STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315455	A. BUILDING _____ B. WING _____	01/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL HEALTH GATE NRSG REHAB	1314 BRUNSWICK AVENUE TRENTON, NJ 08638

(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: 1/26/21 Census: 89 Sample: 10 A COVID-19 Focused Infection Control Survey was conducted by the New Jersey Department of Health 1/22/21 and 1/26/21. The facility was found to not be 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 implement mitigation strategies, including the use of transmission-based precautions (TBP), to prevent the transmission of COVID-19 by not appropriately identifying residents exposed to COVID-19 as persons under investigation (PUI) for the virus for the period of 1/21/21 to 1/22/21. This failure posed a serious and immediate threat to the safety and wellbeing of all non-ill residents. The facility was notified of the Immediate Jeopardy (IJ) situation on 1/22/21 at 3:28 PM. On 1/25/21 the facility submitted a Removal Plan	F 000		

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

Electronically Signed | 02/10/2021

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F 000	Continued From page 1 by email to the New Jersey Department of Health (NJDOH). On 1/26/21 during an onsite Removal Plan verification survey, the facility was found to have corrected the IJ.	F 000		
F 880 SS=K	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 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	F 880		5/31/21

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F 880	Continued From page 2 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 IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, medical record review, and other facility documentation, it was determined that the facility failed to a.) identify	F 880	F-tag 880 1. On 1/23/21, Contact tracing was done	

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F 880	Continued From page 3 residents exposed to COVID-19 as persons under investigation (PUI) through contact tracing, implement mitigation strategies to prevent transmission of COVID-19, and to always perform appropriate hand hygiene This placed [redacted] out of [redacted] unit at risk for infection during a survey on [redacted] This deficient practice was identified for [redacted] of [redacted] units during a focused infection control survey on [redacted] On 1/21/21, the facility became aware that a Licensed Practical Nurse (LPN #1) tested positive for COVID-19 using a rapid antigen COVID-19 test, a nasal swab test that detected a body's immune response to COVID-19 in fifteen minutes. LPN #1 had been assigned to well and non-ill residents on the [redacted] unit on [redacted] The facility did not conduct contact tracing to identify any residents that the LPN came in contact with forty-eight hours prior to testing positive to COVID-19. The facility did not conduct an exposure risk assessment to determine the level of exposure these residents had to the LPN. The facility did not have a policy to reflect the procedure for contact tracing or exposure risk assessment. The facility failed to identify the [redacted] on the LPN's assignment as Persons Under Investigation (PUI) post exposure to a Covid positive person. Upon known exposure these residents remained on the [redacted] nursing unit and were not placed on transmission-based precautions (TBP) in an effort to mitigate the spread of the virus. During the survey conducted on 1/22/21, the surveyors observed staff on the [redacted] section	F 880	on LPN #1. Exposure Risk assessments were immediately done on all residents that LPN #1 came in contact with 48 hours prior to testing positive for COVID-19. On 1/23/21 a policy was created for Contact Tracing and Exposure Risk protocols. On 1/23/21,the Corporate Consultant reviewed with the Administrator and Director of Nurses and Assistant Director of Nurses the policy for Contact Tracing and Risk assessments for residents and the protocols to determine the level of exposure these residents had to LPN #1. All residents found to have exposure to LPN #1 were immediately placed on PUI (Person Under Investigation) precautions x 14 days in order to mitigate the spread of the virus. On 1/23/21, sinage was posted by the Administrator to identify residents on the second floor who were in TBP (Transmission Based Precautions). All employees were in-serviced by the Director of Nurses and the Administrator in regards to the correct PPE to wear when entering rooms were residents are in TBP (Transmission Based Precautions). On 1/23/21, all PPE was made readily available. On 1/23/21, The Housekeeper was given individual counseling by the Housekeeping Director as to the proper hand washing protocol and donning and doffing of PPE. 2. All residents have the potential to be affected when the proper protocols and policies are not followed for residents that have come in contact with a employee that test positive for COVID-19 virus. All	

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F 880	Continued From page 4 of the [redacted] unit wearing at minimum a surgical mask or KN95 mask with eye protection as the only personal protective equipment (PPE). There was no signage that indicated any residents on the "well non-exposed" nursing unit were on TBP and no readily available PPE. In addition, staff were unaware of the appropriate TBP or protocols that should have been implemented for exposure to the virus. The facility's failure to identify residents on the "well non-exposed" nursing unit as exposed to COVID-19 or implement strategies to prevent the spread of COVID-19 posed a serious and immediate threat to safety and wellbeing of all non-ill residents. This resulted in an Immediate Jeopardy (IJ) situation that began on 1/21/21 when the facility was notified of the confirmed positive LPN. The facility Administration was notified of the IJ on 1/22/21 at 3:28 PM. The immediacy was removed on 1/25/21 at 10:54 AM 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 1/26/21. The evidence was as follows: 1. On 1/22/21 at 9:00 AM, the surveyors met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), and the Regional DON. The DON informed the surveyors that the facility had two nursing units, [redacted] The DON stated that on the [redacted] there were residents who were [redacted], residents who were [redacted] to the	F 880	residents have the potential to be affected when staff are not aware of the correct PPE to wear when entering a TBP (Transmission Based Precautions) room. 3. On 1/23/21, the Management staff were in-serviced by the Corporate Consultant on the policy for Contact Tracing and Risk Assessments. All staff were in-serviced on 1/23/21, by the Administrator, Director of Nurses (DON) and the Infection Preventionist (IP) as to the policies and procedures for Contact Tracing and Risk Assessments for residents with potential for exposure to COVID-19 virus. On 1/28/21 the Management staff conducted a (RCA) Root Cause Analysis to identify the cause of the event and to establish corrective actions. It was determeined that the cause of the event was due to a lack in identification of residents with potential for exposure from a staff member who tested positive for COVID-19 virus. The policies for handwashing and donning and doffing PPE with the correct PPE had to be reviewed with all staff members. On 1/29/21, the Director of Nurses, IP (Infection Preventionist)in-serviced all staff on the correct PPE to be worn along with the donning and doffing of PPE. The LTC Self-Assessment has been updated and verifies that the required PPE is available to all staff. Training provided to Topline staff/IP with Nursing Home Infection Preventionist Training Course; Module 1 (Infection prevention & Control Program) and Module 6B (Principles of Transmission Based Precautions). Also training has been provided to all staff for	

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F 880	Continued From page 5 [redacted] residents. The DON stated that for residents who were [redacted] staff donned (wore) full PPE of a N95 (respirator) mask, face shields, bonnets (hair covering), gloves, and gowns. The DON stated that for residents who were [redacted] staff donned eye protection, a surgical mask or KN95 mask. The DON informed the survey team that the last staff member to test positive for COVID-19 was LPN #1 on [redacted]. The DON stated that the LPN worked yesterday on the [redacted] section for approximately [redacted] before receiving a [redacted]. At that time, the LPN tested positive for COVID-19 and was immediately sent home for a minimum of ten days. The DON stated that the LPN was a full time employee who was permanently assigned to the [redacted] unit. The DON stated that the residents the LPN cared for were checked to see if anyone was exhibiting signs and symptoms of COVID-19 that day. The DON stated that none of the residents were exhibiting any signs and symptoms of COVID-19 so residents were not given a rapid antigen COVID-19 test, but the facility was in the process of conducting their routine weekly COVID-19 PCR test (test for qualitative detection of nucleic acid from SARS-CoV-2/COVID-19) on residents. At this time, the LNHA informed the survey team, that the facility conducted no contact tracing for staff or residents who tested positive for COVID-19 because all staff wore PPE. At 9:50 AM, the surveyor entered the [redacted]	F 880	CDC COVID-19 Prevention Messages for Front Line LTC Staff (Keep COVID-19 Out!) & (Use PPE Correctly for COVID-19). CIC obtained. approved by the NJDOH, zoom meeting with CIC scheduled for May 19,2021 at 11Am, implemented Infection Prevention and Intervention Plan. CIC on site visit scheduled for June 14,2021 4. The Administrator, Director of Nurses, IP (Infection Preventionist) will observe 5 staff members daily x 30 days in regards to donning and doffing of PPE as well as the correct choice of PPE when entering a resident room. This will include return competency for performance of tasks, then 3 staff members daily, x 30 days. The Director of Nurses and Assistant Director of Nurses will monitor daily lab results for employees testing of COVID-19 virus to ensure that contact tracing is done on the employee and risk assessments are done on residents for possible exposure ongoing. All findings will be reviewed at the Quality Assurance meeting x 3 quarters.	

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F 880	Continued From page 6 [redacted] section. The surveyor observed no signs indicating any of these residents were on TBP. The surveyor also observed no readily accessible PPE bins. At 9:57 AM, the surveyor observed a Certified Nursing Aide (CNA) wearing a surgical mask with a KN95 over that mask and eye protection. The surveyor questioned the CNA about her mask. She stated that she preferred to wear the masks that way. The CNA stated that she had no permanent assignment, but today she was assigned to both well and non-ill residents and COVID-19 positive residents. The CNA stated that she worked from well to ill residents. The CNA stated that for the well residents, she only had to wear her mask and eye protection and gloves when performing care. At 10:00 AM, the surveyor interviewed LPN #2 who stated that she worked per diem, and today she was assigned to the [redacted] residents on the [redacted] unit. The LPN stated that when taking care of these residents, she was only required to wear a KN95 mask and eye protection. At 10:07 AM, the surveyor interviewed the [redacted] who stated that her job was to transfer residents to the rehabilitation gym. The [redacted] stated that she only interacted with the [redacted] residents. The [redacted] stated that she was only required to wear a KN95 mask and goggles when interacting with these residents. At 10:10 AM, the surveyor interviewed a Temporary Nursing Aide (TNA) who stated that she only worked with the well and	F 880		

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F 880	Continued From page 7 non-ill/non-exposed residents on the [redacted]. The TNA stated that she wore a KN95 mask and eye protection in these rooms and gloves when providing care. The TNA stated that residents do not wear masks when care was rendered and only wore masks when they left their rooms. At 10:23 AM, the surveyor interviewed a Housekeeper who stated that she only cleaned the [redacted] rooms on the [redacted] unit. The Housekeeper stated that she wore a surgical mask, eye protection, and gloves only when cleaning these rooms. At 10:28 AM, the surveyor interviewed the LPN/Unit Manager (LPN/UM) who stated that staff on the [redacted] side only wear a KN95 mask and eye protection. The LPN/UM stated that she was not involved in the process if a staff member tested positive to COVID-19. At 11:21 AM, the surveyor interviewed the DON who stated that the facility monitored all residents every shift for signs and symptoms of COVID-19 including temperature, vital signs, and screened for shortness of breath, loss of appetite, muscle weakness, and pain. The DON stated that the facility did conduct risk assessments, but not on COVID-19. The DON stated that she was probably going to start a quality assurance and performance improvement (QAPI) plan on that soon. At 11:25 AM, the Regional DON provided the surveyor with LPN #1's assignment sheets for the week. The assignment sheets revealed that the	F 880		

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F 880	Continued From page 8 LPN worked in the forty-eight hours prior to [redacted] on [redacted] and [redacted] on the [redacted] At 11:31 AM, the Assistant Director of Nursing/Infection Preventionist (ADON/IP) stated that LPN #1 always worked on the [redacted] side of the [redacted] unit. At 11:38 AM, the LPN/Corporate Nurse Minimum Data Set (MDS) stated that the facility does not perform contact tracing. The facility sent their line list to the Local Health Department (LHD) and the LHD conducted contact tracing. The facility will verbally tell staff who tested COVID-19 positive At 12:10 PM, the surveyor re-interviewed the DON and ADON/IP who stated that the process for when a direct care staff member tested positive for COVID-19 was to send them home immediately making sure they were not touching anything when they left the facility in order to not contaminate anything further. The ADON/IP stated that the facility made sure that the residents cared for by a positive staff member exhibited no signs and symptoms of COVID-19. If the resident exhibited any symptoms, the facility performed a rapid antigen COVID-19 test. The facility already monitored all residents every shift for signs and symptoms of COVID-19, so no additional monitoring needed to be initiated. The staff wore PPE so the resident would not have a full exposure. The ADON acknowledged that the majority of her staff and residents who tested positive for COVID-19 were asymptomatic. The ADON/IP confirmed that the facility does not conduct an exposure risk assessment to determine what level of exposure a resident might have. The ADON/IP stated that staff wore either	F 880		

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F 880	Continued From page 9	F 880		

a surgical mask or a KN95 mask. Staff also wore goggles or a half face shield which was considered eye protection because it did not cover the face mask. The ADON/IP stated on the COVID-19 positive unit, staff had to wear a full-face shield that covered the face mask as well as a N95 mask. The ADON/IP stated that she did do rounds to ensure staff are wearing the appropriate PPE and wearing the PPE correctly. The ADON/IP stated that a surgical mask should not be worn under the KN95 mask, but on top of the KN95 mask.

At 12:40 PM, the surveyor interviewed the LNHA who stated that everyday he emailed the LHD the NOVI Survey (COVID-19 Facility Outbreak Reporting Daily Survey) and line list. The LNHA stated that the LHD usually did not reply to those emails. The LNHA stated that the LHD has not recently offered any guidance to the facility. The LHD did not ask about risk levels of exposure to COVID-19. The LNHA stated that in the beginning, the LHD had a more active role with the facility, conducting on-site visits. The LNHA stated that he at this point feels that the LHD thinks the facility has a good grip on things.

A review of the facility's Outbreak Plan dated last revised 1/6/21 included conduct control activities such as contact tracing of exposed individuals and monitoring for additional cases under the guidance of the local health authorities, and in keeping with guidance from the Centers for Disease Control (CDC). The plan also included to activate quarantine interventions for residents and staff with suspected exposure as directed by local and state public health authorities and in keeping with guidance from the CDC. The plan also included for the evaluation and management

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F 880	Continued From page 10	F 880		

of residents and healthcare personnel during an outbreak. The facility will assess close contact including healthcare personnel and other residents based on their exposures to positive case(s) of the infectious disease. The healthcare personnel and residents with exposure will be identified and an appropriate risk assessment completed to determine if they have a high, medium, low, or no identifiable risk. Close contact is identified as being within approximately six feet of a positive case for prolonged period of time or having close contact with an infectious case, for example being coughed on. Close contacts should be quarantined for fourteen days after the exposure. Adhere to standard and TBP including the use of a face mask, gown, gloves, and eye protection for all confirmed or suspected case(s).

A further review of the facility's Outbreak Plan under cohorting included under Cohort B - negative but exposed that this cohort consisted of symptomatic and asymptomatic residents who test negative for the virus with identified exposure to someone who was positive. Exposed individuals should be quarantined for fourteen days from last exposure, regardless of test results. All symptomatic residents in this cohort should be evaluated for causes of their symptoms. Residents who test negative for the virus could be incubating and later test positive. To the best of our ability, facility will separate symptomatic and asymptomatic residents, ideally having one group housed in private rooms. Even though symptomatic negative residents might not be a threat to transmit the infectious disease virus, they still may have another respiratory illness. Asymptomatic residents should be closely monitored for symptom development.

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F 880	Continued From page 11 At 3:20 PM, the survey team met with the LNHA, DON, ADON/IP, Regional DON, and LPN/Corporate Nurse MDS and reviewed the facility's Outbreak Plan. When asked why the facility did not follow their Outbreak Plan, the DON replied again that the LPN wore PPE so there was not a "full" exposure. The facility Administration confirmed that there was no contact tracing or risk assessment conducted. The LNHA confirmed that the facility had no policy regarding the procedure for contact tracing or a risk assessment for exposure. The LNHA stated that for contact tracing, the facility needed to look back forty-eight hours to determine who the LPN was in contact with. A review of the guidance 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 included that cohort 2 COVID-19 negative, exposed consisted of both symptomatic and asymptomatic residents who tested negative for COVID-19 with an identified exposure to someone who was positive. These individuals should be quarantined for fourteen days from their last exposure, regardless of test results. The guideline further included that residents in Cohort Group 2 should be placed on TBP using COVID-19 recommended PPE consisting of an N95 mask, eye protection, gloves, and isolation gowns. A review of the NJDOH/CDS Testing in Response to a Newly Identified COVID-19 Case in Long-term Care Facilities dated 10/29/2020 included that regardless of attribution of the case,	F 880		

