STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	75A001	A. BUILDING: _____ B. WING _____	01/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERION GARDENS ASSISTED LIVING	315 MERION AVENUE CARNEYS POINT, NJ 08069

(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) COMPLETE DATE
A 000	Initial Comments Initial Comments: Census: 37 Sample: 12 A Covid-19 Focused Infection Control Survey was conducted by the State Agency on 1/19/21. The facility was found not to be in compliance with the New Jersey Administrative Code 8:36 infection control regulations standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19.	A 000		
A 310	8:36-3.4(a)(1) Administration (a) The administrator or designee shall be responsible for, but not limited to, the following: 1. Ensuring the development, implementation, and enforcement of all policies and procedures, including resident rights; This REQUIREMENT is not met as evidenced by: Based on staff interview and review of pertinent	A 310		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 03/31/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A 310	Continued From page 1 facility documents, it was determined that the facility failed to develop and maintain a complete and updated Covid Outbreak Response Plan on the facility's website, in accordance with Executive Directive No. 20-0261 , dated 01/06/2021, for Outbreak Plans. This deficient practice was identified during the COVID-19 Focused Infection Control survey conducted on 1/19/2021, and was evidenced by the following: A removal plan was requested and was received via email on 01/19/2021. Reference: NJDOH Required Outbreak Response Plan memo dated 03/06/2020, indicated, "This memorandum is a reminder that pursuant to N.J.S.A. 2H-12.87 ("Act") long-term care facilities, defined in the Act as nursing homes, assisted living residences, comprehensive personal care homes, residential health care facilities and dementia care homes are required to have an Outbreak Response Plan ("Plan"). The Act took effect on August 15, 2019 and gave facilities until February 11, 2020 to develop the Plan. Reference: In accordance with Executive Directive 20-013, no later than May 19, 2020, "... all long-term care facilities as defined in N.J.S.A. 26:2H-12.871 shall supplement or amend their current disease outbreak plan to include a COVID-19 testing plan (Plan) for all staff and patients/residents. "Staff" be tested pursuant to this Directive include all direct care workers and nondirect care workers within the LTC (such as administrative, janitorial and kitchen staff) ...	A 310		

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A 310	Continued From page 2 At a minimum, the Outbreak Response Plan must contain the following components: a. Testing procedures and frequency; b. Post-testing protocols for patients such as cohorting of residents/patients and separation of those with "laboratory confirmed COVID-19 infection from others; c. Procedures to obtain staff authorizations for release of laboratory test results to the LTC to inform infection control and prevention strategies; d. Work exclusion of staff who test positive for COVID-19 infection, refuse to participate in COVID-19 testing, or refuse to authorize release of their testing results to LTC, until such time as such staff undergoes testing and the results to the LTC, until such time as such staff undergoes testing and the results of such testing are disclosed to the LTC; e. Return to work protocols after home isolation for staff who test positive; and f. Plans to address staffing (including worker absences) and facility demands due to the outbreak ...." Reference: Executive Directive NO. 20-0261 "Directive for the Resumption of Services in all Long-Term Care Facilities licensed pursuant to N.J.A.C. 8:43, N.J.A.C. 8:39, N.J.A.C. 8:36 and N.J.A.C. 8:37," revised date 01/06/2021 "...Item -12.87. Item 3. Facilities are required to have a documented "Outbreak Plan" as required by N.J.S.A. 26:2H-12.87. The plan must include but not be limited to lessons learned from the response to and experience with COVID-19. Further, the plan must include a strategy for effective and clear communication with staff, patients/residents, their families, or guardians about any infectious disease outbreaks as required by N.J.S.A. 26:2H-12.87...	A 310		

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A 310	Continued From page 3 The Outbreak Plan: must also include: 1. Methods to communicate information on mitigating actions implemented by the facility to prevent or reduce the risk of transmission, including if normal operations of the facility will be altered. Notifications shall not include personally identifiable information... ii. Methods to provide cumulative updates for residents, their representatives, and families of those residing in the facilities at lease once weekly, during a curtailed visitation period. iii. Written standards, policies and procedures that provide for virtual communication (e.g. phone, video-communication, Facetime, etc.) with residents, families and resident representatives, in the event of visitation restrictions due to an outbreak of infectious disease or in the event of an emergency. iv. A documented strategy for securing more staff in the event of a new outbreak of COVID-19 or any other infectious disease or emergency among staff ... 4. The outbreak plan must be posted on the facility's website for public viewing order [sic] to meet the requirements of this directive ...." On [redacted] at [redacted] the surveyor interviewed the Administrator who stated that [redacted] was responsible to update all policies and procedures at the facility including the "Outbreak Response Plan" that was posted on the facility's website. The Administrator provided the surveyor with a copy of the Outbreak Response Plan for review. The policy titled, "Infection Control Program", (IC #1, Initiated 8/2000) and included	A 310		

