STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315201	A. BUILDING _____ B. WING _____	01/06/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMBRIDGE REHABILITATION AND HEALTHCARE CENTER	255 EAST MAIN ST MOORESTOWN, NJ 08057

(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: 1/6/21 Census: 104 Sample: 6 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 and has implemented 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 §483.70(e) and following accepted national standards;	F 880		1/29/21

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

Electronically Signed | 01/15/2021

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 §483.80(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 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 2 IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, and review of pertinent facility documentation, it was determined that the facility failed to maintain proper infection control practices for donning (putting on) the appropriate Personal Protective Equipment (PPE) prior to entering an isolation room to prevent the transmission of infection. This deficient practice was identified on 1 of 2 nursing units in the facility and identified for 1 of 6 residents reviewed (Resident #6) during a COVID-19 Focused Infection Control Survey and was evidenced by the following: According to the Admission Record, Resident #6 was admitted in [redacted] Review of the resident's Care Plan (CP) dated [redacted] included that the resident was at risk for infection due to potential/actual exposure to COVID-19 and included an intervention dated [redacted] that the resident was on Droplet Precautions. Review of Resident #6's COVID-19 test dated [redacted] included a result of "Not Detected" for COVID-19. On 1/6/21 at 8:45 am, upon entrance to the facility, the Director of Nursing (DON) stated that all of the residents in the facility were on isolation due to a potential exposure from a staff member that tested positive for COVID-19 on 1/3/21. The DON further stated that staff were required to wear full PPE (N95 or surgical mask, face shield or goggles, gown and gloves) when entering an isolation room.	F 880	Preparation and/or execution of this plan of correction does not constitute an admission or agreement by Provider of the truth or facts alleged or conclusion set forth in the Statement of Deficiencies. This plan of correction is prepared and/or executed because the provisions of Federal and State laws require it. F0880 Infection Prevention and Control 1. Resident #6 was not affected. Resident #6 was PCR tested for COVID-19 on 1/4/21 and was negative. Another test was completed on 1/15/21 and was negative. The agency CNA identified during the survey has not worked in the facility since the survey's completion and has been added to the Do Not Return list with their agency. 2. All residents have the potential to be affected. PPE audits were initiated for 100% of facility and agency staff with on the spot education for any breaks in infection control procedures. 3. Root Cause Analysis was initiated to prevent reoccurrence and in compliance with the Directed Plan of Correction (DPOC). The Root cause analysis determined that washable gowns and all other PPE were available near the PUI room observed. The agency CNA made a conscious decision not to wear a gown and was subsequently relieved of her duties and her agency was instructed to add her to the Do Not Return (DNR) list. Directed In-Service Training (DIST) for front-line staff will be completed on 1/29/2021 utilizing the CDC COVID-19	

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F 880	Continued From page 3 On 1/6/21 at 9:00 am the surveyors entered the nursing unit and observed Resident #6's room with the door closed and signage posted on the door which included the following: "SPECIAL DROPLET/CONTACT PRECAUTIONS Everyone Must: Clean hands when entering and leaving the room Wear mask Wear eye protection Gown and glove at the door" On 1/6/21 at 9:01 am the surveyors observed the Certified Nursing Assistant (CNA) wearing an N95 mask and face shield enter Resident #6's room without wearing a gown. At 9:02 am the surveyors observed the Speech Therapist (ST) open the door to exit the room thus allowing the surveyor to observe the CNA standing at the resident's bedside wearing gloves but not a gown. At 9:14 am, the CNA exited the resident's room. When interviewed at that time, the CNA stated she was providing bathing and dressing assistance to Resident #6 and acknowledged she was not wearing a gown. When asked about the signage on resident's door, the CNA stated that staff are required to wear full PPE when providing care. The CNA further stated that the importance of following the signage was to "prevent people from getting sick." During an interview on 1/6/21 at 9:39 am, the ST stated that staff are required to wear full PPE if the resident is on isolation. The ST further stated it is important to wear the correct PPE to decrease cross contamination. During an interview on 1/6/21 at 9:50 am, the	F 880	Prevention: Keep COVID-19 Out! and Use PPE Correctly for COVID-19 videos. Topline staff will also complete Module 1 – Infection Prevention & Control Program video. All newly hired personnel will complete CDC COVID-19 Prevention: Keep COVID-19 Out! and Use PPE Correctly for COVID-19 videos. 4. To monitor and maintain ongoing compliance, the Director of Nursing and/or designee(s) will audit/observe staff for proper use of PPE for COVID-19 and infection control procedures daily for two weeks and then twice weekly for one month. Results will be presented to the QAPI team monthly for continued review and recommendations.	

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F 880	Continued From page 4	F 880		

Licensed Practical Nurse (LPN) assigned to Resident #6 stated staff are required to wear full PPE prior to entering isolation rooms to prevent the spread of infection.

During an interview on 1/6/21 at 10:00 am, the Unit Manager (UM) stated staff are required to don full PPE prior to entering an isolation room in order to prevent the spread of infection.

During an interview on 1/6/21 at 11:00 am the surveyor made the DON aware of the observation of the CNA. The DON stated that all residents were on isolation and that all staff were required to wear full PPE when entering resident rooms. The DON further stated that the CNA should have donned full PPE prior to entering Resident #6's room.

Review of the facility's "Transmission Precautions for Residents and Donning and Doffing Personal Protective Equipment (PPE) When Caring for Residents with Confirmed or Suspected COVID-19" policy adopted March 2020, included a section for "Special Droplet/Contact Precautions" which contained "Gown and glove at the door."

Review of the facility's "Personal Protective Equipment-Using Gowns" policy included "When use of a gown is indicated, all personnel must put on the gown before treating or touching the resident."

NJAC 8:39-19.4(a)(2); 27.1(a)