STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315423	A. BUILDING _____ B. WING _____	01/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE HEALTHCARE AND REHABILITATION, LLC	2300 HAMILTON AVE HAMILTON, NJ 08619

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F 000	INITIAL COMMENTS	F 000		

Survey date: 1/19/2021

Census: 155

Sample: 10

A COVID-19 Focused Infection Control Survey was conducted by the New Jersey Department of Health on 1/11/21, 1/14/21 and 1/19/21. 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 Centers for Medicare and Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices for COVID-19.

COVID-19 (Coronavirus Disease 2019) is a disease caused by the coronavirus SARS-CoV-2. COVID-19 is thought to spread mainly from person to person, mainly through respiratory droplets produced when an infected person coughs or sneezes.

The facility failed to isolate residents on transmission-based precautions (TBP) for unknown COVID-19 community exposure in a high risk COVID-19 positive county from their well and non-exposed roommates to prevent the transmission of COVID-19.

The facility's failure to isolate Resident [redacted] and [redacted] from their well, non-exposed roommates posed a serious and immediate threat to the safety and wellbing of well non-exposed residents.

This resulted in an Immediate Jeopardy (IJ) situation that began on 12/22/2020 when

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

Electronically Signed | 02/08/2021

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F 000	Continued From page 1 Resident [redacted] returned to their same room in the facility on TBP for an unknown COVID-19 community exposure with their three well and non-exposed roommates. The facility was notified of the IJ situation on 1/11/21 at 4:30 PM. On 1/13/21 the facility submitted a removal plan by e-mail to The New Jersey Department of Health (NJDOH). On 1/14/21 during an onsite Removal Plan verification survey, the facility was found to have corrected the IJ. PART B On 1/14/21 during an onsite Removal Plan verification survey, a second IJ situation was identified. The facility failed maintain TBP for residents identified as a person under investigation (PUI) for a known COVID-19 exposure by a.) not changing gowns between residents, b.) not donning (wearing) a N95 (respirator) mask, c.) not donning a gown or gloves in resident rooms on TBP, and d.) not performing hand hygiene prior to exiting resident rooms in an effort to mitigate the spread of COVID-19. The facility's failure to ensure that appropriate TBP were followed for residents with a known exposure to COVID-19 posed a serious and immediate threat to safety and wellbeing of all non-ill residents. This resulted in a second IJ situation that began	F 000		

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F 000	Continued From page 2 on 1/12/21 when the facility identified that the nurse was COVID-19 positive. The facility was notified of the IJ situation on 1/14/21 at 4:20 PM. On 1/15/21 the facility submitted a Removal Plan by email to the NJDOH. On 1/19/21 during an onsite Removal Plan verification survey, the facility was found to have corrected the IJ.	F 000		
F 835 SS=L	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of medical records and other pertinent facility documentation, during a survey conducted on 1/11/21, it was determined that the facility's Licensed Nursing Home Administrator (LNHA) failed to ensure: a.) that the facility was in compliance with all recommended infection control measures in accordance with the Centers for Disease Control (CDC) and the New Jersey Department of Health (NJDOH) guidelines and b.) the implementation of mitigation strategies to prevent the transmission of COVID-19 were appropriately followed to prevent the spread of the infection which affected residents' safety. Additionally, during a removal plan verification survey on 1/14/21, it was determined the facility	F 835	1. Actions(s) accomplished for resident(s) found to be affected by this deficient practice. The Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON) and Assistant Director of Nursing/Infection Practitioner (ADON/IP) Nurse received education by the Regional Nurse Consultant on risk assessment and placement planning for residents who leave and return to the facility for medical and non-medical related purposes. The Licensed Nursing Home Administrator (LNHA) was educated 1/14/2021 on guidelines for maintaining appropriate infection control measures including use of adequate Personal	3/8/21

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F 835	Continued From page 3 failed to ensure that a.) staff donned (wore) appropriate personal protective equipment (PPE) for residents who were considered persons under investigation (PUI) for a known COVID-19 exposure and b.) staff changed PPE between residents on transmission-based precautions (TBP) which resulted in a second Immediate Jeopardy (IJ). Refer to F880K as it pertains to the facility's failure to ensure the implementation of Infection Control Practices and Precautions during an identified COVID-19 outbreak. During the survey conducted on 1/11/21, the surveyors identified and observed deficient practices for infection control regarding the isolation of two residents who were placed on TBP for community based exposure to COVID-19 from their well and non-exposed roommates. This deficient practice was identified on 1 of 4 nursing units. The facility submitted a Removal Plan by email on 1/12/21, and after several revisions and review at the Department of Health (DOH), the RP was accepted on 1/13/21. On 1/14/21, the surveyors conducted an onsite visit to verify the Removal Plan. During the verification of the Removal Plan, the surveyors observed staff members wearing the same isolation gowns from resident to resident who were considered PUI and on TBP for a known exposure to COVID-19. Staff members were also observed not wearing the recommended N95 (respirator) mask while caring for PUI residents on TBP. The surveyor also observed a Maintenance Assistant go from one isolation room to the next wearing only a KN95 mask and goggles. The Maintenance Assistant did not wear	F 835	Protective Equipment (PPE) for residents on Transmission-Based Precautions (TBP) in accordance with CDC and NJDOH guidelines and mitigation strategies to prevent the transmission of COVID-19. The LNHA resigned from his position at the facility effective 2/5/2021. The new LNHA received in-servicing on guidelines for maintaining Personal Protective Equipment (PPE) for residents on TBP in accordance with CDC and NJDOH guidelines and mitigation strategies to prevent the transmission of COVID-19. The facility has retained an Administrative Consultant that has been approved by the New Jersey Department of Health who will present in the facility for no less than 20 hours per week on site and an additional 20 hours a week off site, until further notice from the New Jersey Department of Health with a start date of Monday, March 8th, 2021. The Administrative Consultant's resume was sent to and approved by the New Jersey Department Health. The Administrative Consultant will continuously assess the facility's compliance with regards to all applicable state licensing standards. If any areas of non-compliance are identified, the Administrative Consultant will meet with the Administrator to discuss those areas identified and educate the administrator on how to ensure that operating procedures, systems, and standards align with compliance requirements. Residents identified in F880 SS=L PART A had the potential to be affected by this	

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F 835	Continued From page 4 the required isolation gown or gloves in any of the rooms. The Maintenance Assistant was observed opening doors and touching light switches with no hand hygiene in between resident rooms. This resulted in a second IJ situation. These deficient practices were identified in 2 of 2 nursing units with residents who were on TBP for a known COVID-19 exposure from a staff member. The facility submitted a Removal Plan by email which after one revision was reviewed and accepted on 1/15/21 at the DOH. This deficient practice was evidenced as follows: A review of the Administrator's job description provided by the facility revealed the following: Purpose of Your Job Position: The primary purpose of your job position is to direct day-to-day functions of the facility in accordance with current federal, and local standards, guidelines, and regulations that govern long-term care facilities to assure that the highest degree of quality care can be provided to our residents at all times. Duties and Responsibilities: Administrative Functions - Essential Duties Plan, develop, organize, implement, evaluate, and direct facility's programs and activities. Develop and maintain written policies and procedures that govern the operation of the facility. Assist department directors in the development and use of departmental policies and procedures, and establish a rapport in and among departments so that each can realize the importance of teamwork. Review the facility's policies and procedures periodically, at least semi-annually, and make	F 835	deficient practice. Symptom and surveillance monitoring and COVID-19 testing was complete with no resulting positive tests results. All identified residents were maintained on Transmission-Based Precautions (TBP) for 14 days. Residents #1 and #2 identified in F880 SS=L PART A were moved into private rooms and maintained on TBP for 14 days. Residents identified in F880 SS=L Part B residing on the Klockner and Mercer Units had the potential to be affected. Facility-wide resident testing was done for 3 consecutive weeks with no residents identified as COVID-19 positive. 2. All residents identified having the potential to be affected and corrective action(s) taken. All residents residing in the facility had the potential to be affected. Facility-wide resident testing utilizing rapid COVID-19 (SARS-COV-2) antigen testing was done on 1/15/2021 for residents not already identified and tested on 1/12/2021 or 1/13/2021. Resident testing was done facility-wide for three consecutive weeks for COVID-19. No residents were identified as COVID-19 positive. 3. Measures that will be put into place to ensure deficient practice will not recur. A policy was created for determining risk assessment and placement planning for residents who leave and return to the facility for medical or non-medical related purposes. The policy was created based on the assessment of exposure risk to	

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F 835	Continued From page 5 changes as necessary to assure continued compliance with current regulations. Ensure all employees, residents, visitors, and the general public follow established policies and procedures. Assume the administrative authority, responsibility, and accountability of directing activities and programs of the facility. Make routine inspections of the facility to assure that established policies and procedures are being implemented and followed. Participate in facility surveys (inspections) made by authorized government agencies. Safety and Sanitation - Essential Duties Ensure that all facility personnel, residents, visitors, ect., follow established safety regulations, to include fire protection/prevention, smoking regulations, infection control, ect. Ensure that personnel follow established policies governing the use/disposal of personnel protective equipment and disposal of infectious wastes. Other(s) that may become necessary/appropriate to assure that the facility is maintained in a clean, safe and sanitary manner. Specific Requirements: Must be thoroughly familiar with laws, regulations, and guidelines governing personnel administration. On 1/11/21 at 4:30 PM, the facility's Licensed Nursing Home Administrator (LNHA) was notified that an IJ situation was identified related to the facility cohorting residents identified as PUIs on TBP for a possible community based exposure to COVID-19, with their well and non-exposed roommates.	F 835	COVID-19 for a resident while they are out of the facility and set to return. This policy is not utilized for new or re-admissions. The policy also contains guidance for staff if the exposure risk can't be determined. A risk assessment template for assessing a resident's risk of exposure to COVID-19 while out of the facility and placement planning for their return was created for residents who leave for medical and non-medical related purposes. In-services were conducted for licensed nursing and admission staff on the COVID-19 Exposure Risk Assessment Policy and Exposure Risk Template to ensure proper placement of residents upon their return from outside of this facility for medical and non-medical related purposes. An audit tool was created to utilize when determining compliance with completion of the COVID-19 Exposure Risk Assessment Template. The Administrator met with nursing administration and housekeeping on 1/14/2021 and implemented appropriate PPE for residents on TBP for the Klockner and Mercer Units in accordance with CDC and NJDOH guidelines. Nursing and ancillary staff received in-servicing starting 1/14/2021 on use and disposal of PPE when caring for residents on TBP including hand-hygiene, changing gloves per encounter, changing gowns per encounter, use of N95 masks and eye protection. The Maintenance Assistant was contacted via telephone on 1/14/2021 to in-service	

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F 835	Continued From page 6 On 1/13/21, the facility's Removal Plan was accepted. According to the Removal Plan, Resident [redacted] and [redacted] were moved to private rooms to continue on TBP until the end of their fourteen-day quarantine and their roommates remained on TBP until the end of a fourteen-day quarantine. Licensed staff were in-serviced on the policy created on 1/11/21 for the use of the COVID-19 Exposure Risk Assessment Template for Patients in Post-Acute Care settings which included COVID-19 exposure risk for assessing and planning placement considerations for residents upon their return to the facility. During verification of the Removal Plan on 1/14/21, the Director of Nursing (DON) and Assistant Director of Nursing/Infection Preventionist (ADON/IP) informed the survey team that the facility had three additional COVID-19 positive staff members since 1/11/21. The ADON/IP stated that a Licensed Practical Nurse (LPN) tested COVID-19 positive on 1/12/21. She added that this LPN had worked on 1/11/21 on both the [redacted] nursing units so all the residents on both units were considered PUIs and were placed on TBP for fourteen days. Observations and interviews of both the [redacted] nursing units revealed that staff wore the same gown for all residents unless the gown became visibly soiled or staff left the nursing unit. Observations of multiple staff members revealed staff not wearing N95 (respirator) masks for residents on TBP in accordance to CDC and NJDOH guidance. Observation and interview revealed a Maintenance Assistant traveled from isolation room to isolation wearing no gown or gloves, and performing no hand hygiene in between resident	F 835	him on the proper use of PPE, hand-hygiene, and disposal of PPE to prevent the potential spread of infection in rooms where residents are on TBP. The Maintenance Assistant received additional in-person in-servicing prior to the start of his shift on 1/15/2021. The 7-3 Certified Nurse Aides that were present on the Mercer Unit during the survey visit on 1/14/2021 were educated on hand-hygiene and the proper use and disposal of PPE to prevent the potential spread of infection when caring for residents who are on TBP. Additional PPE including disposable gowns and storage bins for the PPE were placed throughout the Klockner and Mercer Units on 1/14/2021 to assure availability and accessibility for staff. In-services were conducted for staff in each department on hand-hygiene and the proper use, donning and doffing of PPE for TBP in rooms with residents who are considered PUI to prevent the spread of infections. An audit tool was created to utilize when determining compliance with hand-hygiene and appropriate use of PPE for TBP. 4. Corrective action(s) will be monitored to ensure that deficient practice does not recur. The Director of Nursing or designee will conduct twice/week audits for 14 days, then weekly audits for 4 weeks and will complete monthly audits for 6 months on completed COVID-19 Exposure Risk Assessment Templates to ensure	

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F 835	Continued From page 7 rooms. This lead to a second IJ situation, which the facility Administration was notified of on 1/14/21 at 4:20 PM. On 1/11/21 at 9:15 AM, the survey team conducted an entrance conference with the DON and ADON/IP. The LNHA was unavailable/had not joined the meeting. At 4:28 PM, upon request by the survey team for the LNHA to join a meeting with the DON, ADON/IP, and Assistant Administrator, the survey team called the first IJ situation at the facility at 4:30 PM. The LNHA had no response or comment during this time. On 1/12/21 and 1/13/21, the surveyor had multiple communications with the DON regarding the Removal Plan and revisions required. The LNHA was not in contact with the DOH during this time. On 1/14/21 at 9:18 AM during a RP verification survey, the surveyor conducted an entrance conference with the DON and ADON/IP for the Removal Plan from the IJ called on 1/11/21. The LNHA was not present for this meeting. At 3:37 PM, the surveyor interviewed the LNHA who stated that he had been the Administrator at this facility for ten years. At this time, the surveyor requested a copy of his Administrator's license and a copy of his job description. The surveyor also informed the LNHA that the survey team requested to meet with him, the Assistant Administrator (Assist Admin), DON, and ADON/IP at 4:00 PM. At 4:01 PM, the ADON/IP provided the surveyor	F 835	completion of and compliance with the risk assessment tool. Any infractions will be rectified immediately. The Director of Nursing or designee will report the results of the weekly and monthly COVID-19 Exposure Risk Assessment Template audits, including any discrepancies/corrective actions taken, to the Quality Assurance Performance Improvement (QAPI) Committee for the next two quarters. The QAPI Committee will determine additional follow-up as needed. The Director of Nursing or designee will conduct daily audits for 14 days, then weekly audits for 4 weeks, then monthly audits for 6 months to determine compliance of proper hand-hygiene and use of PPE including donning and doffing in rooms that have TBP. Any infractions will be rectified immediately. The Director of Nursing or designee will report the results of the weekly and monthly hand-hygiene and proper use of PPE audits, including any discrepancies/corrective actions taken, to the Quality Assurance Performance Improvement (QAPI) Committee for the next two quarters. The QAPI Committee will determine any additional follow-up is needed. The Director of Nursing/designee will submit completed audits to the LNHA for review. The LNHA will submit the completed audits in a timely manner to the Administrator Consultant once in place.	

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F 835	Continued From page 8 team with the LNHA's license and job description. At this time, the ADON/IP stated that for TBP, staff should be donning a N95 mask, gown, gloves, and goggles, The ADON/IP stated that staff were all wearing the same gown because all the residents were on TBP so all were at the same risk level. The ADON/IP stated that the facility was in contact today with their Local Health Department (LHD) regarding the usage of the same gowns. The ADON/IP stated that contact person from the LHD informed the facility that the preferred process was to change gowns in each PUI room unless the facility did not have an adequate supply of gowns. At 4:09 PM, the DON stated that the facility determined that they would need approximately 2,500 gowns a day to do this. The DON confirmed that the facility was utilizing washable gowns and had both an active supply of PPE and a thirty day emergency supply of PPE with more than eight sister facilities. At this time, the survey team requested for the LNHA and the Assist Admin to join the discussion. At 4:11 PM, the LNHA and Assist Admin joined the survey team, DON, and ADON in the conference room. The Assist Admin stated that the facility had both an active supply of PPE as well as a thirty day emergency supply. At this time, the LNHA stated that the emergency supply needs were determined possibly back in May using a burn rate calculator accessed online that determined the amount of each PPE needed per day based on the highest amount used per day during a surge. The LNHA stated that the	F 835		

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F 835	Continued From page 9	F 835		

facility had no difficulty ordering or receiving PPE. The facility also had no restrictions on ordering PPE and they ordered PPE as often as needed. The LNHA stated that the facility at times received PPE the same day ordered. The LNHA confirmed that the facility also had access to a corporate supply of PPE if needed.

At 4:16 PM, the survey team asked the facility Administration why staff were wearing the same PPE from resident to resident in light of sufficient PPE supply and no difficulty obtaining additional supplies. The DON stated because all the residents were" at the same risk level."

At 4:17 PM, the survey team asked the LNHA what his role was with infection control for the facility and what he has done since the first IJ on 1/11/21. The LNHA stated that his role in infection control was to oversee that the facility has the proper people in place which would be the ADON/IP. The LNHA stated that he meets with the ADON/IP to discuss different infection control issues that come up. The LNHA stated that he was at the facility late on 1/11/21 because he was "very involved" with the creating of the Removal Plan (which after multiple attempts to contact the facility, multiple conversations with the DON and Regional staff, and multiple revisions, the Removal Plan was accepted on 1/14/21). The LNHA stated that he was aware that staff were wearing the same gowns for all residents on TBP. The LNHA stated that he was aware that the ADON/IP and DON spoke with [name redacted] from the LHD today, but he was unaware that the LHD advised against this practice unless there was a PPE shortage until now. The LNHA stated "that is why I have staff." The LNHA stated that he oversees and discusses

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F 835	Continued From page 10 with the staff. At 4:20 PM, an IJ was called and the facility Administration was notified. An acceptable Removal Plan was submitted by email to the DOH by the DON on 1/15/21. The Removal Plan included the LNHA was educated on guidelines for maintaining PPE for residents on TBP in accordance with CDC and NJDOH guidelines and mitigation strategies to prevent the transmission of COVID-19. On 1/19/21 at 9:27 AM, the survey team conducted an onsite verification of the Removal Plan from 1/15/21. At 11:12 AM, the survey team met with the facility Administration which included the DON, ADON/IP, and the Assist Admin. The survey team was informed that LNHA was sent home from the facility today upon arrival for experiencing COVID-19 like symptoms. A review of the New Jersey Department of Health/Communicable Disease Services (NJDOH/CDS) Considerations for Cohorting COVID-19 Patients in Post-Acute Care Facilities dated revised 10/22/2020 which was provided by the DON as the facility's cohorting policy included cohorting using traditional symptom-based screening alone should be avoided if possible but when necessary, done with caution given the risk of asymptomatic or pre-symptomatic infection. The facility should review or develop a cohorting plan before the identification of the first case. When testing capacity is available and facility spacing permits, residents should be organized into the following cohorts. The guidance included Cohort 3 as residents who are COVID-19	F 835		

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negative and non-exposed who have tested COVID-19 negative with no COVID-19 like symptoms and no known exposures. The guidance also included Cohort 4 new or re-admissions which includes all persons from the community or other healthcare facilities who are newly or readmitted. These residents should remain on TBP for fourteen days being monitored for COVID-19. If after fourteen days, these residents have not met the criteria to discontinue TBP, then the resident should be placed as a Cohort 1 (COVID-19 positive).

A review of the facility's undated Outbreak Investigation/Management policy included that cohort residents and staff as available.

A review of the facility's undated Outbreak Response Plan accessed from the facility's website on 1/11/21 included that the Facility will cohort residents to the extent possible according to most current applicable Government Guidelines and Directives.

Review of the facility's undated Infection Prevention and Control Program included isolate or cohort residents with known or suspected infectious diseases in effort to reduce the risk of disease transmission.

A review of the undated CDC Transmission-Based Precautions provided to the surveyor by the ADON/IP as the facility's TBP policy included under droplet precautions that ensure appropriate patient placement in a single room if possible. In long-term care, make decisions regarding patient placement on a case-by-case basis considering infection risks to other patients in the room and available

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alternatives.

A review of the CDC Responding to Coronavirus (COVID-19) in Nursing Homes dated updated 4/30/2020 included that exposed residents may be permitted to room share with other exposed residents if space is not available for them to remain in a single room.

A review of the CDC's Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic dated updated 12/14/2020 included that the infection prevention and control recommendation for patients on a fourteen day quarantine for a close contact to COVID-19 or suspected COVID-19 should be isolated in a single-person room and care for by healthcare personnel using all PPE recommended. These patients should not be cohorted with COVID-19. The recommendation also included under patient placement that if admitted, place a patient with suspected or confirmed COVID-19 in a single-person room with the door closed. The patient should have a dedicated bathroom.

A review of the Center for Disease Control's (CDC) Strategies for Optimizing the Supply of Isolation Gowns dated updated 10/9/2020, included under Crisis Capacity Strategies that extended use of isolation gown consideration can be made to extend the use of isolation gowns (disposable or washable) such that the gown is worn by the same healthcare personnel when interacting with more than one patient housed in the same room location known to be infected with the same infectious disease (such as COVID-19 residents residing in an isolation cohort). The

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guidance also included that the risks to healthcare personnel and patient safety must be carefully considered before implementing a gown reuse strategy. Disposable gowns generally should NOT be reused, and washable gowns should NOT be reused before laundering because reuse poses risks for possible transmission among healthcare personnel and patients that likely outweigh any benefits. If reuse is considered, gowns should be dedicated to care of individual patients.

A review of the CDC's Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic dated updated 12/14/2020 included the PPE recommended when caring for a patient with suspected or confirmed COVID-19 includes the following: N95 respirator or equivalent or higher-level respirator (facemask if respirator is not available), eye protection, gloves, and gown. The guidance also included that when the supply chain is restored, facilities should return to use respirators for patients with suspected or confirmed COVID-19 infection. The guidance also included that clean isolation gowns should be put on upon entry to patient room or area, and removed and discarded in a dedicated container for waste or linen before leaving the patient room or care area.

A review of the facility's Infection Prevention and Control Program Guidelines dated updated 2/2020 included in the topic Hand Hygiene, that hand hygiene is the single most important measure to prevent infection. The guidelines also included that hand hygiene should be performed after contact with inanimate objects (including

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F 835	Continued From page 14 medical equipment) in the immediate vicinity of the patient. The guidance also included, under Universal (Standard) Precautions, that hand hygiene should be performed immediately after gloves are removed, between resident contacts, and when otherwise indicated to avoid transfer of microorganisms to other residents or enviroments.	F 835		
F 880 SS=L	N.J.A.C 8:39-27.1(a) Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and	F 880		3/9/21

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F 880	Continued From page 15 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 infection. §483.80(f) Annual review. The facility will conduct an annual review of its	F 880		

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F 880	Continued From page 16 IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: PART A ~~Based on~~ observation, interview, medical record review, and other facility documentation, during a survey conducted on 1/11/21, it was determined that the facility failed to isolate residents on transmission-based precautions (TBP) for unknown COVID-19 community exposure in a high risk COVID-19 positive county from their well and non-exposed roommates to prevent the transmission of COVID-19. This deficient practice was identified for 2 of 3 residents (Resident [redacted] and [redacted] reviewed for community based medical appointments. On 12/22/2020 and 1/4/2021, Resident [redacted] left the facility for a same day medical appointment in a high risk COVID-19 positive county (8.2%, and 10.64% respectively). On both dates Resident [redacted] returned to their same room in the facility with their same three well non-exposed roomates and all were placed on TBP for a possible unknown COVID-19 community exposure in effort to mitigate the spread of the virus to their three well and non-exposed roommates. On [redacted], Resident [redacted] the facility for a same day medical appointment in a high risk COVID-19 positive county (10.64%). On the same date the resident returned to their same room in the facility with their two well and non-exposed roommates and all were placed on TBP for a possible unknown COVID-19	F 880	1. Corrective actions(s) accomplished for ~~resident~~(s) found to be affected by this deficient practice. PART A Resident [redacted] and Resident [redacted] were [redacted] based on [redacted] on [redacted]. Resident [redacted] was moved to a private room on the [redacted] unit on [redacted] and was maintained on Transmission-Based Precautions (TBP) for the remainder of a 14-day quarantine while a Person Under Investigation (PUI). Resident [redacted] was moved to a private room on the [redacted] unit on [redacted] 1 and was maintained on TBP for the remainder of a 14-day quarantine while a PUI. Residents [redacted] and [redacted] did not exhibit any COVID-19 related signs or symptoms during their 14-day quarantine. PART B Residents on the [redacted] Units who were identified as persons under investigation (PUI) had the potential to be affected. Facility-wide resident testing was done for 3 consecutive weeks with no residents identified as COVID-19 positive. 2. All residents identified having the potential to be affected and corrective action(s) taken. PART A The well, non-exposed roommates of	