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A 310	Continued From page 4 Policy IC #9, titled, "Infection Control Outbreak/Reporting Infectious Disease." (initiated 03/2020). The surveyor reviewed the policy in the presence of the Administrator and noted that it failed to contain all required elements as described in Executive Directive NO. 20-0261. The Administrator stated that the Outbreak Response Plan that was posted to the facility website was last updated in April 2020. At [redacted], the surveyor interviewed the Administrator who stated that on [redacted], [redacted] sent a request for revision of the "Outbreak Response Plan" related to emergency staffing to the company responsible to update the facility website. [redacted] further stated that the facility contracted with an Infection Preventionist who was responsible to review the Outbreak Response Plan and revise the policy to ensure that it contained all required elements before it was updated on the facility website. The Administrator was unable to confirm when the Infection Preventionist planned to review and update the Outbreak Response Plan. A Removal Plan to correct the problem was requested and was received via email on [redacted]. The surveyor confirmed that the facility failed to fully implement the Removal Plan on [redacted] as required.	A 310		
A 313	8:36-3.4(a)(4) Administration (a) The administrator or designee shall be responsible for, but not limited to, the following: 4. Ensuring the provision of staff orientation	A 313		

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A 313	Continued From page 5 and staff education; 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 Executive Director (ED) failed to ensure the staff were educated about COVID-19 and procedures to stop the spread of COVID-19 in accordance with the New Jersey Department of Health's (NJDOH) Executive Order No. 20-026 and infection control topics at least 2 times a year according to their policy. Reference: NJDOH Executive Order No. 20-026, updated 1/6/21, indicated the following: "Under Required Core Practices for Infection Prevention and Control. i. Facilities must educate residents, staff, and visitors about COVID-19, current precautions being taken in the facility, and protective actions ...." On [redacted] at [redacted], in the presence of another surveyor, the surveyor requested to view the staff education that was given in the last year. The Director of Wellness (DOW) stated that the [redacted] and the Assistant DOW give the in-services to the staff and that the last one was in September. At [redacted], the facility provided the surveyors the educational in-services for the last year which included the in-service topic and content and also the staff sign in sheets. The facility also provided a document with a grid that included all the staff names and all the in-services that were given in	A 313		

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A 313	Continued From page 6 2020 with the dates that the in-services were given. At [redacted], the surveyor reviewed the in-service sign in sheets and the in-service grid which revealed the following: An infection control in-service was given to 34 of 50 staff members listed on the sign sheet during [redacted] to [redacted]. There was no documented evidence that any information on COVID-19 was included. Other topics of in-services that were given during 2020 were Concepts of Assisted Living, Resident Rights, Abuse, Fire Drill, Alzheimer's/Dementia Training, Pain Management, Employee Handbook, HIPPA Caregiver Guide and Human Trafficking/Peggy's Law. At [redacted], the surveyor reviewed the facility provided policy titled, Infection Control In-services," with an initiated date of 8/2000 which read: Under Procedure: 1. Infection control in-services will be conducted at orientation and at least two (2) times per year. a. Handwashing technique...c. isolation precautions...e. specific infectious diseases/organisms (as needed)... At [redacted], the surveyor asked the ED if the staff were in-serviced on COVID-19. The ED stated that the [redacted] the staff received an in-service on COVID-19 signs and symptoms, Personal Protection Equipment and Handwashing. The ED then stated she would have to get the sign sheet. At [redacted] during the exit conference in the presence of the survey team, the facility did not provide documented evidence that the staff were	A 313		

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A 313	Continued From page 7 given an in-service about COVID-19. The facility also could not provide any documented evidence that the staff were educated on any infection prevention topics since [redacted]. The surveyor requested that the information be sent via email by the end of that business day. The facility did not provide any documented evidence that the staff were given an in-service about COVID-19 or any other infection control topics since [redacted] via email. During a removal plan verification survey on [redacted], it was determined that the facility failed to ensure their removal plan was implemented and the non-compliance continued. The ED could not provide documented evidence that [redacted] had given the staff an in-service according to the removal plan. On [redacted], during a revisit for the removal plan, the ED provided the surveyor an in-service sign in sheet which revealed the following: a COVID-19 review in-service was given to 17 of 45 staff members listed on the sign sheet on [redacted]. The COVID-19 in-service was not given to all facility staff. During surveyor interview, the ED stated that she thought she emailed the [redacted] in-service to the surveyors on [redacted]. On [redacted] the facility submitted a removal plan by e-mail to the [redacted]	A 313		
A1271	8:36-18.1(a) Infection Prevention and Control Services (a) The facility shall develop and implement an infection prevention and control program.	A1271		

