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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: 10/4/22 Census: 143 Sample: 6 A COVID-19 Focused Infection Control Survey was conducted by the New Jersey Department of Health. The facility was found to be not in compliance with 42 CFR §483.80 infection control regulations as it relates to the implementation of the CMS and Centers for Disease Control and Prevention (CDC) recommended practices for COVID-19.	F 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	F 880		11/18/22

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

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F 880	Continued From page 2 infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and a review of pertinent facility documents, it was determined that the facility failed to ensure personal protective equipment (PPE) was removed in accordance with nationally accepted guidelines for infection prevention and control. This deficient practice was identified for 2 of 3 staff members (2 Housekeepers) exiting rooms that were identified as Persons Under Investigation for COVID-19. The evidence was as follows: According to the U.S. Centers for Disease Control and Prevention (CDC) guidelines, Protecting Healthcare Personnel reviewed 10/13/22 included, resources for the use of Personal Protective Equipment (PPE), specifically the "Sequence for Donning and Doffing ,(Removing Personal Protective Equipment)." The guidelines included, "Remove all PPE before exiting the patient room except a respirator, if worn. Remove the respirator after leaving the patient room and closing the door." Further revealed, section for Doffing PPE included, "PPE is doffed in the designated PPE removal area in the healthcare facility. As with all PPE doffing, meticulous care should be taken to avoid self-contamination. Place all PPE waste in a leak-proof infectious waste container." A review of EX. Order 26.(4) B1 floor PUI [Persons	F 880	1. Resident # 2, #4, and #6 were not affected as it occurred outside of their rooms and cleaning was complete. Assessed Resident #2, #4, and #6 with no concerns. Immediate in-service conducted with Housekeeper #1 and #2 regarding doffing and proper disposal of PPE. Root Cause Analysis completed, resulting in Housekeeper #1 and #2 requiring additional training. Housekeeping cart utilized by Housekeeper #1 and #2 was sanitized prior to being put back into use. 2. All residents on these housekeeper's assignments have the potential to be at risk. 3. In-service completed for all housekeeping staff on 10/4/2022. Audit conducted of doffing of PPE and disposal of PPE with no concerns. Module 1-Infection Prevention & Control Program completed by Topline Staff and Infection Preventionist Keep Covid Out training completed for Frontline Staff. Use PPE Correctly for Covid-19 completed for Frontline Staff. Module 5- Outbreaks completed by Topline Staff and Infection Preventionist.	

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Under Investigation]/COVID-19 list provided by the facility's regional Director of Population Health reflected Resident #2, #4, #6 were on Transmission-Based Precautions (use of PPE including gowns and gloves to prevent the spread of COVID-19).

On 10/3/2022 at 10:44 AM, the surveyor interviewed the Housekeeping Director (HKD). He stated, "I have been at the facility for five years and I am a contracted employee." The surveyor asked if his employees were contracted staff as well, and he replied, "They are all facility staff." The Housekeeping Director stated that "there are four total housekeepers, one on each floor and one in the EX. C hall."

On 10/3/2022 at 11:14 AM, the surveyor observed two housekeeping staff (HK-1 and HK-2) working together on the EX. Order 26.(4) B1 unit on the first floor. The surveyor observed both Housekeepers wearing blue disposable gowns and gloves as they exited room of Resident #2 and Resident #6 in room 112. The surveyor then observed HK-1 doff (remove) her gloves and gown in the hallway and placed the gloves and gown into the housekeeping trash container on the housekeeping cart. The housekeeper HK-1 was training HK-2 and instructed him to remove his PPE while they stood in the hallway. The surveyor watched HK-2 doff his PPE in the hallway and disposed of the gloves and gown in the housekeeping cart trash. Outside of the room was a PPE storage bin hanging over the door, which indicated that the residents were on Transmission Based Precautions.

On 10/3/2022 at 11:49 AM, the surveyor observed the same two housekeepers exit room EX. Ord, which

F 880

Module 11B-Environmental Cleaning and Disinfection training completed by all staff, including Topline staff and Infection Preventionist.
Module 6A-Principles of Standard Precautions completed by all staff, including Topline staff and Infection Preventionist.
Module 6B- Principles of Transmission Based Precautions completed by all staff, including Topline staff and Infection Preventionist.

4. Infection Preventionist/designee will audit housekeeping 2 x weekly x 4 weeks. Audit will then occur 1 x weekly for 3 months until QAPI determine next steps needed.
Audit results will be reported monthly to QAPI Committee by Infection Preventionist/designee.