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F 880	Continued From page 17 community exposure in effort to mitigate the spread of the virus to their two well non-exposed roomates. The facility's failure to isolate Resident [redacted] and [redacted] from their well, non-exposed roommates posed a serious and immediate threat to the safety and wellbeing of well non-exposed residents. This resulted in an Immediate Jeopardy (IJ) situation that began on 12/22/2020 when Resident [redacted] returned to their same room in the facility on TBP for an unknown COVID-19 community exposure with their three well and non-exposed roommates. The facility Administration was notified of the IJ on 1/11/21 at 4:30 PM. The immediacy was removed on 1/13/21 at 3:16 PM based on an acceptable Removal Plan that was implemented by the facility and verified by the surveyors during an on-site revisit survey conducted on 1/14/21. The evidence was as follows: On 1/11/21 at 9:15 AM, the surveyors met with the Director of Nursing (DON) and the Assistant Director of Nursing/Infection Preventionist (ADON/IP). The ADON/IP stated that each nursing unit had residents who were considered persons under investigation (PUI) as a new admission or readmission to the facility from a same day medical appointment or dialysis. These residents were placed on TBP for fourteen days. Staff upon entering these rooms donned (wore) personnel protective equipment (PPE) including a N95 (respirator) mask, eye protection, gown, and gloves. The ADON/IP stated that residents who were newly admitted or went to dialysis resided in a private room, while residents	F 880	Residents #1 and #2 had the potential to be affected by this deficient practice. The 5 identified roommates were maintained on TBP for the remainder of a 14-day quarantine and were tested via rapid antigen testing for COVID-19 on 1/12/2021 with all negative results. Weekly testing results for two additional weeks resulted in negative test results for these identified residents. None of the identified residents exhibited any signs or symptoms of COVID-19. PART B All residents in contact with staff who did not perform adequate hand-hygiene or don and/or doff PPE appropriately had the potential to be affected by this deficient practice. Facility-wide resident testing was done for 3 consecutive weeks with no residents identified as being COVID-19 positive. 3. Measures that will be put into place to ensure deficient practice will not recur. PART A The Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON) and Assistant Director of Nursing/Infection Practitioner (ADON/IP) Nurse received education by the Regional Nurse Consultant on risk assessment and placement planning for residents who leave and return to the facility for medical and non-medical related purposes. In-services were conducted for the LNHA, DON and ADON/IP Nurse by the Regional	

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F 880	Continued From page 18 who were readmitted from a medical appointment returned to their room with their roommates. This was determined by the amount of time (same day) the resident was out of the facility. The ADON/IP stated that the facility followed the infection control guidance from both the Centers for Disease Control (CDC) and the New Jersey Department of Health (NJDOH). The ADON/IP also stated that the facility was in contact with the Local Health Department (LHD) daily for their guidance. The surveyor reviewed the facility's floorplan provided by the ADON/IP. A review of the Executive Order 26, 4.b. revealed that resident room Executive Or and Executive Or were on TBP from a readmission to the facility from a medical appointment. The floor plan reflected that both rooms could accommodate four residents in total. At 11:22 AM, the surveyor observed that resident room Executive Or had a sign outside the door which indicated TBP from Executive Order 26, 4.b. served the Registered Nurse (RN) enter this room carrying a supplemental dietary shake. The RN wore only a surgical mask and eye protection. At 11:23 AM, the surveyor interviewed the RN who stated that all the residents on this wing were considered well and non-exposed. The RN stated that to enter all of these residents' rooms, there was no requirement for additional PPE. The RN stated that if a resident was on TBP, then she would have to don the N95 mask, gown, and gloves. At 11:30 AM, the surveyor observed resident room Executive Or had a sign outside the door which	F 880	Nurse Consultant on hand-hygiene and the proper use and donning/doffing of PPE for TBP in rooms with residents who are considered PUI to prevent the spread of infections. The staff member identified in the 2567 as the Registered Nurse (RN) received education on TBP for residents that are PUI and donning/doffing PPE. The staff member identified in the 2567 as the Certified Nursing Aide (CNA) received education on TBP for residents that are PUI and donning/doffing PPE. In-services were conducted for staff in each department on hand-hygiene and the proper use, donning and doffing of PPE for TBP in rooms with residents who are considered PUI to prevent the spread of infections. A policy was created for determining risk assessment and placement planning for residents who leave and return to the facility for medical or non-medical related purposes. The policy was created based on the assessment of exposure risk to COVID-19 for a resident while they are out of the facility and set to return. This policy is not utilized for new or re-admissions. The policy also contains guidance for staff if the exposure risk cant be determined. A risk assessment template for assessing a residents risk of exposure to COVID-19 while out of the facility and placement planning for their return was created for residents who leave for medical and non-medical related purposes. In-services were conducted for licensed nursing and admission staff on the	

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F 880	Continued From page 19 indicated TBP from Executive Order 26, 4.b. . The surveyor observed a PPE bin outside the door which contained washable gowns, gloves, and N95 masks. At 11:35 AM, the surveyor interviewed the Certified Nursing Aide (CNA) who stated that she was a fulltime CNA with no permanent assignment. The CNA stated that resident room [redacted] was on her assignment for the day. The CNA stated that outside that room today was both a sign indicating TBP and a PPE bin so she had to don in addition to her eye protection a N95 mask, gown, and gloves prior to entering the room. The CNA stated she was unaware if there was a particular resident on TBP in that room so she donned full PPE prior to entering the room for all residents. The CNA stated that out of the three residents who resided in that room, two residents were mobile and used the bathroom. The CNA stated that in room [redacted], Resident [redacted] was recently out for an appointment. The CNA stated that the resident was only on "precautions" and not "isolation" so you do not have to don a N95 mask. The CNA stated that if the resident was on full TBP, then there would be a PPE bin outside the door. The CNA also stated that Resident [redacted] was mostly independent and used the bathroom. At 11:48 AM, the surveyor interviewed the RN/Unit Manager (RN/UM) who stated that all the residents in rooms [redacted] and [redacted] were on TBP since one resident in each room went out of the facility. The RN/UM stated that both Resident [redacted] and [redacted] went out separately for appointments and were considered "exposed from the community" and were on TBP for fourteen days. The RN/UM stated that all staff prior to entering these rooms	F 880	COVID-19 Exposure Risk Assessment Policy and Exposure Risk Template to ensure proper placement of residents upon their return from outside of this facility for medical and non-medical related purposes. An audit tool was created to utilize when determining compliance with completion of the COVID-19 Exposure Risk Assessment Template. The Infection Preventionist and Director of Nursing will review infection prevention tracking and trending daily. Any unexpected increases in infection will result in communication with the Medical Director, Public Health Department and the N.J. Department of Health in order to obtain further assistance to control infection. In-services were conducted for facility staff on hand-hygiene and use of proper Personal Protective Equipment (PPE) for TBP when caring for residents that are considered PUI. The facility Cohorting Policy was reviewed and updated as needed. The Administrative team received in-servicing on this policy. PART B In-services were conducted for the LNHA, DON and ADON/IP Nurse by the Regional Nurse Consultant on hand-hygiene and the proper use and donning/doffing of PPE for TBP in rooms with residents who are considered PUI to prevent the spread of infections. The facility Standard and	

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F 880	Continued From page 20 donned a N95 mask, eye protection, gown, and gloves, which was to be changed in between residents. The RN/UM stated that the facility posted TBP signs outside these doors with the dates that the TBP started and ended. The RN/UM stated there was no PPE bin outside of resident room [redacted] since the facility was low on bins, but the PPE bin next to room [redacted] was accessible to room [redacted]. At 12:34 PM, the surveyor observed the RN deliver Resident [redacted] their lunch meal tray. The RN wore only a surgical mask and eye protection. The RN then proceeded to bring Resident [redacted]s roommate (Resident [redacted] their lunch tray. The RN still wore only a surgical mask and eye protection. The RN proceeded to feed Resident [redacted]. At 12:41 PM, the surveyor and the RN/UM observed the RN feeding Resident [redacted] wearing only a surgical mask and eye protection. The RN/UM stated that despite there being no PPE bin outside the resident's room, the RN should be aware that she needed to don a N95 mask, gown, and gloves to enter the room because of the TBP sign. The RN/UM at this time instructed the RN to leave the room. The RN/UM informed the RN that she needed to don full PPE to enter that room. At 12:44 PM, the RN/UM provided the surveyor with Resident [redacted] and [redacted]s medical appointment consultation sheets. The consultation sheets revealed that Resident [redacted] left the facility on [redacted] for a medical appointment, and Resident [redacted] left the facility on [redacted] and [redacted] for medical appointments. At 1:30 PM, the surveyor interviewed the DON,	F 880	Transmission-Based Precautions Policy was reviewed and updated. In-services were conducted for staff in each department on hand-hygiene and the proper use, donning and doffing of PPE for TBP in rooms with residents who are considered PUI to prevent the spread of infections. Twice weekly COVID-19 testing of staff continued as of the date of submission of this POC. Facility-wide resident testing was done for 3 consecutive weeks with no residents identified as being COVID-19 positive. Signs were added for each room and additional PPE and PPE storage bins were provided to the Klockner and Mercer Units for ease of accessibility for each room for the remainder of the time residents remained on TBP for PUI. The facility will continue sign and symptom tracking in the electronic health record to monitor all residents for communicable, respiratory infection. The facility will continue sign and symptom tracking of staff upon arrival to the facility before entering the resident care area for communicable, respiratory infection. The Director of Nursing and Infection Preventionist or designee will monitor daily to ensure that all signs and bins are in place for all residents on TBP for PUI. The facility has retained a Certified Infection Control Practitioner (ICP) consultant that has been approved by the New Jersey Department of Health who will present in the facility for a minimum of six months for no less than 20 hours per week or its equivalent as approved by the	

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F 880	Continued From page 21 ADON/IP, and the ADON/Licensed Practical Nurse (ADON/LPN). The ADON/IP stated that all residents were last tested for COVID-19 on 12/18/2020. The ADON/IP stated that residents were no longer required weekly testing because their outbreak concluded. The ADON/IP stated that if a resident was admitted to the facility, the facility would perform a baseline COVID-19 test for them, then the facility would retest that resident seven days later. The facility only tested residents going to a medical appointment if the incoming facility requested a negative COVID-19 test. At this time the ADON/LPN stated that she performed rapid antigen COVID-19 tests (a nasal swab test that detected a body's immune response to COVID-19 which results were known in fifteen minutes) last week on newly admitted residents. At 1:37 PM, the surveyor reviewed the facility's Resident COVID Testing Week of 1/4/21 provided by the ADON/LPN. This documentation reflected that Resident [redacted] and [redacted] had not received a COVID-19 test last week as stated by the ADON/LPN. At 2:08 PM, the ADON/IP confirmed that a resident who left the facility for a medical appointment did not receive COVID-19 testing prior to leaving the facility or upon their return. The ADON/IP stated that upon their return, residents were automatically placed on TBP for fourteen days and monitored for signs and symptoms of COVID-19 because of their possible exposure to COVID-19 in the community. The ADON/IP acknowledged that a person could be COVID-19 positive, but be asymptomatic. The	F 880	New Jersey Department of Health until further notice from the New Jersey Department of Health, with a start date of Tuesday, March 9th, 2021. The Certified Infection Control Practitioner□s resume was sent to and approved by the New Jersey Department of Health. A root cause analysis was conducted and determined there were no environmental or physical factors contributing to the deficient practice. It was determined that there was confusion in what was communicated to front line staff related to the proper use of PPE. A complete review of the The Long-Term Care Infection Control Self-Assessment was done by the Infection Preventionist, Medical Director and clinicians to determine potential areas needing improvement. The following directed in-service trainings were completed by the Infection Preventionist as of 2/24/2021 and was completed by additional top line staff (Director of Nursing, Assistant Director of Nursing, Unit Managers, Supervisors) as of 3/5/2021: Module 1 □ Infection Prevention & Control Program The following directed in-service training was completed by the Infection Preventionist as of 2/24/2021 and were completed by additional top line staff (Director or Nursing, Assistant Director of Nursing, Unit Managers, Supervisors) as of 3/5/2021: Module 6B □ Principles of Transmission Based Precautions	

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F 880	Continued From page 22 ADON/IP confirmed that both Resident [redacted] and [redacted]s roommates had all remained in the facility, and had no possible community exposure. The ADON/IP stated that only residents who were newly admitted or readmitted to the facility from the hospital or dialysis went into a private room. The ADON/IP could not speak to why Resident [redacted] and [redacted] would not be isolated from their well, non-exposed roommates. The ADON/IP stated that the facility used the guidance from the NJDOH Communicable Disease Services (CDS) for their cohorting policy and procedures. A review of the NJDOH/CDS COVID-19 Activity Level Report provided to the surveyor by the facility, reflected that the facility was in a region of High COVID-19 Activity level for both the weeks ending on 12/26/2020 and 1/2/21 (8.2% and 10.64% respectively). At 2:40 PM, the DON stated that the facility had only received the COVID-19 Activity Level Report for the week ending on 1/2/21 which indicated the county positivity rate increased from 8.2% from the week ending on 12/26/2020 to a 10.64% in the week ending on 1/2/21. The DON stated that because of the increase in that rate, staff would now be tested twice a week. The DON also confirmed that the facility had unoccupied rooms that could have been utilized. A review of the Daily Census dated 12/22/2020 reflected that the facility had 23 unoccupied rooms on that day. A review of the Daily Census dated 12/30/2020 reflected that the facility had 27 unoccupied rooms on that day. A review of the Daily Census dated 1/4/21 reflected that the facility had 29 unoccupied	F 880	The following directed in-service training was be completed by the Infection Preventionist as of 2/24/2021 and was completed by front-line staff as of 3/5/2021: CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff: Keep COVID-19 Out! The following directed in-service training was completed by the Infection Preventionist as of 2/24/2021 and for staff in each department as of 3/5/2021: CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff: Use PPE Correctly for COVID-19 An audit tool was created to utilize when determining compliance with hand-hygiene and appropriate use of PPE for TBP. The facility policy on Outbreak Investigation and Management was reviewed and updated. The Administrative team received in-servicing on this policy. The facility Outbreak Response Plan was reviewed and updated. The Administrative team received in-servicing on this policy. The facility Infection Prevention and Control Program previously dated 2/2020, was reviewed and updated. The Administrative team received in-servicing on this policy. The facility Standard and Transmission-Based Precautions Policy was reviewed and updated. 4. Corrective action(s) will be monitored to	

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F 880	Continued From page 23 rooms on that day. At 3:48 PM, the DON provided the survey team with an email from the LDH. The DON stated that the information provided to them from the LHD was from the State Epidemiologist regarding cohorting of residents. A review of the email provided by the LHD dated 1/11/21 at 3:39 PM reflected a forwarded email from [name redacted] from the NJDOH. The email included from the NJDOH/CDS cohorting documentation that for residents who routinely left the facility, the exposure risk may vary based on local community transmission. The email also included that if available, these residents may be prioritized for a private room or cohorted with others who frequently leave the facility. The writer stated, "if this is someone who left once and it was deemed from the above to have been a risky enough exposure outside the facility to warrant being admitted to the new admit/readmit unit then they would not be placed back with their previous roommate if say they were both in Cohort 3." At 3:49 PM, the surveyor spoke with [name redacted] from the LHD via telephone who stated to refer to the email sent to the facility today regarding cohorting guidance. A review of the NJDOH/CDS Considerations for Cohorting COVID-19 Patients in Post-Acute Care Facilities revised 10/22/2020 provided by the DON as the facility's cohorting policy, included cohorting using traditional symptom-based screening alone should be avoided if possible but when necessary, done with caution given the risk of asymptomatic or pre-symptomatic infection.	F 880	ensure that deficient practice does not recur. PART A The Director of Nursing or designee will conduct twice/week audits for 14 days, then weekly audits for 4 weeks and will complete monthly audits for 6 months on completed COVID-19 Exposure Risk Assessment Templates to ensure completion of and compliance with the risk assessment tool. Any infractions will be rectified immediately. The Director of Nursing or designee will report the results of the weekly and monthly COVID-19 Exposure Risk Assessment Template audits, including any discrepancies/corrective actions taken, to the Quality Assurance Performance Improvement (QAPI) Committee for the next two quarters. The QAPI Committee will determine additional follow-up as needed. PART B The Director of Nursing or designee will conduct daily audits for 14 days, then weekly audits for 4 weeks, then monthly audits for 6 months to determine compliance of proper hand-hygiene and use of PPE including donning and doffing in rooms that have TBP. Any infractions will be rectified immediately. The Director of Nursing or designee will report the results of the weekly and monthly hand-hygiene and proper use of PPE audits, including any discrepancies/corrective actions taken, to the Quality Assurance Performance Improvement (QAPI) Committee for the	

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F 880	Continued From page 24 The facility should review or develop a cohorting plan before the identification of the first case. When testing capacity is available and facility spacing permits, residents should be organized into the following cohorts which included: Cohort 3 as residents who are COVID-19 negative and non-exposed who have tested COVID-19 negative with no COVID-19 like symptoms and no known exposures. The guidance also included Cohort 4 as new or re-admissions which includes all persons from the community or other healthcare facilities who are newly or readmitted. These residents should remain on TBP for fourteen days being monitored for COVID-19. If after fourteen days, these residents have not met the criteria to discontinue TBP, then the resident should be placed as a Cohort 1 (COVID-19 positive). A review of the facility's undated Outbreak Investigation/Management policy included to cohort residents and staff as available. A review of the facility's undated Outbreak Response Plan accessed from the facility's website on 1/11/21 included that the facility will cohort residents to the extent possible according to most current applicable Government Guidelines and Directives. Review of the facility's undated Infection Prevention and Control Program included to isolate or cohort residents with known or suspected infectious diseases in effort to reduce the risk of disease transmission. A review of the undated CDC Transmission-Based Precautions provided to the surveyor by the ADON/IP as the facility's TBP	F 880	next two quarters. The QAPI Committee will determine any additional follow-up is needed.	

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policy included under droplet precautions to "ensure appropriate patient placement in a single room if possible. In long-term care, make decisions regarding patient placement on a case-by-case basis considering infection risks to other patients in the room and available alternatives."

A review of the CDC Responding to Coronavirus (COVID-19) in Nursing Homes updated 4/30/2020 included that exposed residents may be permitted to room share with other exposed residents if space is not available for them to remain in a single room.