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A1271	Continued From page 8 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 develop and implement facility policies and procedures in accordance with the Centers for Disease Control (CDC) guidelines, the New Jersey Department of Health (NJDOH) guidelines and the NJDOH's Executive Order No. 20-026[1] to prevent the spread of COVID-19. The facility failed to develop an Outbreak Response Plan with all the required elements listed in the NJDOH Executive Order No. 20-026[1], failed to perform weekly COVID-19 tests on all previously COVID-19 negative residents and to wait three months to test previously COVID-19 positive residents unless they developed new symptoms consistent with COVID-19, and failed to ensure staff performed appropriate screening of residents in accordance with the requirements in Executive Order No. 20-026[1] for Phase 0 for 5 of 5 residents (Residents [redacted]) reviewed. The facility failed to limit communal dining or maintain social distancing of six feet apart of residents while eating for 4 of 4 residents (Residents [redacted]). The facility failed to ensure that staff used disinfectant products that were on the EPA List N, disinfectants for use against SARs-CoV, the virus that causes COVID-19. The facility failed to perform ongoing COVID-19 testing of all facility staff related to the extent of COVID-19 in the community according to the regional positivity rate reported in the COVID-19 Activity Level Index Weekly Report in the prior week in accordance with QSO-20-38 of Executive Directive No. 20-0261.	A1271		

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A1271	Continued From page 9 This deficient practice was identified during the COVID-19 Focused Infection Control survey conducted on [redacted], and was evidenced by the following: Reference: The New Jersey Department of Health (NJDOH) Executive Order No. 20-026, updated 01/6/21, indicated the following: Under Phases per this Directive: " ...Phase 0: Any facility with an active outbreak of COVID-19, as defined by the Communicable Disease Service (CDS) ... 5. A facility with a COVID-19 outbreak will remain in Phase 0 (maximum restrictions) until their outbreak of COVID-19 has concluded ...iv. Outbreaks are considered concluded when there are no symptomatic/asymptomatic probable or confirmed COVID-19 cases among employees or residents after 28 days (two incubation periods) have passed since the last case's onset date or specimen collection date (whichever is later) ...The determination of an outbreak's conclusion will be made by either NJDOH or local health officers, pursuant to N.J.A.C. 8:57-1.10 ... Section I. Requirements for initiating a phased reopening of Long-term Care facilities, Assisted Living Residences ...9. Facilities must conduct testing in accordance with this directive. All facilities must test residents and staff as follows: Testing of residents: i. Initiate testing of all residents (every 3 to 7 days) until no new facility onset cases of COVID-19 are identified among residents and positive cases in staff and at least 14 days have elapsed since the most recent positive result and during this 14-day period at least two weekly tests have been conducted with all individuals having tested negative. ii. Retest residents who previously tested positive	A1271		

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A1271	Continued From page 10 according to CDC and NJDOH guidance ... Continued testing of staff as follows: i. Ongoing testing of all facility staff in accordance with QSO-20-38, and this directive until otherwise directed by the NJDOH ...a. Routine testing should be based on the extent of the virus in the community, therefore facilities should use the regional positivity rate reported in the COVID-19 Activity Level Index (CALI) Weekly Report in the prior week, as the trigger for staff testing frequency as follows: ...[Table] Regional CALI Level-Low, Regional Percent Positivity Rate in the past week-<3%, Minimum testing frequency-Once a week. Regional CALI Level-Moderate, Regional Percent Positivity Rate in the past week-3-10%, Minimum testing frequency-Once a week. Regional CALI Level-High/Very High, Regional Percent Positivity Rate in the past week->10%, Minimum testing frequency-Twice a week ... c. Facilities should begin testing all staff at the frequency prescribed in the testing table above, based on the regional positivity rate reported in the past week. d. Facilities should monitor their regional CALI level every week and adjust the frequency of staff testing according to the table above. If the regional CALI level increases to a higher level of activity, the facility should begin testing staff at the frequency shown in the table above as soon as the criteria for the higher activity are met. If the regional CALI level decreases to a lower level of activity, the facility should continue testing staff at the higher frequency level until the county positivity rate has remained at the lower activity level for at least two weeks before reducing testing frequency. ii. Retest staff who have previously tested positive according to CDC guidance ...	A1271		

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A1271	Continued From page 11 Section IV. Required standards for services during each phase. 1. Phase 0 ... iv. Facilities shall screen all residents, at minimum during every shift with questions and observations for signs or symptoms of COVID-19 and by monitoring vital signs. Vital signs recorded shall include heart rate, blood pressure, temperature and pulse oximetry ...." Reference: The NJDOH guidelines titled "Testing in Response to a Newly Identified COVID-19 Case in Long-Term Care Facilities," updated 10/29/20, indicated the following: " ... For persons previously diagnosed with COVID-19 who remain asymptomatic after recovery, retesting is not recommended within three (3) months after the date of symptom onset or first positive test ...For persons who develop new symptoms consistent with COVID-19 <3 months after the date of initial symptom onset, if an alternative etiology cannot be identified by a provider, then the person may warrant re-testing; consultation with infectious disease or infection control experts is recommended... Test-based methods for discontinuation of Transmission-Based Precautions (TBP) and HCP return to work guidance. In general, a test-based method to discontinue TBP or return HCP to work is not recommended ...Upon identification of a facility-onset COVID-19 case in their facility, and in addition to the steps outlined above, the facility should: Perform weekly testing of all residents until no new facility-onset cases of COVID-19 are identified among residents and positive cases in HCP and at least 14 days have elapsed since the most recent positive result and during this 14-day period at least two weekly tests have been	A1271		