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housed Resident #4. Both were wearing PPE, blue disposable gown, and gloves in the hallway. They both doffed their gloves and gowns in the hallway and placed the gloves and gown into the housekeeping trash bin on the housekeeping cart. Outside the room was a PPE storage bin hanging over the door, indicating that the resident in the room was on Transmission Based Precautions.

On 10/3/2022 at 11:55 AM, the surveyor interviewed HK-1. The HK-1 stated, "I have to use PPE in the rooms that have yellow PPE bins on the door or a cohort sign." The survey then asked about doffing PPE in the hallway. The HK-1 replied that "yes" she would "doff [the PPE] in the hallway and place my PPE in the trash of the housekeeping cart and then I wash my hands with sanitizer." The surveyor then asked why she chose to doff in the hallway instead of inside the resident's room and discarding the PPE in a waste receptacle inside the room? She replied, "I didn't know I had too." The HK-1 stated that she had been in-serviced in the past on COVID-19 protocols.

On 10/3/2022 at 11:59 AM, the surveyor interviewed HK-2. He stated, "I just started a few weeks ago, I am new to the facility, and I am employed by the housekeeping agency." The surveyor asked him if he was in-serviced on the expectations during a COVID-19 outbreak? He responded, "Yes, I was given a packet by my agency."

On 10/3/2022 at 12:05 PM, the surveyor interviewed the Licensed Practical Nurse/ Unit Manager (LPN/UM). When asked about the yellow PPE storage bin hanging on the door? She

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F 880	Continued From page 5	F 880		

stated, "They are yellow isolation door kits, which hold the PPE prior to entering any isolation room." When the surveyor asked what was the expectation for doffing PPE? She stated that PPE was removed inside the resident's room "prior to exiting and disposed of in the trash can provided in the room. Then the staff should wash their hands and clean their goggles."

On 10/3/2022 at 2:00 PM, the survey team met with the Administrator, Director of Nursing, the Infection Preventionist, and the facility's regional Director of Population Health (DPH) to discuss the surveyor's findings.

On 10/4/2022 at 9:59 AM, the HKD stated, "The housekeepers were re-educated regarding doffing of PPE. The DON, DPH, and the HKD acknowledged that the housekeepers did not discard their PPE (blue disposable gown and gloves) in accordance with infection prevention and control standards.

On 10/4/2022 at 12:22 PM, the surveyor interviewed the LPN/UM regarding Residents #2, #4, and #6. The LPN/UM stated that Residents #2 and #6 were roommates and are on a Cohort 3. She stated that the residents received their initial two dose series of vaccines but did not have a booster vaccine. The LPN/UM confirmed that both residents had EX. Order 26.(4) B1 for COVID-19 and both are vaccinated times 2 doses without boosters. Resident # 4 was alone in their room on cohort 2, they are EX. Order 26.(4) B1 for COVID-19 and tested 4 times weekly due to going to the EX. Order 26.(4) center several times a week and has been vaccinated with two doses but has not received the booster.... the LPN/UM added, "Per my facility outbreak plan they are placed on

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PUI starting with day of admission as day 0, and isolation continues for 7 days for a total of 8 days".

A review of the Electronic Medical Records (eMR) for Resident #2, who resided in room EX. O, reflected an admission date of EX. Order 26.(4) B1 The progress note (PN) dated EX. Order 26.(4) B1 revealed, COVID-19 testing results were EX. Order 26.(4) B1 EX. Order 26.(4) B1. Per facility COVID-19 Outbreak Plan, revised 9/21/2022, on admission this resident was placed in Cohort 3 on PUI. A review of the resident's vaccination record revealed the resident was vaccinated with a two dose vaccine series and was eligible for a booster, but had not yet received it.

A review of the eMR for Resident #6, who resided in room EX. Ord, eMR, reflected an admission date of EX. Order 26.(4) B1. The PN dated EX. Order 26.(4) B1 revealed COVID-19 testing results were EX. Order 26.(4) B1 EX. Order 26.(4) B1. According to the COVID-19 Outbreak Plan, revised 9/21/2022, on admission this resident was placed in Cohort 3 on PUI because he/she was negative, and his/her immunization status was vaccinated with a two dose vaccine series and was eligible for a booster, but had not yet received it.

A review of the eMR for Resident #4, who resided in room EX. Ord, revealed an admission date of EX. Order 26.(4) B1. The PN dated EX. Order 26.(4) B1 revealed, COVID-19 results were EX. Order 26.(4) B1, and patient was EX. Order 26.(4) B1. Further review of PN dated EX. Order 26.(4) B1 resident was still COVID-19 EX. Order 26.(4) B1 and EX. Order 26.(4) B1

According to the the facility's cohorting grid that was provided by the administration on entrance

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on 10/3/22, Resident #4 was placed originally on cohort 3 due to their vaccine status but his/her roommate tested EX. Order 26.(4) B and EX. Or was downgraded to cohort 2. The resident was EX. Order 26.(4) B for COVID-19.

A review of the facility's revised 05/2020 COVID-19 Isolation Room Cleaning Housekeeping In-service, provided by HKD, in section "after finishing room" it read,
Remove PPE, place in isolation bag, dispose in appropriate receptacle.

A review of the COVID-19 Outbreak Plan, revised 9/21/2022, provided by the DON, defines cohort sections as follows:
*Cohort 1 (red zone): positive for infectious disease outbreak. Consistent of both symptomatic and asymptomatic residents who test positive for COVID-19, regardless of vaccination status.
*Cohort 2 (orange zone): symptomatic with suspected SARS CoV-2 infection. Consistent of all symptomatic residents and test negative but could be incubating to test positive later.
*Cohort 3 (yellow zone): asymptomatic residents who are not up to date with all the recommended COVID-19 vaccine doses, have a viral test that is negative and have had close contact with someone with SARS-CoV-2
*Cohort 4 (green zone): asymptomatic residents who are up to date with all recommended COVID-19 vaccine doses and have had a viral test that is negative.

A review of the COVID-19 Outbreak Plan, revised 9/21/2022, provided by the DON, included donning and doffing "sequence for putting on and removal of PPE" from Center Disease Control,

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S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interviews and a review of pertinent facility documentation, it was determined that the facility failed to maintain the required minimum direct care staff to resident ratios for 4 of 14-day shifts as mandated by the state of New Jersey. This deficient practice was identified and the findings were as follows: Reference: New Jersey Department of Health (DOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which established minimum staffing requirements in	S 560	1. Proactive review of the staffing schedule for the next two weeks through the next month. Nursing Administration was assigned to work on the units where needed. 2. All residents have the potential to be affected. 3. Rates have been significantly increased for CNA's and licensed/registered nurse staff. Recruitment ads were updated to reflect increases. Agency contracts reviewed and new	11/21/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed
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S 560	Continued From page 1 nursing homes. The following ratio(s) were effective on 02/01/2021: One Certified Nurse Aide (CNA) to every eight residents for the day shift. One direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. 1. A review of the "Nursing Staffing Report" completed by the facility for the weeks of 9/18/22 through 9/24/22 and 9/25/22 through 10/1/22, revealed the staffing to resident census ratio did not meet the minimum requirement of one CNA to eight residents for the day shift as documented below: -09/18/22 had 11 CNAs for 143 residents on the day shift, required 18 CNAs. -09/20/22 had 17 CNAs for 143 residents on the day shift, required 18 CNAs. -09/24/22 had 16 CNAs for 141 residents on the day shift, required 18 CNAs. -09/25/22 had 12 CNAs for 141 residents on the day shift, required 18 CNAs. On 10/3/22 at 11:22 AM, the surveyor interviewed	S 560	contracts signed. The call out policy was reviewed and the staff re-educated. Staffing policy updated to reflect staffing mandate. The Director of Nursing/designee will have weekly meetings to determine upcoming schedules to anticipate needs with Administrator, Staffing Coordinator, and Human Resources. 4. The Director of Nursing/designee will have weekly meetings with Administrator, Staffing Coordinator, and Human Resources x 4 weeks. Meetings will then occur bi-weekly until QAPI Committee determines next steps. The DON/designee will report the findings to the Administrator and findings to the QAPI Committee on a monthly basis.	

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the Director of Human Resources and Staffing (DHR/S) who acknowledged the new minimum staffing requirements for nursing homes. The DHR/S stated, "I try to meet the requirements as best as can but it is so hard." The DHR/S also stated that she felt during the week that she was able to fulfill the requirements but thought that she probably was not meeting the requirements on some weekends. The DHR/S added that the Licensed Nursing Home Administrator (LNHA) was aware of the staffing because she worked with the LNHA to give incentives for employees to work on the weekend.

On 10/5/22 at 9:42 AM, the surveyor interviewed the DHR/S via the telephone who stated that she was unsure if there was a facility policy for Staffing. The DHR/S stated that the policy would be to follow the state mandated regulation requirements.

A review of the facility's "Staffing" policy dated 7/2/2020, and provided by the LNHA, included, "The facility uses staffing guidance as per DOHSS [Department of Health and Senior Services] and CMS [Centers for Medicare and Medicaid Services]." In addition, the facility policy included, "The staffing coordinator produces the schedule to meet the needs of the residents and to follow the regulatory guidance by DOHSS and CMS."