The IJ was identified on 1/11/21 at 4:30 PM and the Licensed Nursing Home Administrator (LNHA), Assistant Administrator, DON, ADON/IP, and ADON/LPN were notified of the IJ at 4:30 PM. A Removal Plan was accepted on 1/13/21 which included that Resident [redacted] and [redacted] were COVID-19 tested immediately and placed in private rooms on TBP until the end of their fourteen day quarantine, Resident [redacted] and [redacted] roommates remained on TBP until the end of the fourteen day quarantine. Licensed staff were inserviced on the policy created on 1/11/21 for the use of the COVID-19 Exposure Risk Assessment Template for Patients in Post-Acute Care settings which included COVID-19 exposure risk for assessing and planning placement considerations for residents upon their return to the facility.

The implementation of the removal plan was verified on-site on 1/14/21.

On 1/14/21 at 10:30 AM, the surveyors toured the [redacted] Wing and verified through observations, interviews with facility staff, and review of

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F 880	Continued From page 26 in-service education and facility documents that the Removal Plan had been implemented. A review of the CDC's Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic dated updated 12/14/2020 included that the infection prevention and control recommendation for patients on a fourteen day quarantine for a close contact to COVID-19 or suspected COVID-19 should be isolated in a single-person room and care for by healthcare personnel using all PPE recommended. These patients should not be cohorted with COVID-19. The recommendation also included under patient placement that if admitted, place a patient with suspected or confirmed COVID-19 in a single-person room with the door closed. The patient should also have a dedicated bathroom. PART B Based on observation, interview, medical record review, and other facility documentation, it was determined that the facility failed to maintain transmission-based precautions (TBP) for residents identified as a person under investigation (PUI) for a known COVID-19 exposure by a.) not changing gowns between residents, b.) not donning (wear) a N95 (respirator) mask, c.) not donning a gown and gloves in resident rooms on TBP, and d.) not performing hand hygiene prior to exiting resident rooms in an effort to mitigate the spread of COVID-19.	F 880		

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F 880	Continued From page 27 This deficient practice was identified on 2 of 2 nursing units ([redacted]) reviewed for TBP for a known COVID-19 exposure on 1/14/2021 during a verification of a removal plan survey previously conducted on 1/11/2021. 1. On 1/12/21, the facility became aware that a Licensed Practical Nurse #1 (LPN) tested positive for COVID-19 using a rapid antigen test (a nasal swab test that detected the body's immune response to COVID-19 which results are known in fifteen minutes). The facility immediately sent the LPN home and conducted contact tracing for possible exposure. The facility determined that the LPN had worked two shifts on 1/11/21; the first shift was on the [redacted] Unit and the second shift was on the [redacted] Unit. All residents on both the [redacted] Unit and [redacted] Unit were identified as exposed to COVID-19 as persons under investigation (PUI) and placed on TBP for fourteen days in an effort to mitigate the spread of the virus. Staff were to don PPE which included a N95 mask, eye protection, gown, and gloves prior to entering these residents' rooms. During the survey conducted on 1/14/21, staff were observed wearing the same gown between residents. Interview with staff confirmed that they wore the same gown between residents, changing the gown only if visibly soiled or exiting the unit. Certified Nursing Aide #1 (CNA), in addition to not changing her gown between residents, was observed donning only a surgical mask in residents' rooms and not a N95 mask. The Maintenance Assistant was observed entering/exiting resident rooms entering the residents' bathrooms and testing their light switches. The Maintenance Assistant did not don gloves or gown and did not perform hand hygiene	F 880		

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prior to entering or exiting resident rooms. Staff were unaware of the appropriate TBP protocol that should have been implemented for exposure to the virus.

The facility's failure to ensure that appropriate TBP were followed for residents with a known exposure to COVID-19 posed a serious and immediate threat to the safety and wellbeing of all non-ill residents.

This resulted in an Immediate Jeopardy (IJ) situation that began on 1/12/21 when the facility identified that LPN #1 was COVID-19 positive. The facility Administration was notified of the IJ on 1/14/21 at 4:20 PM. The immediacy was removed on 1/15/21 at 10:13 AM based on an acceptable Removal Plan that was implemented by the facility and verified by the surveyors during an on-site survey conducted on 1/19/21.

The evidence was as follows:

1. On 1/14/21 at 9:18 AM, the surveyors met with the Director of Nursing (DON) and the Assistant Director of Nursing/Infection Preventionist (ADON/IP). The ADON/IP stated that the facility had two additional staff members (LPN #1 and Staff Coordinator) test positive for COVID-19 on 1/12/21. The two staff members were immediately sent home and contact tracing was conducted. It was determined that LPN #1 worked two shifts on 1/11/21; the first shift on the [redacted] Unit and the second shift on the [redacted] Unit. The facility determined that all residents on both units were exposed to COVID-19 by LPN #1 so they were considered PUIs and placed on TBP for fourteen days. The ADON/IP stated that no risk assessment was conducted on these

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residents since the LPN was the only nurse on the [Executive Order 2] Unit so she came in contact with every resident on that unit. The ADON/IP also stated that no risk assessment was conducted on the [Executive Order 26, 4] Unit since the unit was a locked [Executive Order 26, 4 b] unit and residents tended to wander. All residents were placed on TBP.

At this time, the DON stated that staff donned full PPE of a N95 mask, gown, gloves, and eye protection on that unit. The DON stated that staff were wearing the same gown room to room for all residents and in the hallways unless visibly soiled or exiting the unit. The DON stated that since the residents all had the same exposure to COVID-19, staff were permitted to do this. The DON confirmed that the facility used washable gowns and had no gown shortage.

At 12:10 PM, the surveyor observed at the entrance to [Executive Order 2] Unit a Stop sign which indicated before entering [Executive Order 20] Unit Droplet Precautions (TBP). At the entrance was a PPE bin which contained gowns, gloves, and N95 masks.

At 12:16 PM, the surveyor observed LPN #2 in the hallway wearing a gown, N95 mask, and eye protection. The LPN informed the surveyor that on this unit, all the residents were on TBP so staff donned a N95 mask, gown, gloves, and eye protection. The LPN stated that staff changed gloves in between residents, but they wore the same gown throughout the unit. The LPN stated that staff do not have to change their gown from resident to resident because no resident on that unit was COVID-19 positive.

At 12:18 PM, the surveyor observed CNA #2 exit

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F 880	Continued From page 30 resident room [redacted] without doffing (removing) or changing her gown. At 12:25 PM, the surveyor observed the Maintenance Assistant enter resident room [redacted] wearing only goggles and a KN95 mask. The Maintenance Assistant proceeded to open the closed bathroom door, enter into the bathroom and immediately exit the bathroom and close the bathroom door. The Maintenance Assistant then proceeded towards the bed in the room and turned on and off the light. The Maintenance Assistant then exited the room with no observed hand hygiene and proceeded directly into resident room [redacted] and performed the same tasks as in resident room [redacted]. The Maintenance Assistant then exited resident room [redacted] with no observed hand hygiene and walk directly into resident room [redacted] The Maintenance Assistant performed the same tasks as the other two resident rooms and then exited the resident room with no observed hand hygiene. At this time, the surveyor interviewed the Maintenance Assistant who stated that he was going resident room to room ensuring that all the light switches worked. When asked if he had to do anything different when entering these rooms, the Maintenance Assistant looked at the TBP sign outside the door and stated "No". The Maintenance Assistant stated that he already wore a mask and eye protection, which was all that he needed. The surveyor questioned if he had to do anything prior to entering or exiting a resident's room. He stated that he should sanitize his hands, but he "forgot to", and "forgets a lot" to sanitize his hands. The Maintenance Assistant then proceeded down the hall continuing to enter each resident room donning	F 880		

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F 880	Continued From page 31 only his KN95 mask and goggles with no observed hand hygiene. At 12:30 PM, the surveyor questioned LPN #2 if the Maintenance Assistant needed to don a gown or gloves prior to entering these residents' rooms. The LPN#2 confirmed yes and went to instruct the Maintenance Assistant to don additional PPE while entering every resident room on that wing. At 12:33 PM, the surveyor observed the Maintenance Assistant don a gown only at the entrance to the [redacted] Unit. No hand hygiene was observed at this time. The Maintenance Assistant then proceed to the other wing into resident room [redacted] wearing a KN95 mask, gown, and goggles. The Maintenance Assistant opened the bathroom door went into the bathroom and proceeded immediately out of the bathroom and closed the bathroom door. The Maintenance Assistant went towards the bed and turned on and off the light. He proceeded out of the room without doffing his gown or performing hand hygiene and went directly to resident room [redacted]. The resident was sitting in the entrance of room [redacted] so the Maintenance Assistant had to go around the resident brushing his gown against the resident's wheelchair. The Maintenance Assistant then proceeded to the bathroom and performed the same tasks prior to exiting the room brushing by the resident again. The Maintenance Assistant performed no hand hygiene or doffed his gown. The Maintenance Assistant then went directly to resident room [redacted] and performed the same tasks as he had in previous resident rooms with no hand hygiene or doffing of PPE prior to exiting the room. At this time the surveyor re-interviewed the	F 880		

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Maintenance Assistant who stated that he could wear the same gown from room to room without having to change it. The Maintenance Assistant stated that he did not have to wear gloves and he acknowledged that he keeps "forgetting" to perform hand hygiene. The Maintenance Assistant confirmed that the Maintenance Director was currently on a leave of absence, but he was recently in-serviced on the appropriate mask to wear in resident care areas. The Maintenance Assistant then proceeded directly into resident room [redacted] without changing his gown, donning gloves, or performing hand hygiene.

At 12:45 PM, the surveyor observed CNA #2 in resident room [redacted]. The CNA wore a gown, gloves, eye protection, and surgical mask. The CNA was observed removing linen from the resident's bed while the resident was in bed. The CNA then placed clean linen on top of the resident. The CNA then proceeded to the doorway where she removed only her gloves and performed hand hygiene. The CNA then proceeded to resident room [redacted] to remove a finished lunch tray.

At this time, the surveyor interviewed CNA #2 who stated that these residents were on TBP because they could possibly have COVID-19. The CNA stated that "you have to don in these rooms a mask, gown, gloves, and eye protection." When asked what type of mask she should be wearing, the CNA stated that she should be wearing a N95 mask and not the surgical mask. The CNA stated that she did not need to change her gown unless it was visibly soiled or she was leaving the unit because all the residents were on the same TBP.

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F 880	Continued From page 33 At 12:55 PM, the surveyor observed CNA #3 enter resident room [redacted] with a hoyer lift (an assistive device used to transfer residents from a bed to chair or vise versa) wearing a gown, gloves, N95 mask, and eye protection. CNA #1 followed into the room wearing a gown, gloves, eye protection, and surgical mask. CNA #1 closed the door behind her. At 1:06 PM, CNA #1 exited resident room [redacted] with the hoyer lift wearing the same gown. At this time, the surveyor interviewed the CNA regarding why the residents on this unit were on TBP and what PPE was required to enter these rooms. The CNA stated that these residents on this unit were on TBP because they returned to the facility from either the hospital or a doctor's appointment so they were being monitored for fourteen days for possible COVID-19. The CNA stated that staff were required to wear a N95 mask, gown, gloves, and eye protection upon entering these residents rooms. The CNA acknowledged that she was wearing a surgical mask and not a N95 mask because she preferred the surgical mask; it was easier to breathe with. The CNA stated that she wore the same gown for all the residents unless it was visibly soiled or she was leaving the unit because the residents were all on the same precautions so this practice was acceptable. At 1:52 PM, the surveyor reviewed the Maintenance Assistant's education transcripts which reflected that he received education on 2/17/2020 for Infection Control Essentials, 12/7/2020 for Infection Control: Droplet Precautions, and 12/7/2020 for Personal Protective Equipment.	F 880		

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At 4:01 PM, the survey team interviewed the DON and ADON/IP again. The ADON/IP stated that for Droplet Precautions (TBP), staff should be donning a N95 mask (preferably), gown, gloves, and goggles. The ADON/IP stated that staff were all wearing the same gown because all the residents were on TBP so they all had the same risk level. The ADON/IP stated that the facility was in contact today with their Local Health Department (LHD) regarding the usage of the same gowns. The ADON/IP stated that [name redacted] from the LHD informed the facility that the preferred process was to change gowns in each PUI room unless the facility did not have an adequate supply of gowns.

At this time, the DON stated that the facility determined that they would need approximately 2,500 gowns a day to do this. The DON confirmed that the facility was utilizing washable gowns and had both an active supply of PPE and a thirty day emergency supply of PPE with more than eight sister facilities.

At 4:11 PM, the Licensed Nursing Home Administrator (LNHA) and the Assistant Administrator (Assist Admin) joined the DON and ADON/IP in the conference room. The Assist Admin informed the survey team that he was in charge of ordering PPE. The Assist Admin stated that the facility had both an active supply of PPE as well as a thirty day emergency supply.

At this time, the LNHA stated that the emergency supply needs were determined possibly back in May using a burn rate calculator accessed online that determined the amount of each PPE needed per day based on the highest amount used per day during a surge. The LNHA stated that the

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facility had no difficulty ordering/receiving PPE. The facility also had no restrictions on ordering PPE, and they ordered PPE as often as needed. The LNHA stated that the facility at times received PPE the same day ordered. The LNHA confirmed that the facility also had access to a Corporate supply of PPE.

At 4:16 PM, the surveyor asked the facility Administration if the facility had no shortage of PPE and had no difficulty obtaining PPE, to clarify the re-use of staff wearing the same PPE from resident to resident. At this time, the DON stated because all the residents were at the same risk level.

At 4:17 PM, the LNHA stated that he was aware that staff were wearing the same gowns for all residents on TBP. The LNHA stated that he was aware that the ADON/IP and DON spoke with [name redacted] from the LHD today, but he was unaware that the LHD advised against this practice unless there was a PPE shortage.

The IJ was identified on 1/14/21 and the LNHA, Assist Admin, DON, ADON/IP were notified of the IJ at 4:20 PM. A Removal Plan was accepted on 1/15/21 which included that nursing and ancillary staff were educated on the use and disposal of PPE for residents on TBP including removing gowns after each resident, performing hand hygiene, and the use of a N95 mask.

The implementation of the Removal Plan was verified on-site on 1/19/21.

On 1/19/21 at 10:18 AM, the surveyors toured the [redacted] nursing units and verified through observations, interviews with facility staff,

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and review of in-service education and facility documents that the Removal Plan had been implemented.

A review of the Center for Disease Control's (CDC) Strategies for Optimizing the Supply of Isolation Gowns dated updated 10/9/2020, included under Crisis Capacity Strategies that extended use of isolation gown consideration can be made to extend the use of isolation gowns (disposable or washable) such that the gown is worn by the same healthcare personnel when interacting with more than one patient housed in the same room location known to be infected with the same infectious disease (such as COVID-19 residents residing in an isolation cohort). The guidance also included that the risks to healthcare personnel and patient safety must be carefully considered before implementing a gown reuse strategy. Disposable gowns generally should NOT be reused, and washable gowns should NOT be reused before laundering because reuse poses risks for possible transmission among healthcare personnel and patients that likely outweigh any benefits. If reuse is considered, gowns should be dedicated to care of individual patients.

A review of the CDC's Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic dated updated 12/14/2020 included the PPE recommended when caring for a patient with suspected or confirmed COVID-19 includes the following: N95 respirator or equivalent or higher-level respirator (facemask if respirator is not available), eye protection, gloves, and gown. The guidance also included that when the supply

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chain is restored, facilities should return to use respirators for patients with suspected or confirmed COVID-19 infection. The guidance also included that clean isolation gowns should be put on upon entry to patient room or area, and removed and discarded in a dedicated container for waste or linen before leaving the patient room or care area.

A review of the guidance of the New Jersey Department of Health/Communicable Disease Services (CDS) Considerations for Cohorting COVID-19 Patients in Post-Acute Care Facilities dated revised 10/22/2020 included that cohort 2 COVID-19 negative, exposed consisted of both symptomatic and asymptomatic residents who tested negative to COVID-19 with an identified exposure to someone who was positive. These individuals should be quarantined for fourteen days from the last exposure, regardless of test results. The guidance further included that residents in cohort 2 should be placed on TBP using COVID-19 recommended PPE of a N95 mask, eye protection, gloves, and isolation gown.

A review of the facility's Infection Prevention and Control Program Guidelines dated updated 2/2020 included in the topic Hand Hygiene, that hand hygiene is the single most important measure to prevent infection. The guidelines also included that hand hygiene should be performed after contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. The guidance also included under Universal (Standard) Precautions that hand hygiene should be performed immediately after gloves are removed, between resident contacts, and when otherwise indicated to avoid transfer of microorganisms to other residents or

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F 880	Continued From page 38 enviroments. 2. On 1/14/2021 at 10:17 AM the surveyor toured the [redacted] Unit dedicated to residents under investigation (PUI) for exposure to COVID-19. Staff observed with KN95 mask, face shield and non- disposable gowns on the unit. An interview with the nurse revealed that all residents on this unit are on isolation for being exposed to staff who [redacted]. The nurse told the surveyor that PPE required for the unit since the exposure are: Gown, mask, face shield or goggles. The surveyors observed the Certified Nursing Assistant (CNA) entering and exiting the rooms with the same non disposable gown. The nurse was administering medication from room to room with the same gown. On 11/14/2021 at 10:30 AM the surveyor observed a staff member with a yellow gown in the common area by the sink. The staff who identified herself as a speech pathologist told the surveyor that this unit was an isolation unit, she wore the gown to enter the room. The surveyor observed the staff removed the gown in the hallway and disposed of it in the yellow bin next to the exit door. On 11/14/2021 at 10:37 AM, the surveyor observed a CNA in the hallway with a face shield, a surgical mask and a yellow non- disposable gown. The CNA did not have an N95 mask as	F 880		

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required for the Unit. An interview with the CNA revealed that she could not tolerate the N95 mask. The CNA told the surveyor she received in-service education on Droplets Precautions, all residents were to stay in their rooms for 14 days, she also received in service education on donning and doffing.

On 1/14/21 at 10:42 AM the surveyor observed a white cart in the hallway with the following: Sani cloth, yellow non disposable gowns, gloves. Signages regarding "Donning and Doffing were noted attached to the handrails. Droplets Precautions signages were posted on the wall leading to every room.

On 1/14/2021 at 10:52 AM the surveyor interviewed the housekeeping staff from the [redacted] Unit. The staff told the surveyor that PPE required for the Unit were N95 mask, goggles, gown and gloves when cleaning the rooms. The housekeeping staff indicated that all isolation room has a poster which read "Stop, ask the nurse". She indicated that isolation gowns were easily accessible. She does not have to change gown between room. The surveyor observed the housekeeping leaving room [redacted] and proceeded to enter room [redacted] with the same non-disposable isolation gown.

The surveyor toured the [redacted] Unit [redacted] on 1/14/21 at 11:11 AM. The following were noted in the hallway leading to the entrance door: Droplet Precautions signage posted both in Spanish and English on the double door, Stop sign "Read before entering [redacted] Unit", signage regarding donning and doffing, Isolation cart with N95 mask, gloves, yellow isolation gown, [redacted] wipes. ABHR was mounted on the

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wall next to the entrance door was noted in the hallway. The double door was locked restricted entrance to the unit.

On 01/14/21 at 11:12 AM the surveyor pressed the entrance button, Certified Nursing Assistant (CNA) #1 met the surveyor in the hallway. The surveyor observed this CNA with a surgical mask and a face shield. Upon inquiry CNA#1 told the surveyor that a yellow non-disposable gown is required on the unit and added that she received in service training on PPE and social distancing. She further stated that fellow CNA's encouraged her to wear an isolation gown for safety and if she observed Droplet Precautions signs posted at the resident's door and an isolation cart next to the resident's room, she would use caution. The surveyor observed the same CNA going from room to room with the same gown. The Unit has two wings with a census of 55. The surveyor observed only 1 isolation bin and one signage for droplet precautions on each wing of the unit.

While on the unit on 1/14/2021 at 11:15 AM, the surveyor observed a laundry staff on the Unit with an N95 mask and eye shield. The employee picked up the soiled linen and left the unit. The employee did not have an isolation gown as required to enter the Unit.

On 01/14/2021 at 11:18 AM, the surveyor observed CNA #2 with a surgical mask, goggle and non-disposable gown. CNA #2 did not have an N95 mask on and when asked by the surveyor, she indicated that she received in service education on PPE and social distancing. The surveyor observed CNA #2 going from room to room with the same isolation gown.

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F 880	Continued From page 41 On 01/14/21 at 11:20 AM the surveyor observed CNA#2 exiting Room [redacted] and went to the other wing with the same non-disposable isolation gown. On 01/14/2021 at 11:25 AM, the surveyor interviewed LPN #1 who revealed that the Unit was placed on Droplets Precautions on 01/12/2021 because of exposure. LPN #1 indicated that she had to wear an isolation gown on while on the unit. LPN #1 was observed inside the Nursing Station with the yellow non disposable gown on. On 01/14/2021 at 12:12 PM, the surveyor observed a staff member sitting in Resident's room [redacted] bed and was interacting with the Resident. The staff had a yellow surgical mask and a yellow non disposable gown on. The staff exited Room [redacted] went to Room [redacted], then Room [redacted] and Room [redacted] with the same isolation gown and surgical mask. The staff then proceeded to the Nursing Station with the same isolation gown and sat and entered orders on the computer. The staff was later identified by LPN #1 as the Nurse Practitioner (NP). On 01/14/2021 at 12:29 PM the surveyor interviewed the NP who stated that she was a contracted employee. She further stated that she had been in serviced on Donning/ Doffing for COVID-19. As far as for the facility she could not recall the last time she attended in-service education. The NP stated she had to change her gown only if the resident had a cough or the resident tested positive for COVID-19. At 12:30 PM the NP exited the unit with the	F 880		

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isolation gown on and went in the hallway. The NP then reentered the Unit and disposed of the non-disposable isolation gown in the bin next to the exit door designated for soiled isolation gown and used ABHR for hand hygiene prior to exiting the hallway.

On 01/14/2021 at 12:39 PM the surveyor observed CNA #3 with N95 mask, face shield and a yellow non-disposable isolation gown in the hallway. During an interview with CNA #3, she told the surveyor that she wore an isolation gown to protect herself against infection and minimize infection. CNA #3 indicated that she would change her gown if posted signs at the door indicated that the Resident was on Droplet Precautions.

On 1/14/2021 at 12:20 PM the surveyor observed staff, distributing lunch trays from room to room with the same non disposable isolation gown.

On 01/14/2021 at 12:39 PM the surveyor observed staff (mostly CNAs) going from room to room to collect disposable trays with the same non disposable gown. CNA #1 did not have gloves on.

On 01/14/2021 at 12:42 PM the surveyor interviewed CNA #4 who revealed that she needs a yellow non disposable isolation gown to go to the resident's room. The surveyor asked the CNA when she would change her isolation gown, the CNA indicated that she would change her gown only if the resident had signs for Droplet Precautions and an isolation bin in front of the room.

On 01/14/2021 at 12:47 PM the surveyor

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F 880	Continued From page 43 interviewed LPN#2 Unit Manager Nurse, regarding the Unit Status. The Unit Manager indicated that all residents are on Droplet Precautions, all staff need an isolation gown to enter the room. Staff will know that residents are on Droplet Precautions by signages and isolation bins placed at Resident's doors. The surveyor told the Unit Manager that only two residents had signage for Droplet Precautions and two isolation bins were noted on the Unit. The Unit Manager told the surveyor, that signage for Droplet Precautions are posted on the Entrance door in the hallway. The Unit Manager confirmed that the isolation gown was removed only when exiting the unit. She further stated that staff do not have to change gown between resident care, the entire unit is on Droplet Precautions it will be very hard to change gowns between residents. At 12:50 PM, LPN #2 told the surveyor that staff will change the non-disposable isolation gown if the gown was soiled. On 01/14/2021 at 4:01 PM a second interview with DON and the ADON/IP the surveyors inquired again about the PPE required for [redacted] units. The ADON/IP indicated that PPE required were N95 mask, Gown, gloves. The ADON/IP further stated another acceptable mask would be a mask with a face covering. She went on to state that most of the staff can have a surgical mask over the N95 mask to keep the N95 mask clean. She confirmed that staff wore the same gown from room to room. On 01/14/2021 at 4:05 PM the DON confirmed that staff caring for residents on both [redacted] units wore the same gown because of same risk level. The DON stated that the facility received guidance from the Local Health	F 880		

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Department regarding use of Gown for Residents on Droplets Precautions.

On 01/14/21 at 4:09 PM the ADON/IP told the surveyors that the "Preferred method would be to change gown in each PUI room unless the facility did not have adequate supply.

On 01/14/2021 at 4:17 PM the Administrative staff including the Licensed Nursing Home Administrator (LNHA) and Assistant Administrator indicated that the facility had enough Active PPE supply and 30 days of emergency PPE. The LNHA also indicated that the facility had access to Corporate supply. The LNHA further stated that the facility used the same gown between residents because of the same risk level.

The facility was made aware of the IJ situation on 1/14/2021 at 4:20 PM. The facility submited an acceptable Removal Plan on 1/15/19.

The implementation of the Removal Plan was verified on-site on 1/19/21.

On 1/19/21 at 10:18 AM, the surveyors toured the [redacted] nursing units and verified through observations, interviews with facility staff, and review of in-service education and facility documents that the Removal Plan had been implemented.

A review of the facility's policy updated 2/2020 indicated that PPE is provided to employees at no cost. Training in the use of appropriate PPE for specific tasks or procedures is provided by the Nursing Department. PPE is located on each unit in the supply room. Employees have access to supply rooms, there is sufficient stock in each

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HAMILTON GROVE HEALTHCARE AND REHABILITATION, LLC	**2300 HAMILTON AVE HAMILTON, NJ 08619**

(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 880	Continued From page 45 room, if there is no stock on the unit the employee shall ask the Nursing Supervisor for assistance. The nursing supervisor has access to obtain the necessary supplies. Employees using PPE must observe the following precautions: Remove PPE after it becomes contaminated and before leaving the room. Used PPE may be disposed of in the garbage at the door of the room and brought to soiled utility, all linen is treated as if it is infectious. NJAC 8:39-19.4 (a)(b)(c)(d)	F 880		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
315423		4/30/2021

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HAMILTON GROVE HEALTHCARE AND REHABILITATION, LLC	2300 HAMILTON AVE HAMILTON, NJ 08619

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 F0835 Reg. # 483.70 LSC	Correction Completed 03/08/2021	ID Prefix F0880 Reg. # 483.80(a)(1)(2)(4)(e)(f) LSC	Correction Completed 03/09/2021	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

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