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A1271	Continued From page 12 conducted with all individuals having tested negative ... Upon identification of a new COVID-19 case in HCP, and in addition to the steps outlined above the facility should: Perform facility-wide testing of residents, as described above, if the facility is not already conducting routine testing of all residents. Results of testing will guide further response activities and recommendations ...." Reference: Centers for Disease Control (CDC) Guidelines titled, "Testing Guidelines for Nursing Homes" updated 1/7/21 indicated the following: After initially performing viral testing of all residents in response to an outbreak ... repeat testing to ensure there are no new infections among residents and HCP and that transmission has been terminated as described below. Continue repeat viral testing of all previously negative residents, generally every 3 days to 7 days, until the testing identifies no new cases of SARS-CoV-2 infection among residents or HCP for a period of at least 14 days since the most recent positive result ... CDC Guideline titled, "Preparing for COVID-19 in Nursing Homes" updated 11/20/2020, indicated the following: ",,, Additional Strategies Depending on the Facility's Reopening Status. These strategies will depend on the stages described in the CMS Reopening Guidance or the direction of state and local officials ... Implement Social Distancing Measures: Implement aggressive social distancing measures (remaining at least 6 feet apart from others): Cancel communal dining and group activities, such as internal and external activities. Remind residents to practice social distancing,	A1271		

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A1271	Continued From page 13 wear a cloth face covering (if tolerated), and perform hand hygiene ... Considerations when restrictions are being relaxed include: Allowing communal dining and group activities for residents without COVID-19, including those who have fully recovered while maintaining social distancing, source control measures, and limiting the numbers of residents who participate...." CDC guidelines titled, "Cleaning and Disinfecting Your Facility" updated on 7/28/2020, indicated the following: "Practice routine cleaning of frequently touched surfaces. High touch surfaces include tables, doorknobs, light switches, countertops, handles, desks, phones, keyboards, toilets, faucets, sinks, etc. Disinfect with a List N: disinfectants for use against SARs-CoV, the virus that causes COVID 19 ...." NJDOH guidelines titled, "Recommendations for Long-Term Care Facilities during COVID-19 Pandemic" updated 11/10/2020, indicated the following: " ...Implement environmental infection control measures. Conduct routine cleaning and disinfection of frequently touched surfaces and shared medical equipment using an EPA-registered, hospital-grade disinfectant on List N ...." 1. Surveyor #1: On [redacted] at [redacted], during the entrance conference in the presence of the survey team (surveyor #1 and Surveyor #2), the Executive Director (ED) stated that the facility did not currently have any COVID-19 positive residents. The ED stated that the facility's current COVID-19 outbreak started on [redacted] with [redacted] staff members having COVID-19 positive	A1271		

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A1271	Continued From page 14	A1271		

test results during the weekly testing of staff. The ED then stated that they started testing the residents weekly and that the county local health department told them to just test the COVID-19 positive residents. The ED further stated that they were going to test 15 randomly selected residents that day [redacted]). The surveyor then asked if the residents were still being tested weekly since the outbreak started. The ED stated that the residents were tested weekly on [redacted] and [redacted]. The surveyor then asked the ED if the residents were tested the week of [redacted] and the ED stated that only the COVID-19 positive residents were tested on [redacted]

At [redacted] the surveyor requested all COVID-19 test results that were performed since [redacted] for [redacted] randomly selected residents. After the surveyor received and reviewed the results of the [redacted] residents, the surveyor requested an additional [redacted] randomly selected residents.

A [redacted], the surveyor reviewed the test results of the [redacted] residents and their results included the following:

Resident [redacted] COVID-19 test performed [redacted] was negative. COVID-19 test performed [redacted] was negative. There was no documented evidence that a COVID-19 test was performed on [redacted] or [redacted] as required.

Residen [redacted] COVID-19 test performed [redacted] was negative. COVID-19 test performed [redacted] was negative. There was no documented evidence that a COVID-19 test was performed on [redacted] or [redacted] as required.

Resident [redacted] COVID-19 test performed [redacted] was positive. COVID-19 test

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A1271	Continued From page 15 performed [redacted] was positive. After the positive COVID-19 test result was obtained on [redacted], further COVID-19 testing was not required. Resident [redacted] COVID-19 test performed [redacted] was positive. COVID-19 test performed [redacted] was positive. After the positive COVID-19 test result was obtained on [redacted] further COVID-19 testing was not required. Resident [redacted] COVID-19 test performed [redacted] was positive. COVID-19 test performed [redacted] was positive. COVID-19 test performed [redacted] was negative. After the positive COVID-19 test result was obtained on [redacted], further COVID-19 testing was not required. Residen [redacted] COVID-19 test performed [redacted] was positive. COVID-19 test performed [redacted] was positive. COVID-19 test performed [redacted] positive. After the positive COVID-19 test result was obtained on [redacted], further COVID-19 testing was not required. Resident [redacted]- COVID-19 test performed [redacted] was positive. COVID-19 test performed [redacted] was positive. COVID-19 test performed [redacted] was positive. After the positive COVID-19 test result was obtained on [redacted], further COVID-19 testing was not required. Resident [redacted]- COVID-19 test performed [redacted] was negative. COVID-19 test performed [redacted] was positive. After the positive COVID-19 test result was obtained on [redacted],	A1271		

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A1271	Continued From page 16 further COVID-19 testing was not required. Resident [redacted] - COVID-19 test performed [redacted] was negative. COVID-19 test performed [redacted] was negative. There was no documented evidence that a COVID-19 test was performed on [redacted] or [redacted] as required. Resident [redacted] - COVID-19 test performed [redacted] was negative. COVID-19 test performed [redacted] was negative. There was no documented evidence that a COVID-19 test was performed on [redacted] or [redacted] as required. At [redacted] the surveyor reviewed the facility provided outbreak line listing which included the following: -Two staff members tested COVID positive on [redacted]. - One staff member tested COVID positive on [redacted] - One resident tested COVID positive on [redacted]. - [redacted] residents tested COVID positive on [redacted] - [redacted] residents tested COVID positive on [redacted] - One staff member tested COVID positive on [redacted]. - [redacted] resident tested COVID positive on [redacted] At [redacted], the surveyor asked the ED for the last date a staff member or resident tested positive for COVID-19. The ED stated that a [redacted] staff member that worked and was "tested yesterday [redacted] received a positive test result today [redacted]. At [redacted] the surveyor reviewed the facility provided email correspondence with the Local	A1271		

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A1271	Continued From page 17 County Health Department (LCHD), dated 12/23/2020 at 11:59 AM, which included the following guidance and recommendation: "Perform facility-wide testing of all residents (who have not tested positive in the previous 3 months) until at least 14 days have elapsed since the most recent positive result and during this 14-day period at least two weekly tests have been conducted with all individuals testing negative." At [redacted], during surveyor interview and in the presence of another surveyor, the ED stated that the last date all the residents were tested for COVID-19 was [redacted] and that they did not test the residents on [redacted] but that they continued to test the staff. The ED then stated that [redacted] was following the guidance of the county health department and performing weekly tests on staff. [redacted] further stated that they could have tested the residents but that they did not. The ED could not provide a reason why the testing of residents was not continued. At [redacted] the surveyor reviewed the facility provided policy titled, Infection Control Outbreak/Reporting Infectious Disease with an initiated date of 3/2020 which did not contain any information regarding the testing process for residents of the facility. The surveyor then reviewed the facility provided policy titled, "Emergency Preparedness Plan for the Management of an Coronavirus Outbreak" updated in 7/2020, which did not contain any information regarding the testing process for residents of the facility. 2. On [redacted] at [redacted] during tour of the [redacted] unit, the surveyor observed both rectangle folding tables and square dining tables	A1271		

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A1271	Continued From page 18 in the dining room. The surveyor observed that the square tables that were occupied with a resident eating lunch, only had one resident sitting at those occupied square tables. There was one square table that was not occupied by any resident. The surveyor then observed that at each of the two folding tables, there were two residents seated diagonally across from each other on opposite sides of the long side of the table. Resident [redacted] and Resident [redacted] were seated at Table [redacted] and were not six feet apart while they were unmasked and eating lunch. Resident [redacted] and Resident [redacted] were seated at Table [redacted] and were not six feet apart while they were unmasked and eating lunch. At [redacted], during surveyor interview, the Certified Nursing Assistant (CNA) seated at Table [redacted] stated the residents started eating in the Dining Room last week and that the seating of the residents was assigned by the ED or the nurse upon admission. The surveyor then asked the CNA if Resident [redacted] and Resident [redacted] were six feet apart. The CNA stated, "I wouldn't say they are exactly six feet apart". At [redacted], during surveyor interview and in the presence of another surveyor, the Marketing Director/Licensed Practical Nurse stated that the folding table looked like a six foot table but could not say if the residents were six feet apart without measuring. At [redacted], the surveyor, in the presence of another surveyor, asked the Director of Maintenance (DOM) for the measurements of the folding table. The DOM measured the folding table and stated that it was six feet by 30 inches. The surveyor then asked the DOM to measure the approximate distance between Resident [redacted]	A1271		

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A1271	Continued From page 19 and Resident [redacted] at Table [redacted] The DOM stated that the approximate distance was three feet. The surveyor then asked the DOM to measure the approximate distance between Resident [redacted] and Resident [redacted] at Table [redacted]. The DOM stated that the approximate distance was [redacted]. A review of the NJDOH guidelines titled, Recommendations for Long-Term Care Facilities during COVID-19 Pandemic, updated 11/10/2020, indicated the following: Under section Implement environmental infection control measures. Conduct routine cleaning and disinfection of frequently touched surfaces and shared medical equipment using an EPA-registered, hospital-grade disinfectant on List N. 3. On [redacted] during the entrance conference with the ED, the surveyors requested a list of the EPA-registered products that were on the EPA's List N (disinfectants for use against SARs-CoV, the virus that causes COVID 19) that the facility was using to clean and disinfect frequently touched surfaces and shared medical equipment. At [redacted] during surveyor interview, the CNA stated that [redacted] uses Reliance wipes to clean the tables in the memory care unit. The surveyor observed the container and the container's label did not contain an EPA registration number on it. At [redacted], during surveyor interview, the Licensed Practical Nurse stated that [redacted] uses Carmel Wipe It Way antibacterial wipes to clean reusable medical equipment. The surveyor observed the container that was on top of the medication cart and the container's label did not contain an EPA registration number on it.	A1271		

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A1271	Continued From page 20 At [redacted], during surveyor interview, the ED stated that the wipes the facility used were provided to them by their contracted supply company and they were told that they could be used for COVID-19. At [redacted] the surveyor reviewed the facility provided policy titled, "Disinfectants" with an updated date of 9/2020, which read: The facility shall use germicides and disinfectants that are approved by the FDA, EPA and Center for Disease Control. At the time of the exit conference, the facility could not provide documented evidence that the Reliance Gym Wipes and the Carmel Wipe It Way wipes the facility used were on the EPA's List N. 4. Surveyor #2: On [redacted] at [redacted] during the Entrance Conference, the Administrator stated that the Director of Wellness (DOW) and the Assistant Director of Wellness (ADOW) performed COVID-19 testing for all employees weekly on Monday or Tuesday based on staff availability. At [redacted] the surveyor interviewed the DOW who stated that staff were always tested weekly. [redacted] stated that while [redacted] knew that the positivity rate of COVID-19 was very high in the surrounding community she did not know what the Regional Percent Positivity Rate was in the prior week and did not conduct testing based on that rate. The DOW further stated that the facility tested employees weekly prior to the latest COVID-19 Outbreak that began on [redacted] and continued to test employees weekly on Mondays or Tuesdays.	A1271		

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A1271	Continued From page 21 At [redacted], in a later interview with the Administrator, [redacted] stated that [redacted] was not aware of the current CALI Level or Regional Percent Positivity Rates. [redacted] further stated that the facility continued to test employees weekly based on guidance that was provided by the Local Health Department (LHD). The Administrator provided the surveyor with e-mail correspondence that [redacted] received from the Salem County Health Department on 01/07/21, which contained a COVID-19 Weekly Activity Report which indicated that as of the week ending 01/02/21, all six regions of the state had a high CALI Score of three. A table included in the report recorded that the Percent Positivity Rate in the Southwest Region of New Jersey where the facility was located was 14.42 Percent Positivity. A link to the New Jersey Department of Health Website was attached for reference: https://www.nj.gov/health/cd/statistics/covid/index.shtml. A phone number was provided with instructions to contact the Communicable Disease Service with any questions about the report. The surveyor reviewed a second e-mail correspondence from the Salem County Health Department dated 01/14/21, which contained a COVID-19 Weekly Activity Report for the week ending January 9, 2021. The report detailed that all six regions of the state had a high COVID-19 Current Activity Level and the Percent Positivity Rate in the Southwest Region had a 13.08 Percent Positivity Rate. Between [redacted] and [redacted], the surveyor interviewed a [redacted] all the employees stated that they were tested for COVID-19 once a week by the facility.	A1271		

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A1271	Continued From page 22 The surveyor reviewed COVID-19 test results for six random employees which confirmed that the facility conducted testing on a weekly basis, rather than twice a week as the CALI level and the Percent Positivity Rates in the reported period indicated during the month of [redacted]. The facility was unable to provide documented evidence that facility staff were tested for COVID-19 twice weekly for rapid detection as required to prevent further spread of COVID-19. During a Removal Plan Verification survey on [redacted], it was determined that the facility failed to ensure that their removal plan was fully implemented and therefore, continued to be non-compliant.	A1271		
A1273	8:36-18.1(b) Infection Prevention and Control Services (b) The licensed professional nurse, in coordination with the administrator, shall be responsible for the direction, provision, and quality of infection prevention and control services. The health care services director, in coordination with the administrator, shall be responsible for, but not limited to, developing and maintaining written objectives, a policy and procedure manual, and an organizational plan for the infection prevention and control service.	A1273		

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A1273	Continued From page 23 This REQUIREMENT is not met as evidenced by: Based on staff interview and review of pertinent facility documents, it was determined that the facility failed to retain a qualified Infection Preventionist or contract with an infection control service accordance with Executive Directive 20-0261 to prevent the spread of infection during the COVID-19 Pandemic. This deficient practice was identified during the COVID-19 Focused Infection Control survey conducted on [redacted], and was evidenced by the following: A removal plan was requested and was received via email on [redacted]. Reference: EXECUTIVE DIRECTIVE NO. 20-0261 dated 01/06/2021, Directive for the Resumption of Services in all Long-Term Care Facilities licensed pursuant to N.J.A.C. 8:43, N.J.A.C. 8:39, N.J.A.C. 8:36 and N.J.A.C. 8:37: "Required Core Practices for Infection Prevention and Control ii. All facilities, except for facilities with ventilator dependent residents, are required to have one or more individuals with training in infection prevention and control employed or contracted on a full-time or part-time basis to provide on-site management of the Infection Prevention Control (IPC) program. The requirements of this Directive may be fulfilled by: a. An individual certified by the Certification Board of Infection Control and Epidemiology or meets the requirements under N.J.A.C. 8:39-20.2;	A1273		

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A1273	Continued From page 24 b. A physician who has completed an infectious disease fellowship, c. A healthcare professional licensed in good standing by the State of New Jersey, with five (5) or more years of infection control experience. iv. Facilities with No Ventilator Beds b. Facilities with less than 100 beds, or no on-site hemodialysis services must: 1. Staff their IPC program based on the resident population and facility service needs identified in the facility risk assessment available at: https://www.cdc.gov/longtermcare/excel/IPC-Risk Assessment.xlsx. 2. Prior to the hiring of any staff for their IPC program identified in section b. 1) above facilities will [sic] must enter a contract for infection control services. Facilities may terminate the contract once they hire or staff their IPC program and submit an attestation to the NJDOH, as required within this directive. 3. Responsibilities of this position include, at a minimum, developing infection prevention and control policies and procedures, performing infection surveillance, providing competency-based training of staff and auditing adherence to recommended infection prevention and control practices." On [redacted] at [redacted] the surveyor interviewed the Director of Wellness (DOW) who stated that [redacted] had not completed any official infection control training program. [redacted] further stated that the Administrator served as the facility Infection Preventionist and recently completed an	A1273		

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A1273	Continued From page 25 infection prevention course offered by the Department of Health. At [redacted], The surveyor interviewed the Administrator who stated that [redacted] served as the facility Infection Preventionist and collaborated with the DOW and the Assistant Director of Wellness (ADOW) as needed. [redacted] stated that if [redacted] had questions related to infection control, [redacted] asked the Medical Director. [redacted] further stated that [redacted] did not know if the Medical Director possessed an infection prevention certification or if he completed an Infection Control Fellowship. The Administrator provided the surveyor with a training certificate which indicated that [redacted] completed an online course between [redacted] and [redacted] titled, "The Northeastern Basic Course for Principles of Infection and Control." She further stated that the facility had not secured a contract with an infection control service for an Infection Preventionist at any time during the pandemic. At [redacted] the surveyor interviewed the ADOW who confirmed that [redacted] had not completed any formal infection control training. On [redacted], the facility submitted a Removal Plan effective beginning [redacted]. On [redacted], a Revisit was conducted to confirm that the Removal Plan was implemented. At [redacted] the surveyor interviewed the DOW who stated that [redacted] didn't believe that the Administrator had contracted with an Infection Preventionist yet. At [redacted], the surveyor interviewed the	A1273		

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A1273	Continued From page 26 Administrator who confirmed that [redacted] contracted with a consulting service for an Infection Preventionist effective [redacted]. On [redacted] in a post-survey e-mail exchange, the Administrator confirmed that [redacted] dedicated at least one hour daily to infection control at the facility five days per week. [redacted] also clarified that the Medical Director was a Medical Doctor and was not an Infectious Disease Specialist. [redacted] confirmed that the MD was available to assist both the Administrator and the DOW with any infection control issues as needed. The surveyor confirmed that the facility failed to fully implement the Removal Plan on [redacted] as required.	A1273		
A1297	8:36-18.3(a)(4) Infection Prevention and Control Services (a) Written policies and procedures shall be established and implemented regarding infection prevention and control, including, but not limited to, policies and procedures for the following: 4. Surveillance techniques to minimize sources and transmission of infection; This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, it was determined that the facility, failed to appropriately screened residents in phase 0 of re-opening, to minimize sources and transmission of infection in accordance with the requirements	A1297		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	75A001	A. BUILDING: _____ B. WING _____	01/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERION GARDENS ASSISTED LIVING	315 MERION AVENUE CARNEYS POINT, NJ 08069

(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) COMPLETE DATE
A1297	Continued From page 27 in the New Jersey Department of Health's (NJDOH) Executive Order No. 20-026[1] for 5 of 5 residents (Residents [redacted] reviewed. The facility failed to perform appropriate surveillance technique and contact tracing of COVID-19 positive staff to ensure the prevention of continued spread of COVID-19. This deficient practice was identified during the COVID-19 Focused Infection Control survey conducted on [redacted], and was evidenced by the following: Reference: New Jersey Executive Order No. 20-026, updated 1/6/21, indicated the following: " ...Section IV. Required standards for services during each phase. 1. Phase 0 ... iv. Facilities shall screen all residents, at minimum during every shift with questions and observations for signs or symptoms of COVID-19 and by monitoring vital signs. Vital signs recorded shall include heart rate, blood pressure, temperature and pulse oximetry ... Section IV. Required standards for services during each phase. 1. Phase 0 ... iv. Facilities shall screen all residents, at minimum during every shift with questions and observations for signs or symptoms of COVID-19 and by monitoring vital signs. Vital signs recorded shall include heart rate, blood pressure, temperature and pulse oximetry ...." Reference: "Testing in Response to a Newly Identified COVID-19 Case in Long-Term Care Facilities" dated 09/23/2020, indicated that regardless of attribution of the case, all facilities should take the following steps when a new case of COVID-19 (e.g., residents, health care providers (HCP),	A1297		

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	75A001	A. BUILDING: _____ B. WING _____	01/19/2021

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A1297	Continued From page 28 essential caregivers) is identified in their facility: "...Perform a risk assessment to determine any potential exposures and/or infection control breaches at the facility... Determine any possible exposures the new case of COVID-19 (e.g., resident, HCP, essential caregiver) may have had prior to diagnosis including contact with other known COVID-19 positive persons or those who later developed symptoms consistent with COVID-19... Alert the local health department the newly identified case. Identify close contacts including 48 hours prior to symptom onset/date of specimen collection of associated case, if applicable... Close contact is identified as being within approximately 6 feet of a COVID-19 case for a prolonged period of time (> 10 minutes); or Having direct contact with infectious secretions from an individual with COVID-19. Infectious secretions may include sputum, serum, blood, and respiratory droplets (e.g., being coughed or sneezed on) ... Quarantine close contacts for 14 days from last exposure and provide care using all COVID-19 recommended personal protective equipment (PPE) ...." 1. Surveyor #1: On [redacted] at [redacted] the surveyor reviewed the Medication Record (MR) for five residents (Residents [redacted]). The MR revealed for each resident that their temperature was taken daily and their pulse oximetry (measures oxygen levels in blood) was taken each shift. There was no documented evidence that the facility was asking questions and making observations for signs or symptoms of COVID-19 or checking the resident's blood pressure and heart rate every shift.	A1297		

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A1297	Continued From page 29 At [redacted] in the presence of another surveyor, the ED stated that the facility was in Phase 0. At [redacted] in the presence of another surveyor (Surveyor #2), the Director of Wellness (DOW) confirmed that the facility was only checking the resident's temperature daily and pulse oximetry every shift. [redacted] then confirmed that the facility was not checking the resident's BP or HR every shift unless it was to be done for a specific medication that a resident was taking. [redacted] further confirmed that the facility was not asking questions or making observations for signs or symptoms of COVID-19. 2. Surveyor #2: On [redacted] at [redacted], the surveyor interviewed the Administrator who stated that there were no active cases of COVID-19 in the building as both Resident [redacted] and Residen [redacted] tested positive for COVID-19 on [redacted] and completed a required 14-day quarantine on transmission-based precautions (precautions used to help stop the spread of germs from one person to another). [redacted] stated that all residents were required to remain within their rooms at this time as the facility was in Phase Zero (0) of an outbreak. The Administrator stated that neither Resident [redacted] nor Resident [redacted] had left the building for any reason prior to testing positive for COVID-19. The Administrator stated that several employees tested positive for COVID-19, recovered, and had since returned to work. [redacted] further stated that one employee who tested positive on [redacted], who did not have resident contact, resigned, and would not return to the facility. The Administrator stated that it was unclear how Resident [redacted] and Resident [redacted] contracted COVID-19. [redacted] stated that all staff were required to wear surgical masks	A1297		

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A1297	Continued From page 30 when they entered resident rooms. The surveyor requested to view contact tracing or risk assessment (an effective disease control strategy that involves identification of cases and their contacts to interrupt disease transmission) that was completed for employees who tested positive at the facility. The Administrator stated that [redacted] had not officially written up any type of contact tracing, but [redacted] could if she needed to. At [redacted], in a later interview with the Administrator, [redacted] stated that [redacted] had no idea that [redacted] was required to complete contact tracing or perform a risk assessment. [redacted] stated that [redacted] thought that the DOH did that. On [redacted] the surveyor conducted a revisit and the Administrator provided the surveyor with contact tracing for one of ten employees who previously tested positive for COVID-19 since [redacted] according to the line list maintained by the facility.	A1297		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
75A001 Y1	A. Building B. Wing Y2	3/31/2021 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MERION GARDENS ASSISTED LIVING	315 MERION AVENUE CARNEYS POINT, NJ 08069

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (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 A0310	Correction	ID Prefix A0313	Correction	ID Prefix A1271	Correction
Reg. # 8:36-3.4(a)(1)	Completed	Reg. # 8:36-3.4(a)(4)	Completed	Reg. # 8:36-18.1(a)	Completed
LSC	03/25/2021	LSC	03/25/2021	LSC	03/25/2021
ID Prefix A1273	Correction	ID Prefix A1297	Correction	ID Prefix	Correction
Reg. # 8:36-18.1(b)	Completed	Reg. # 8:36-18.3(a)(4)	Completed	Reg. #	Completed
LSC	03/25/2021	LSC	03/25/2021	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
1/19/2021	☐ YES ☐ NO