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	315455	A. BUILDING _____ B. WING _____	01/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL HEALTH GATE NRSG REHAB	1314 BRUNSWICK AVENUE TRENTON, NJ 08638

(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 12	F 880		

all facilities should take the following steps when a new case of COVID-19 is identified in their facility. The steps included to perform a risk assessment to determine any potential exposures/or infection control breaches at the facility. Determine any possible exposures the new case of COVID-19 (exempli gratia (e.g.) resident, healthcare personnel, essential caregiver) may have had prior to the diagnosis including contact with other known COVID-19 positive persons or those who later developed symptoms consistent with COVID-19. Identify close contact including forty-eight hours prior to symptom onset/date of specimen collection of associated case, if applicable. Close contact is identified as being within approximately six feet of a COVID-19 case for a prolonged period of time, a cumulative of fifteen minutes or more over a twenty-four hour period starting from two days before illness onset (or, for asymptomatic residents, two days prior to test specimen collection) until the time the resident is isolated. Quarantine close contacts for fourteen days from last exposure and provide care using all COVID-19 recommended PPE (N95 mask, gown, gloves, eye protection).

A review of the NJDOH/CDS Guidance for COVID-19 Diagnosed and/or Exposed Healthcare Personnel dated 10/30/2020 included healthcare facilities should establish a plan for how exposures in a healthcare facility will be investigated and how contact tracing will be performed. The guidance also included that when a healthcare personnel was positive for COVID-19, facilities should do their due diligence to identify and notify close contacts (fifteen cumulative minutes of exposure at a distance of less than six feet to an infected person during a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315455	A. BUILDING _____ B. WING _____	01/26/2021

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F 880	Continued From page 13	F 880		

twenty-four hour period). Prolonged close contact should be determined by taking the cumulative contact the potentially exposed individual had with the infected case over a twenty-four hour period from two days before the symptom onset (or positive collection date in asymptomatic infected individual) until the positive case has been effectively isolated. The guidance also included that patients who are identified as a close contact of a positive healthcare personnel at a healthcare facility should be placed on appropriate transmission-based precautions and monitored for the onset of COVID-19 until fourteen days after their last exposure.

The IJ was identified on 1/22/21 and the LNHA, DON, ADON/IP, Regional DON, and LPN/Corporate Nurse MDS were notified of the IJ at 3:28 PM. A removal plan was accepted on 1/25/21 at 10:54 AM which included that contact tracing and risk assessments were done on all twenty residents that LPN #1 exposed, residents were placed on a fourteen day TBP, signs and PPE bins were placed outside of these doors to notify staff of TBP, facility created policies for contact tracing and exposure risk assessment which the DON and ADON/IP were in-serviced on, and all staff were in-serviced on TBP

2. On 1/22/21 at 10:50 AM, the surveyor observed a Housekeeper wearing a KN95 mask covered by a surgical mask, face shield and gloves. The housekeeper had a wheeled cart with a blanket on top in the hallway outside room 234. He removed garbage from the bin inside the room of a resident that was on TBP (precautions for patients who may be infected for which

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	315455	A. BUILDING _____ B. WING _____	01/26/2021

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F 880	Continued From page 14 additional precautions are needed to prevent infection transmission). The Housekeeper placed the bag of garbage into the bin in the hallway and then returned to the room and placed a new black bag in the can in the room, wearing the same gloves. The housekeeper was then observed entering and exiting the bathroom of the resident's room with a garbage bag which he carried to the bin in the hallway. The surveyor did not observe hand hygiene. The Housekeeper then entered and exited room 233 wearing the same gloves. The surveyor did not observe hand hygiene. The Housekeeper then pushed the cart down the hallway with the same gloved hands and entered room [redacted] where he removed the trash from the garbage bin in the room, wearing the same gloves. The surveyor did not observe hand hygiene. The Housekeeper than pushed the bin down the hall and placed it outside room [redacted]. With the same gloved hands, he knocked on the door, briefly entered and exited the room. The Housekeeper than began to push the bin back down the hallway wearing the same gloves. Upon interview, the Housekeeper stated that he would wash his hands with soap and water for five to six minutes. He then pushed the cart passed the front elevators, down the other hallway and to the 2R (rear) elevator while wearing the same gloves. The Housekeeper pushed the buttons and entered the elevator with the bin of garbage and then pushed the buttons inside the elevator.	F 880		

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	315455	A. BUILDING _____ B. WING _____	01/26/2021

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ROYAL HEALTH GATE NRSG REHAB	1314 BRUNSWICK AVENUE TRENTON, NJ 08638

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F 880	Continued From page 15	F 880		

The Housekeeper then exited the elevator in the basement pushing the cart with the same gloves. He then entered a code for the door, opened it and entered room [redacted] Loading and Receiving and went to the dumpster. The Housekeeper was then observed to remove one glove from his left hand, and with his right gloved hand he proceeded to throw the garbage bags into the dumpster.

The Housekeeper then began to push the cart back into the building. The surveyor asked the Housekeeper when hand hygiene should be done. He stated that handwashing should take place when cleaning a resident's room, but that now he was just removing the garbage. He added that you should also wash your hands before you return to the unit. At that time the Housekeeper removed the glove from his right hand and held it in his left hand as he placed the cart in the hallway outside the break room.

On the same day at 11:05 AM, the surveyor interviewed the Director of Housekeeping and he was aware of the above observations. The Director of Housekeeping confirmed that hand hygiene or handwashing should take place between resident rooms and that the Housekeeper should also have changed his gloves between rooms. The Director of Housekeeping confirmed that the Housekeeping staff had been in serviced on hand hygiene.

On 1/22/21 at 1:49 PM, the surveyor reviewed the facility policy titled Handwashing/Hand Hygiene with a reviewed date of 10/17/2020, that read under Policy Interpretation and Implementation:

6. Wash hands with soap (antimicrobial) or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315455	A. BUILDING _____ B. WING _____	01/26/2021

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F 880	Continued From page 16 non-antimicrobial) and water for the following situations: a. When hands are visibly soiled; and b. After contact with a resident with infectious diarrhea including, but not l limited to infections caused by norovirus, salmonella, shigella and C. difficile. 7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap and water for the following situations: a. Before and after coming on duty. b. Before and after direct contact with residents; ... k. After handling used dressings, contaminated equipment, etc. l. After contact with objects (e.g., medical equipment) in the immediate vicinity of the resident. m. After removing gloves. n. Before and after eating or handling precaution settings. 8. Hand hygiene is the final step after removing and disposing of personal protective equipment. 9. The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections. 10. Single-use disposable gloves should be used: a. Before aseptic procedures. b. When anticipating contact with blood or body fluids; and c. When in contact with a resident, or the equipment or environment of a resident, who is on contact precautions. At 1:56 PM, the surveyor reviewed an undated facility form titled, Guidelines for Providing Care, which read under number 2: Employees must	F 880		

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	315455	A. BUILDING _____ B. WING _____	01/26/2021

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ROYAL HEALTH GATE NRSG REHAB	1314 BRUNSWICK AVENUE TRENTON, NJ 08638

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F 880	Continued From page 17 wash their hands for twenty (20) seconds using soap and water. A. Before and after direct contact with a resident B. When hands are visibly dirty or soiled C. After contact with blood, body fluids, mucous membranes, secretions, or non-intact skin D. After removing gloves E. After handling items potentially contaminate with respiratory secretions F. Before eating and after using a restroom G. When there is likely exposure to a resident that has been diagnoses or has symptoms or the COVID-19 virus The surveyor then reviewed an in-service for Porter, Housekeeping & Laundry titled, Handwashing 20 seconds' scrub! dated 9/20/20. The Housekeeper identified above had signed the form that he participated in the in-service. The information attached was Handwashing, with a review dated 7/20 read: It is the policy of the facility that Handwashing is performed to prevent the spread of bacteria: Before, during, and after preparing food Before meals Before and after care Before and after treatments After using the toilet Breaks After blowing your nose, coughing, or sneezing After personal Hygiene/handling After touching garbage Before and after donning gloves A review of the U.S. CDC's Cleaning and Disinfecting Your Facility updated on 7/28/2020, included, Additional considerations for employers:	F 880		

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F 880	Continued From page 18	F 880		

"Educate workers performing cleaning, laundry, and trash pick-up to recognize the symptoms of COVID-19. Develop policies for worker protection and provide training to all cleaning staff on-site prior to providing cleaning tasks. Ensure workers are trained on the hazards of the cleaning chemicals used in the workplace in accordance with OSHA's Hazard Communication Standard."

According to the U.S. CDC guidelines Hand Hygiene Recommendations, Guidance for Healthcare Providers for Hand Hygiene and COVID-19, updated 5/17/2020 included, "Hands should be washed with soap and water for at least 20 seconds when visibly soiled, before eating, and after using the restroom." It further specified the procedure for hand hygiene which included, "When cleaning your hands with soap and water, wet your hands first with water, apply the amount of product recommended by the manufacturer to your hands, and rub your hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. Rinse your hands with water and use disposable towels to dry. Use a towel to turn off the faucet. Other entities have recommended that cleaning your hands with soap and water should take around 20 seconds. Either time is acceptable. The focus should be on cleaning your hands at the right times."

On 1/22/21 at 10:02 AM, the surveyor observed a female staff member donning (putting on) PPE prior to entering the COVID-19 confirmed area on the second floor. The surveyor observed that the staff member was wearing a surgical mask under a KN95 mask.

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	315455	A. BUILDING _____ B. WING _____	01/26/2021

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F 880	Continued From page 19 At 10:20 AM, the surveyor observed this same staff member on the COVID-19 confirmed unit. She identified herself as a Certified Nursing Assistant (CNA). She CNA was wearing a gown, face shield, hair bonnet, KN95 mask with a surgical mask underneath. The CNA confirmed to the surveyor that she had been in-serviced on donning (putting on) and doffing (taking off) PPE. On the same day at 12:16 PM, the surveyor interviewed the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) who confirmed that a surgical mask should be worn on top of the face mask and not underneath it. At 1:56 PM, the surveyor reviewed a CNA Inservice log signed by the aforementioned CNA, dated 6/4/2020 with the Topic: Stop the spread of germs, Apply PPE on COVID Unit and Exposure, Proper PPE-Masks, Gloves, Shields, Hair Covers, Foot Covers. The attached training information was CDC material titled, Use Personal Protective Equipment (PPE) When Caring for Patients with Confirmed or Suspected COVID-19 and read: Before caring for patients with confirmed or suspected COVID-19, healthcare personnel (HCP) must: Receive comprehensive training on when and what PPE is necessary, how to don (put on) and doff (take off), limitations of PPE, and proper care, maintenance, and disposal of PPE. Demonstrates competency in performing appropriate infection control practices and procedures. It continued as follows; Remember: PPE must be donned correctly before entering	F 880		

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	315455	A. BUILDING _____ B. WING _____	01/26/2021

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F 880	Continued From page 20 the patient area. The implementation of the removal plan was verified with an onsite visit on 1/26/21. On 1/26/21 at 9:52 AM, the surveyors toured the Second Floor nursing unit and verified through observations, interviews with facility staff, and review of in-service education and facility documents that the Removal Plan had been implemented. N.J.A.C 8:39-19.4(a)(b)(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)
315455		7/20/2021

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL HEALTH GATE NRSG REHAB	1314 BRUNSWICK AVENUE TRENTON, NJ 08638

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 05/31/2021	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
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	
1/26/2021	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO