STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315196	A. BUILDING ______ B. WING ______	03/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT MANCHESTER	1770 TOBIAS AVENUE MANCHESTER, NJ 08759

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Survey date: 3/11/21 Census: 137 Sample: 2 A COVID-19 Focused Infection Control Survey was conducted by the New Jersey Department of Health. The facility was found not to be in compliance with 42 CFR §483.80 infection control regulations as it relates to the implementation of the CMS and Centers for Disease Control and Prevention (CDC) recommended practices for COVID-19.	F 000		
F 880 SS=D	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	F 880		7/2/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 03/23/2021

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

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F 880	Continued From page 1 §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and	F 880		

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F 880	Continued From page 2 transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of other pertinent documentation, it was determined that a facility staff member failed to don (put on) appropriate Personal Protective Equipment (PPE) while in the room of a resident placed on Transmission-Based Precaution's (droplet) who resided on the unit designated for Executive Order 26, 4.b. for Executive Order 26, 4.b. This deficient practice was identified for Ex of 1 staff member on the Executive Order 26, 4.b. unit during a focused infection control survey for Executive Order 26, 4.b. as evidenced by the following: On 3/11/21 at 9:26 AM, the surveyors conducted an entrance conference with the facility. During that time, the surveyors were informed that the Executive Order 26, 4.b. residents, Executive O residents, and the Executive Order 26, 4.b. residents. The areas were maintained in separate and designated cohort groups in separate halls on the unit. The facility informed the surveyors that the staff were to don N95 masks, face shields or goggles, PPE gown, and PPE gloves when entering the Executive and Executive Order 26, 4.b. resident rooms. On 3/11/21 at 12:07 PM, the surveyor was on the Executive Order 26, 4.b. unit and observed the resident doors with signs to "STOP" report to nurse before entering and "STOP" Droplet Precautions in	F 880	1. CNA #1 was immediately provided with the correct gown and gloves and re-educated on the proper use of personal protective equipment (PPE). All nursing and ancillary staff were immediately audited to ensure proper use of PPE. Root cause analysis was conducted with an outcome of this being an isolated staff member who was insubordinate and subsequently terminated. 2. All residents residing in the facility have the potential to be affected by any deficient practice of incorrect PPE. 3. Staff education was completed on the proper use of PPE to be worn in designated Cohort areas including while trays are being passed in resident rooms. Topline staff (DON, ADON, IP, LNHA) completed the Module 1 on Infection Prevention and Control program. Frontline staff attended the training on Covid-19: Keep Covid Out course. Staff have also attended the CDC Covid-19 Prevention: Use of PPE Correctly for Covid-19 course. (CNA, LPN, RN, NA, Housekeeping, Laundry, Dietary, Business Office, Activities, Social	

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F 880	Continued From page 3 addition to standard precautions and yellow holders on the doors which contained PPE gowns, gloves, and bags. The surveyor also observed the lunch cart being delivered to the Executive unit. The surveyor observed two Certified Nursing Assistants (CNA) move the cart into the hall by the Executive resident rooms. CNA#1 was observed wearing an N95 mask and goggles. CNA#1 removed a disposable dishware lunch tray from the cart and proceeded to enter room Executive O a PUI room with signage visible and PPE available, without wearing a PPE gown or gloves. Resident Execu was sitting in a wheelchair inside the door of room Executive and was wearing a surgical mask. A review of Resident Executive s Executive Order 26, 4.b. Record revealed the resident was Executive Order 26, 4.b. to the facility from Executive Order 26, 4.b. Resident Execu had a physician's order dated Executive Order 26 to maintain droplet isolation precaution every shift for infection prevention and an order dated Executive Order 26 for Executive Order 26, 4.b. to rule out Executive Order 26, 4.b. upon Executive Order 26, 4.b. . Resident Executive O baseline care plan, dated Executive Order 26, , revealed strict droplet isolation precautions. The LPN/UM was present and interviewed at the time of the observation, and stated that staff were to wear full PPE being N95 mask, eye protection, a PPE gown, and gloves, into the Executive O rooms for infection control purposes to stop the spread of infection; CNA #1 did not go into any other rooms. On 3/11/21 at 12:16 PM, the surveyor interviewed the CNA#2 on the Executive Order 26, 4.b. unit, who was wearing an N95 mask and face shield.	F 880	Workers, Maintenance, Central Supply, Unit Secretaries, Medical Records, MDS Coordinators, all Management Employees. 4. The DON/designee will conduct audits of proper PPE usage by staff 3 times per week. DON/designee will report findings to the QAPI committee on a monthly basis.	

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	315196	A. BUILDING ______ B. WING ______	**03/11/2021**

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F 880	Continued From page 4 The CNA#2 stated that staff must wear full PPE gown, gloves, an N95 mask, and eye protection in Executive Order 26, 4.b. and PUI residents' rooms to stop the spread of infection. On 3/11/21 at 12:20 PM, the surveyor interviewed the LPN working on the Executive Order 26, 4.b. unit who was wearing an N95 mask and a face shield. The LPN stated that all staff must wear full PPE gown, gloves, N95, and face shield to enter the PUI and COVID resident rooms to stop the spread of infection. On 3/11/21 at 12:40 PM, the LPN Infection Preventionist (LPN/IP) stated the droplet precaution signs on the doors of the PUI and Executive Order 26, 4.b. resident rooms indicated that all staff and physicians were to wear N95 masks, eye protection, PPE gowns, and gloves into the rooms to stop the spread of infection. On 3/11/21 at 12:45 PM, CNA#1 stated she was aware room Executive (was a Executive Order 26, 4.b. and on precautions. CNA#1 said she should have worn a PPE gown and gloves into the room to deliver the food tray to protect the residents and staff from infection. CNA#1 stated she had been immediately stopped and then in-serviced on PPE and isolation precautions. On 3/11/21 at 1:37 PM, the Director of Nursing (DON) stated the Executive Order 26, 4.b. Executive Order 26 residents were on precautions. All staff entering the rooms were to wear N95 masks, eye protection, PPE gown, and gloves to protect the residents and the staff from infections. On 3/12/21 at 8:22 AM, the Licensed Nursing	F 880		

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F 880	Continued From page 5 Home Administrator responded to the surveyor that Resident Execu had been Executive Order 26, 4.b on Executive Order 26, and their Executive Order 26, 4.b. were not Executive Order 26, 4.b. A review of the facility, "Proper Use of PPE," in-service dated 1/21/21, revealed CNA#1 had been educated. A review of the facility, "Cohorting," in-service dated 3/1/21, revealed CNA#1 had been educated. Review of the facility, "Outbreak-Covid-19" policy dated 5/28/20, revealed room management cohorting as cohort 4 new or re-admissions; COVID-19 status unknown and serves as an observation where persons remain for 14 days to monitor for symptoms that may be compatible with COVID-19, Review of the facility, "Isolation Steps-Categories of Transmission-Based Precautions" policy updated 5/19/20, revealed droplet precautions in addition to standard precautions, implement for individuals documented or suspected to be infected with microorganisms, transmitted by droplets that can be generated by coughing, sneezing, talking, or by the performance of suctioning. The policy further revealed for staff to don PPE mask, gown, gloves, and eye protection upon entry into the resident room or resident space. NJAC 8:39-19.4 (a)(b)(c)(d); 27.1(a)	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)
315196		7/2/2021

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT MANCHESTER	1770 TOBIAS AVENUE MANCHESTER, NJ 08759

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0880 Reg. # 483.80(a)(1)(2)(4)(e)(f) LSC	Correction Completed 07/02/2021	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	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	
3/11/2021	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO