STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15A113	A. BUILDING: _____ B. WING _____	11/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRACES AT SEACREST VILLAGE, THE	281 MATHISTOWN ROAD LITTLE EGG HARBOR TW, NJ 08087

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Initial Comments: A COVID-19 Focused Infection Control Survey was conducted by the State Agency on 11/11/2020. The facility was found not to be in compliance with the New Jersey Administrative Code 8:36 infection control regulations standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. The census was 63. 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 provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations.	A 000		
A1299	8:36-18.3(a)(5) Infection Prevention and Control Services (a) Written policies and procedures shall be established and implemented regarding infection prevention and control, including, but not limited to, policies and procedures for the following: 5. Techniques to be used during each resident contact, including handwashing before and after caring for a resident; This REQUIREMENT is not met as evidenced by: Based on observations and interviews, the facility	A1299		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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A1299	Continued From page 1	A1299		

failed to ensure staff were performing hand hygiene between passing meal trays in residents' apartments. This affected 15 of 15 apartments observed during tray pass. The census was 63. The deficient practice occurred during the COVID-19 pandemic.

Findings included:

On 11/11/2020 at 12:07 PM, two dining room servers were observed passing lunch trays to 15 apartments. Server #3 was observed passing out lunch trays. Server #3 did not sanitize her hands between each tray pass. Server #3 was adjusting her mask prior to entering an apartment and upon leaving an apartment. She was touching the area closest to her nose to move it back up over her nose. Server #2 was observed passing out lunch trays. Server #2 did not sanitize her hands between tray passes. Server #2 was observed assisting a resident with setting up the resident's tray. Server #2 did not sanitize her hands after assisting the resident with her tray and did not sanitize when she entered or exited the apartments.

On 11/11/2020 at 12:22 PM, Server #3 was interviewed. Server #3 stated she was not taught to sanitize her hands between tray pass. She knew that she was not supposed to touch the front of her mask once it was on. She stated she should have washed her hands before and after she passed out the trays. Server #3 stated she had received training to not touch the front of her mask once it was on.

On 11/11/2020 at 12:25 PM, Server #2 was interviewed. Server #2 stated she did not carry sanitizer with her nor was she trained to do so. Server #2 confirmed she assisted a resident with

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	15A113	A. BUILDING: _____ B. WING _____	11/11/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRACES AT SEACREST VILLAGE, THE	281 MATHISTOWN ROAD LITTLE EGG HARBOR TW, NJ 08087

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A1299	Continued From page 2 lunch tray set up without washing or sanitizing her hands before or after. Server #2 stated, "Since I wasn't touching anything but the tray, I didn't even think about it." On 11/11/2020 at 2:15 PM, the Dietary Manager (DM) was interviewed. The DM confirmed not having trained the servers to carry sanitizer while passing out room trays. The DM stated that delivering room trays was still so new to them and he had not even thought about the importance of the servers sanitizing their hands between tray passes, especially since the servers were going in and out of the residents' apartments. During an interview with the Infection Preventionist Nurse (IP) on 11/11/2020 at 2:55 PM, she stated it was important to perform hygiene during the meal tray services, especially since the staff were going in and out of resident apartments. On 11/11/2020 at 5:00 PM, the Executive Director (ED) was interviewed. The ED stated that the staff always had room to learn and grow.	A1299		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
15A113		12/8/2020

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
TERRACES AT SEACREST VILLAGE, THE	281 MATHISTOWN ROAD LITTLE EGG HARBOR TW, NJ 08087

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A1299 Reg. # 8:36-18.3(a)(5) LSC	Correction Completed 11/12/2020	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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	
11/11/2020	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO