP.

At 9:45 AM, the surveyor observed an Environmental employee entering each resident room to replace the red biohazard sharps containers. Each sharps container was located in the middle half of each resident room and secured to the wall. The surveyor observed him enter the rooms, replace the filled sharps containers and place the filled containers on a cart for transport and disposal. He was wearing a surgical mask and gloves upon entering the resident room.

During a brief initial tour of the unit, two surveyors observed that the resident room doors were kept open, while the resident's remained in their rooms.

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At 10:12 AM, the surveyor interviewed the DON, the Licensed Nursing Home Administrator (LNHA) and the Quality Manager in the presence of the survey team. The DON stated that all the resident rooms are negative pressure rooms (Airborne Infection Isolation Rooms [AIIR]).

According to the U.S. CDC guidelines, "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, updated 7/15/20 included that, "Airborne Infection Isolation Rooms (AIIRs) are single-patient rooms at negative pressure relative to the surrounding areas, and with a minimum of 6 air changes per hour (12 air changes per hour are recommended for new construction or renovation)...Room doors should be kept closed except when entering or leaving the room, and entry and exit should be minimized."

The DON continued to inform the surveyors that the facility currently had no residents that were considered persons under investigation (PUI) for COVID-19. She stated that the average length of stay for residents was 6.7 days, and the LNHA added that all residents must be discharged within eight days (or nine days for special circumstances), so therefore all residents are always admitted for less than 14 days. The DON stated that if the facility had a resident that was a PUI, full PPE would be worn if the resident was symptomatic, including fever greater than 100.4 degrees Fahrenheit, coughing, shortness of breath, diarrhea, loss of taste/smell, or a change in baseline. The DON stated that a PUI would include a resident that had signs or symptoms of

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COVID-19, a known exposure to COVID-19, and residents that refuse testing. She stated that a resident that had to leave the unit and return to the unit for any length of time would not routinely be considered a PUI. She also added that new admissions were not considered PUI and that all new admissions were placed on standard precautions and only placed on TBP if the resident developed symptoms of COVID-19. She confirmed that the 10 residents on the census were not on TBP. The DON acknowledged that residents can be asymptomatic and test positive for COVID-19. The DON stated that the staff wear a surgical mask at all times and that residents are encouraged to wear surgical masks as well during care, and all residents are in private rooms with negative pressure.

At 11:30 AM, two surveyors continued to tour the unit. The surveyors observed that the doors remained opened with the residents in them, and that none of the resident rooms had signage for TBP or a PPE cart within close proximity. The surveyor observed a Housekeeper preparing to clean the room of Resident #6. The Housekeeper was wearing surgical mask and gloves. At that time, the surveyor interviewed the Housekeeper who confirmed none of the residents were on TBP and that she didn't have to don a gown or eye protection unless there was a sign on the door to indicate TBP.

At 11:40 AM, two surveyors observed the CNA obtain a lunch tray from the dietary cart. The CNA showed the surveyor what was provided on the tray, including a pre-packaged supply of silverware and a hand wipe. The surveyor observed the CNA pass the lunch tray to Resident #8 and repositioned the resident's bedside table.

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The CNA was wearing gloves and a surgical mask. The CNA did not offer or encourage the resident to perform hand hygiene before the lunch meal.

At 11:44 AM, two surveyors observed the Registered Nurse (RN) provide a lunch tray to Resident #2. The RN placed the tray on the resident's bedside table, and adjusted the table in front of the resident. The RN was wearing a surgical mask, but not wearing gloves, a gown, or eye protection. The RN did not offer or encourage the resident to perform hand hygiene before the lunch meal.

At 11:50 AM, the surveyor interviewed the RN who confirmed that all 10 residents were new admissions to the facility and that none of them were on TBP. He stated that the facility followed standard precautions for the new admissions. He stated that if a resident developed signs or symptoms of COVID-19, then they would immediately place the resident on TBP and that staff would have to wear the appropriate PPE upon entering the room. The surveyor continued to interview the RN regarding hand hygiene for resident's before the lunch meal. The RN stated that the residents are given a packet of wet wipes and that they should use it before they eat. The RN acknowledged that he did not offer the residents to wash the hands before the lunch meal.

At 11:53 AM, the RN brought the two surveyors to the room of Resident #3. The surveyor observed the resident's lunch tray which still had some pieces of lettuce on the plate. The RN asked the resident if he/she had washed his/her hands before lunch, and Resident #3 replied "No." The

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RN proceeded to show the resident how to open the packet of hand wipes on the resident's bedside table for the resident to wipe his/her hands with, and the resident stated that he/she was already done eating the lunch meal. Upon exiting the room, the RN confirmed that the resident had not been offered or encouraged to perform hand hygiene prior to the lunch meal, but that sanitizer wipes were provided to the resident.

At 11:55 AM, the surveyors interviewed the PTA who stated that she assists residents with their rehab program in the rehab gym area on the unit. She stated that there were allowed to be two residents at a time in the gym on either side of the wall greater than 12 feet apart. She stated that she would only have to wear her surgical mask and gloves when working with the residents and that all equipment was wiped down with an Environmental Protection Agency (EPA)-registered disinfectant wipe. She stated that all residents were provided therapy in their rooms for the first day or two of admission, and once they get a negative test result for COVID-19, then the resident can come out of the room to attend rehab in the gym area. She confirmed she assisted Resident #9 that morning with exercises in the rehab gym.

At 12:01 PM, the two surveyors interviewed the Director of Therapy/Physical Therapist (PT). The PT stated that a max of two residents were allowed in the rehab gym at a time, and that all equipment was cleaned with a disinfectant wipe after use. She stated that all staff get tested for COVID-19 on a weekly basis, and that none of the residents were currently on TBP because they had all tested negative for COVID-19 upon admission.

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At approximately 1:45 PM, the surveyor interviewed the DON, LNHA and the Quality Manager in the presence of the survey team, who acknowledged that the facility had not implemented TBP for their newly admitted residents in accordance with U.S. CDC guidelines. The surveyor discussed the findings of the CNA and RN not offering the resident's hand hygiene before the lunch meal, and the DON acknowledged the surveyors findings and confirmed that while residents were provided sanitizer wipes to use, the residents should be afforded the opportunity from staff to perform hand hygiene before meals.

2. According to the U.S. CDC guidelines, Investigating a COVID-19 Case updated 10/21/2020 included that when interviewing a symptomatic client, a case investigator should elicit all close contacts from two days prior to onset of any symptoms through the beginning of isolation. Start date: 2 days before symptom onset; end date: beginning of isolation period OR until discontinuation of home isolation."

On 10/27/2020 at 10:45 AM, the surveyor interviewed the DON, LNHA and the Quality Manager regarding the process for contact tracing in the event a staff member tested positive for COVID-19. The DON stated that if a staff member tested positive for COVID-19 they would be taken off the assignment and sent home immediately, and that the facility would look back 14 days to determine the origin of infection. The surveyor asked who was responsible for contact tracing and the DON stated that they would reach out to the Infection Preventionist (IP) regarding that question. She confirmed she did

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not do the contact tracing. The administrative team stated that they would have the IP speak to the survey team regarding regarding how contract tracing was conducted in the event a staff member tested positive.

At 11:03 AM, the surveyor interviewed the IP in the presence of the survey team regarding how contact tracing was conducted in the event a CNA was to test positive for COVID-19. The IP stated that if a CNA tested positive for COVID-19, that it would be handled through their employee health system and they would look back on what unit they were assigned to and determine what staff members they had contact with and seek to determine the origin of the CNA's infection. The IP stated that they weren't really involved in that process. The surveyor provided a scenario that if a CNA became symptomatic and tested positive for COVID-19 today, what would be the look-back period to determine what residents the CNA had exposure to and who would be responsible to notify and track the residents that were exposed to COVID-19 from the positive staff? The IP stated that she believed she would use the same day that the CNA developed symptoms to determine contact tracing. The surveyor asked if they had a system or policy to track resident names and exposure risk in the event a staff member tested positive, and the IP stated that she would provide the surveyor with the CDC guidelines for contact tracing.

At approximately 12:05 PM, the DON showed the surveyor the New Jersey Department of Health (NJDOH) algorithm to determine exposure risk and she stated that the facility would utilize that as a guide to assess exposure risk but couldn't speak to who was responsible for determining

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F 880	Continued From page 12	F 880		

what residents were exposed to a positive employee or determining the potential exposure risk, and under what timeframe's it would be conducted based on an employees positive results. At approximately 1:50 PM, the surveyor discussed the findings with the DON, LNHA, and the Quality Manager, and the Quality Manager acknowledged that there should be a two day look-back period prior to symptom onset to determine who the staff member came into contact with and under what circumstances and period of time. The DON was unable to speak to who was responsible for determining resident exposure from a staff member in the event a staff member were to test positive for COVID-19, and who was responsible to notify that resident in the event of designated level of exposure from a positive staff member.

A review of the facility's SARS-CoV-2 (COVID-19) Pandemic Plan Long-Term Care updated 9/21/20 including that "patients/residents who test negative for COVID-19 could be incubating and later test positive." "Cohort 4-New or Re-admissions: Special Droplet/Contact Precautions: This cohort consists of all persons from the community or other healthcare facilities who are newly or readmitted...Cohort 4 residents are placed in a single room and quarantined for 14 days to monitor for symptoms that may be compatible with COVID-19 (day of admission or re-admission is considered day 0) After 14 days without signs or symptoms of COVID-19 resident can be removed from Cohort." The Plan further included that, "If staff develop even mild symptoms consistent with COVID-19, they are expected to: cease resident care activities, leave the work area immediately and notify their supervisor; Supervisor informs the facility's

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	315490	A. BUILDING _____ B. WING _____	10/27/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEDICAL CENTER TCU	99 ROUTE 37 WEST TOMS RIVER, NJ 08755

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F 880	Continued From page 13 Infection Preventionist and include information on individuals, equipment, and locations the person came in contact with; contact their health care provider." The plan for tracing did not address the look-back time period when performing the contact tracing. NJAC 8:39-19.1, 19.2; 19.4; 19.5; 12.1	F 880		
F 886 SS=F	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of 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	F 886		11/30/20

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F 886	Continued From page 14 transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to perform weekly COVID-19 testing for 1 of 3 staff members reviewed for testing (contracted Recreational Activities Tech) who made enrichment visits to 10	F 886	Plan of Correction: - Root Cause Analysis was conducted with the finding of misinterpretation of the guidelines related to COVID - 19 Testing	

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F 886	Continued From page 15 of 10 residents on the unit. This deficient practice was identified during a COVID-19 focus infection control survey conducted on 10/27/20, and was evidenced by the following: On 10/27/2020 at 10:45 AM, the surveyor interviewed the Director of Nursing (DON), in the presence of the survey team. The DON stated that the facility currently had no staff that were confirmed positive for COVID-19 in the facility. The DON informed the surveyors that the facility conducts COVID-19 testing for all staff on a weekly basis. The surveyor requested a copy of the facility's tracking sheets for staff testing. The surveyor reviewed the facility's current Transitional Care Unit (TCU) Staff list provided by the DON, which included the name and phone number of a Recreational Activity Tech. A review of the October 2020 schedule for the Recreational Activity Tech reflected that she was scheduled for visits in the TCU four days a week. A review of the staff tracking for COVID-19 testing for October 2020 did not include the name or COVID-19 testing results of the Recreational Activity Tech. A review of the TCU Daily COVID-19 Screening Log for October 2020 reflected that the Recreational Activity Tech was screened for signs and symptoms of COVID-19, including a temperature check during her daily visits to the facility, and she had no signs or symptoms of COVID-19 including no fevers. At 12:45 PM, the surveyor interviewed the DON in the presence of the survey team. The DON	F 886	of Residents and Staff for Long Term Facilities. - The Director of Nursing (DON) initiated weekly testing of the Recreational Activity Tech on October 29, 2020 including all contractual direct healthcare providers. - Staff Re-education of COVID - 19 Testing of Residents and Staff for Long Term Facilities Guidelines were provided to the staff by DON. - TCU Pandemic Plan update will be completed on November 30, 2020 -Weekly COVID -19 test log book will be monitored for compliance by DON. Random audit of 10 staff tests per week by the Infection preventionist will continue until 100% compliance is achieved for three (3) consecutive months. Findings will be reported monthly to QAA and the Licensure & Accreditation Committee.	

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F 886	Continued From page 16	F 886		

stated that the Recreational Activity Tech visited the residents on the TCU approximately four (4) hours a week and she spends about 30 minutes to one hour a day on the unit going "room to room" visiting all the residents, offering magazines and one-to-one visits. The DON added that the Recreational Activity Tech was a vendor/contracted staff and she did not consider a vendor, an employee that the facility had to perform weekly testing for COVID-19. The DON acknowledged that the Recreational Activity Tech was not being tracked for COVID-19 testing and confirmed that the Recreational Activity Tech had not been tested for COVID-19 that she can recall.

At 1:00 PM, the surveyor conducted a phone interview with the Recreational Activity Tech, who stated that she was a vender and performs enrichment activities for the residents for their short stay and was contracted for four hours a week spread throughout four days a week. She stated that that she spends 30 minutes to one hour a day on the unit and spends approximately ten minutes with each resident at a time and wears a mask while on the unit. She stated that she gets screened for COVID-19 when she enters the room, but that she had not been tested for COVID-19 since June 2020. She stated that she was told because she was a vendor that she did not need weekly testing for COVID-19. The Recreational Activity Tech informed the surveyor that she had never tested positive for COVID-19 and had no signs and symptoms of the virus.

At approximately 1:50 PM, the surveyor discussed the findings with the DON, Licensed Nursing Home Administrator (LNHA) and the Quality Manager who acknowledged that vendors had not previously been tested but that they

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F 886	Continued From page 17 would start weekly testing on them as well. A review of the facility's SARS-CoV-2 (COVID-19) Pandemic Plan Long-Term Care updated 9/21/20 including that "Ongoing weekly testing of all staff until guidance from the NJDOH [New Jersey Department of Health] changes based on epidemiology and data about the circulation of virus in the community." The Pandemic Plan did not address including or excluding vendors from the weekly testing of "all staff." NJAC 8:39-27.1	F 886		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315490	A. Building B. Wing	11/17/2020

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
COMMUNITY MEDICAL CENTER TCU	99 ROUTE 37 WEST TOMS RIVER, NJ 08755

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0880 Reg. # 483.80(a)(1)(2)(4)(e)(f) LSC	Correction Completed 11/16/2020	ID Prefix F0886 Reg. # 483.80 (h)(1)-(6) LSC	Correction Completed 11/17/2020	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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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	
10/27/2020	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO