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	315069	A. BUILDING _____ B. WING _____	01/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER LODGE CARE CENTER	1506 GULLY ROAD WALL, NJ 07719

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F 000	INITIAL COMMENTS Survey Date: 1/6/2021 Census: 43 Sample: 5 sampled +24 un-sampled residents A COVID-19 Focused Infection Control Survey was conducted by the New Jersey Department of Health on 1/5,6, and 8/2021. 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 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 Executive Order 26, 4.b.. This failure posed a serious and immediate threat to the safety and well being of all non-ill residents. The facility was notified of the Immediate Jeopardy (IJ) situation on 1/6/2021 at 4:45 PM.	F 000		

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

Electronically Signed | 01/27/2021

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 000	Continued From page 1 On 1/7/2021 the facility submitted a removal plan by e-mail to The New Jersey Department of Health (NJDOH). On 1/8/2021 during an onsite removal plan verification survey, the facility was found to have corrected the Immediate Jeopardy . PART B At the 1/8/2021 it was determined that the F880 deficiency continued at a D Level for failure to appropriately follow Infection Control Protocols as it related to the removal of contaminated isolation gowns.	F 000		
F 835 SS=J	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview, review of medical records and other pertinent facility documentation, it was determined that the facility's Licensed Nursing Home Administrator (LNHA) failed to ensure that the facility was in compliance with the following regulatory requirement which affected the safety of all residents in the facility. The Administrator failed to a.) ensure the implementation of Transmission Based Precautions (TBP) in a timely manner to prevent the transmission of COVID-19 and b.) by not appropriately identifying residents exposed to COVID-19 as persons	F 835	1. Corrective action(s)accomplished for resident(s)affected: Transmission-based precautions were in place for all residents residing in the facility. Vitals signs and respiratory status are being monitored every shift on all residents residing in the facility. Staff were made aware of the proper protocol of exposure and implementation of Transmission- based precautions, to prevent the spread of infection.	3/15/21

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F 835	Continued From page 2 under investigation (PUI). This placed 25 of 25 residents on 3 of 3 units at risk for Covid-19 Infection. This deficient practice was evidenced by the following: Refer to F880L as it pertains to the facility's failure to ensure the implementation of Infection Control Practices and Precautions during an identified COVID-19 outbreak. During the survey conducted on 01/06/20, the surveyors identified deficient practices concerning Infection Control related to the identification of residents who had been exposed to staff members with a known Covid-19 positive test results; and timely implementation of transmission-based precautions (TBP) for these residents. These deficient practices were identified on 3 of 3 nursing units. On 01/06/21 at 4:45 PM, the facility's LNHA was notified that an Immediate Jeopardy (IJ) situation was identified related to the facility not identifying residents as PUI after they were exposed to two certified nurse aides (CNAs) who tested positive for COVID-19. Additionally, the facility did not implement TBP for the residents who had been exposed to the two known COVID-19 positive staff members for the period of 11/23/2020 to 12/6/2020. On 01/07/21, the facility's removal plan was accepted. According to the removal plan, TBP were in place for all residents residing in the facility, staff were educated on the proper	F 835	2. Residents identified having the potential to be affected and corrective action taken: Residents currently residing in the facility have the potential to be affected. All resident□s physician orders were reviewed to ensure transmission-based precautions were in place. 3. Measures will be put into place to ensure the deficient practice will not recur: A Root Cause Analysis (RCA) has been conducted with the Administrator, Quality Assurance and Performance Improvement (QAPI) Committee and Governing Body as required by the DPOC. Human error was identified as a factor for the practice. The Administrator was re-educated by the Regional Nurse on contact tracing and implementation of Transmission Based Precautions (TBP) by appropriately identifying residents exposed to COVID-19 as persons under investigation (PUI). The facility has retained an Administrative Consultant (AC) to provide on-site services as approved by the Department. All staff were educated by the DON/Designee regarding transmission-based precautions to include the use of N95 respirator, gowns, gloves and eye protection. Transmission-based precautions are in place for all residents residing in the facility.	

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F 835	Continued From page 3 protocol of exposure and implementation of TBP, to prevent the spread of infection. On 1/8/2021 at 10:31 AM, the surveyors toured all three units of the facility and verified through observations, interviews with facility staff, review of in-service education and revised facility infection control policy; that the Removal Plan had been implemented. The implementation of the removal plan was verified on-site on 1/8/2021. A review of the Administrator's job description provided by the facility revealed the following: Responsibilities/Accountabilities included; Establishes, directs and is responsible for the overall operation of the Facility's internal and external activities; Works to ensure regulatory and corporate compliance, quality assurance, and the fiscal viability of the Facility; Responsible for the overall organization and management of the facility; Ensures compliance with all pertinent standards, regulations, and requirements; Ensures a safe residential living environment and reviews physical condition of facility through environmental rounds; Ensures proper resident care services; Ensures accurate documentation, implementation and compliance of all issues. On 1/05/21 from 10:02 AM to 10:40 AM, the surveyors conducted an entrance conference with the Administrative team (LNHA, DON/IP and	F 835	Isolation carts are available in all hallways. All residents exposed, suspected or positive are on transmission-based precautions 4. Corrective actions will be monitored to ensure the deficient practice will not recur: The QA/QAPI committee (to include the Administrative Consultant (AC)) will meet monthly to monitor and ensure that solutions are sustained. The facility will send weekly reports every Friday by 1:00 PM to the CDS Healthcare Associated Infections Coordinator (as required by the DPOC). In addition, the facility will maintain timely communication with the Department as may be required by Communicable Disease Services (CDS) staff, including both the facility□s infection prevention team and the consultant. Unit Manager/Designee will conduct a daily audit for 14 days, then weekly times 2 weeks and monthly times 3 months to validate that transmission-based precautions are being followed on all residents (when applicable. Discrepancies will be reported to the Administrator with follow up actions as necessary. The DON will analyze and trend Audit findings and report outcomes of each to the QA Committee quarterly for recommendations, as necessary.	

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F 835	Continued From page 4 CRN). The DON/IP informed the surveyors that there were [redacted] residents currently residing at the facility and there were [redacted] residents that had been [redacted]. The DON/IP confirmed that [redacted] tive residents had [redacted] at the facility. The DON/IP then handed the surveyor a line listing for staff and residents. The DON/IP stated that the facility had three residents nursing units - [redacted] and [redacted] Units. She added that the facility quarantined residents in place in their rooms for both COVID-19 positive residents and for residents under observation for their potential exposure to COVID-19 positive staff members. The LNHA stated that the facility did not have the physical capacity to designate separate areas for COVID-19 positives residents and the PUIs. The DON/IP stated that everyone was required to wear a N95 mask and face shield when in the facility and that staff were supposed to don gown, N95 mask, eye shield and gloves prior to entering a resident's room because the entire facility was on Transmission Based Precautions. The surveyor reviewed the facility's line listing and noted that the current outbreak at the facility started on 11/23/2020 after a Certified Nursing Assistant (CNA #1) tested positive for Covid-19 while CNA #2 tested positive for Covid-19 on 11/30/2020. The surveyor then inquired about contact tracing and investigations regarding the two positive cases above. The LNHA stated that they talked	F 835		

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F 835	Continued From page 5 about the positive Covid-19 cases in their morning meeting but did not document the discussion. The LNHA stated that the facility did not implement Transmission Based Precaution (TBP) because the facility did not have Covid-19 positive residents in the facility at the time CNA #1 tested positive. The LNHA and the DON/IP stated that they did not complete contact tracing and that they were in communication with their Local Health Department (LHD) and that LHD did not direct them to conduct contact tracing. The facility did not provide any documented evidence of contact tracing/investigation despite multiple requests made by the survey team on 01/05/2021. The surveyor then requested a timeline of events related to the 11/23/20 and 11/30/20 identification of the two COVID-19 positive CNAs. The CRN, DON/IP and the LNHA stated again that they did not document their discussions concerning the two Covid-19 positive CNAs During a follow-up interview with the Administrative team on 01/05/21 at 3:05 PM, the LNHA and the DON/IP stated that CNA #1 and CNA #2 "worked everywhere throughout the facility." The LNHA and the DON/IP added that they did not feel as though they needed to initiate TBP in November 2020 when the CNAs tested positive for Covid-19. The LNHA stated that the first in-house COVID-19 positive resident (Resident [redacted]) with an	F 835		

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F 835	Continued From page 6 onset date of [redacted] was in a private room and TBP was initiated for Resident [redacted] upon receipt of the test results on [redacted] He had no explanation for why TBP was not initiated for all the residents that were exposed to CNA #1 and CNA #2. The LNHA further stated they discussed it as a team and felt that facility wide TBP did not need to be initiated at that time. The LNHA acknowledged that the facility did not implement TBP in a timely manner. On 01/06/21 at 10:50 AM, the surveyor requested additional information as to when they facility initiated TBP. The DON/IP responded that she was actively typing up a timeline as to when they initiated TBP and the CRN stated someone was in the process of completing the contact tracing. During a follow-up interview with the Administrative team on 01/06/21 at 12:00 PM, the DON/IP and the LNHA stated that residents were tested weekly and that they were in communication with the LHD. The LNHA stated that they initiated TBP on 12/06/20, which was eleven days after the facility was made aware that two staff members tested positive for Covid-19. The DON reiterated that facility wide TBP was initiated on 12/06/20. When the surveyor inquired about the policy and guidance the facility followed to address the new Covid-19 outbreak in the facility; both the LNHA and the DON/IP informed the surveyors that the facility followed both the CDC and the NJDOH	F 835		

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F 835	Continued From page 7 guidance. The surveyor reviewed the April 30, 2020 CDC guidance titled "Responding to Coronavirus (COVID-19) in Nursing Homes." Under the "Response to Newly Identified SARS-CoV-2 infected (COVID-19) HCP (health care professional) or Residents." The guidance instructed facilities to determine which residents received direct care from the HCP who worked with symptoms consistent with COVID-19 or in the 48 hours prior to symptom onset. The guidance further revealed that if the HCP is diagnosed with COVID-19, residents should be cared for using all recommended COVID-19 PPE until 14 days after last exposure. The surveyor questioned the LNHA regarding interventions or changes that he implemented following the identification of in-house COVID-19 positive staff and residents. The CRN stated they monitored the 24-hour report, increased the monitoring of residents' vital signs, and monitored for respiratory issues. The LNHA stated that he purchased trash cans for isolation rooms, started fit testing of staff members for N 95 masks, and purchased more blood pressure cuffs. During a follow up interview with the CRN on 01/06/21 at 2:40 PM, the surveyors questioned her regarding the reason for deciding to initiate TBP on 12/06/20. The CRN stated she would have to speak with the DON/IP and would follow up with surveyors. Upon return, the CRN stated that the facility -wide TBP was initiated on 12/06/20 due to an increase in residents with	F 835		

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F 835	Continued From page 8 [redacted].	F 835		

During an interview with the Director of Clinical Services (DCS) on 01/08/21 at 12:30 PM, the DCS stated that she was from the facility's management company and that she consulted with the facility on infection control matters. The DCS added that she knew that DON/IP completed contact tracing but did not document it. The DCS further stated that the LHD did not instruct the facility staff to initiate TBP.

The administrative team did not provide any information regarding how they identified and implemented TBP for the [redacted] residents who were exposed to the two CNAs that tested positive for Covid-19 on [redacted]020.

The surveyor reviewed the facility's 03/2020 COVID-19 Guidance Policy which indicated it was the facility's policy to comply with DOH (Department of Health), CMS (Center For Medicare & Medicaid Services) and CDC (Centers for Disease Control and Prevention) guidelines to contain any potential cases of COVID-19 and prevent spread of infection as much as possible.

The policy also reflected that infection control protocol for outbreaks, including moving and cohorting ill residents, will be followed along with any guidance from the LHD, NJDOH (New Jersey Department of Health), and CDC. The policy further revealed that the facility would "continue to follow updated guidelines from the CDC, LHD, NJDOH and CMS.

There was no procedure documented on the

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F 835	Continued From page 9	F 835		

policy regarding the steps that staff were to take regarding TBP upon identification of positive Covid-19 cases in the facility.

On 01/05/21, the surveyor reviewed the facility's document titled, "Outbreak Response Plan" updated on 9/23/2020, provided by the CRN. The Outbreak Response Plan reflected that the facility would institute control measures to mitigate, reduce and/or eliminate infection control concerns. The control measures included, but not limited to, universal masking, isolation of ill residents, cohorting residents and all appropriate TBPs.

On 01/05/21, the surveyor reviewed the facility's "Infection Control General Policies", revised on 09/2020, provided by the CRN. The policy revealed that the facility's objective included to prevent the spread of communicable disease. The policy further revealed that it was the responsibility of the Administrator, through the Infection Control Committee, to ensure that all infection control policies and procedures are implemented and followed when necessary.

On 01/06/21, the surveyor reviewed the facility's 09/2020 "Isolation Precautions" policy, provided by the CRN. The policy reflected that residents would be placed on appropriate isolation precautions as noted in the most recent state and federal guidelines.

The surveyor reviewed the October 29, 2020 NJDOH guidance titled "Testing in Response to a Newly Identified COVID-19 Case in Long-term Care Facilities (LTCF)." Under the "Identification

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F 835	Continued From page 10 of a COVID-19 case in LTCFs" section, the guidance indicated that upon the facility's identification of a confirmed case of Covid-19 within the Long Term Care Facilities, they should take critical priority actions regardless of where the transmission event occurred. The guidance further reflected that the facility should take some steps when a new case of COVID-19 was identified at their facility, which included but was not limited to the following: Perform risk assessment to determine potential exposures and/or infection control breaches, determine any possible exposures the new case of COVID-19 may have had prior to diagnosis, and identify close contacts including 48 hours prior to symptom onset/date of specimen collection of associated case. The guidance described close contact as being within approximately six feet of a COVID-19 case for a prolong period of time, a cumulative total of 15 minutes or more over a 24-hour period starting from two days before illness onset. The guidance also indicated to quarantine close contacts for 14 days from last exposure and provide care using all COVID-19 recommended PPE. Under the "Newly Positive HCP" section, the guidance reflected that facility should take immediate action to ensure that further transmission did not occur. NJAC 8:39-27.1 (a)	F 835		
F 880 SS=L	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F 880		3/15/21

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F 880	Continued From page 11 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 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:	F 880		

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F 880	Continued From page 12 (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 review of other facility documentation, it was determined that the facility failed to implement Transmission Based Precaution mitigation strategies in a timely manner to prevent the transmission of COVID-19. This deficient practice was identified for [redacted] of [redacted] residents (Residents [redacted]	F 880	Part A: 1.Corrective action(s)accomplished for resident(s)affected: Of the residents identified all data was communicated with the Local Health Department, NJDOH via the New Jersey Hospital Association (NJHA) and CMS via the National Healthcare Safety Network	

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F 880	Continued From page 13 [redacted]) who were exposed to two known [redacted] positive staff members on [redacted] of [redacted] nursing units; during a Covid-19 survey conducted on [redacted] and was evidenced by the following: Part A. 1. On 1/6/2021 at 2:30 PM, the DON/IP provided the team team with a document titled: "Timeline," dated 11/26/2020. Review of the Timeline date indicated that the facility became aware on 11/25/2020, that a Certified Nursing Assistant (CNA #1) who worked 11/23/20 on the 7 AM -3 PM shift; tested positive for COVID-19. The surveyors reviewed CNA #1's assignment and identified that on 11/23/20, CNA #1 had direct contact and provided care to [redacted] residents. Further review of the Timeline showed that the facility became aware on 11/30/2020, that a second CNA (CNA #2) who worked on 7 AM - 3 PM shift on 11/30/20 tested positive for COVID-19. The surveyors reviewed CNA #2's assignment and noted that on 11/30/20, CNA #2 had direct contact and provided care to [redacted] residents. The facility failed to identify these [redacted] residents and failed to place these residents on Transmission Based Precautions to mitigate the spread of the virus. The facility's failure to identify residents exposed to Covid-19 positive staff and implement strategies to prevent the spread of Covid-19 posed a serious and immediate threat to the safety and wellbeing of all non-ill residents (residents who were negative for Covid-19).	F 880	(NHSN). Transmission-based precautions were put in place for all residents residing in the facility and maintained for 14 days after of the last known exposure. Vitals signs and respiratory status are being monitored every shift on all residents residing in the facility. 2.Residents identified having the potential to be affected and corrective action taken: Residents currently residing in the facility have the potential to be affected. All resident□s physician orders were reviewed to ensure transmission-based precautions were in place. 3.Measures will be put into place to ensure the deficient practice will not recur: A Root Cause Analysis (RCA) has been conducted with the DON/Infection Preventionist, Quality Assurance and Performance Improvement (QAPI) Committee and Governing Body as required by the DPOC. Human error was identified as a factor for the practice. The facility has contracted with an on-site Clinical Infection Control Practitioner (ICP) consultant, who is Certified in Infection Prevention and Control (CIC) to provide services as approved by the Department. The facility has implemented an appropriate infection prevention and intervention plan as required by the DPOC. An Infection Control Assessment	

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F 880	Continued From page 14 This resulted in an Immediate Jeopardy (IJ) situation that began on 11/25/2020 when the facility was notified of the confirmed Covid positive CNA #1. The facility Administration was notified of the IJ on 01/06/2021 at 4:45 PM. The immediacy was removed on 01/07/2021, 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 01/08/2021. The evidence was as follows: On 1/05/21 from 10:02 AM to 10:40 AM, the surveyors conducted entrance conference with the Director of Nursing (DON) who is also the Infection Preventionist (IP), the Licensed Nursing Home Administrator (LNHA) and a Corporate Registered Nurse (CRN). The surveyors inquired about the number of Covid-19 positive residents at the facility and were informed that the facility had [redacted] Covid-19 positive residents currently residing at the facility and [redacted] Covid-19 positive residents that had been sent out to the hospital. The DON/IP confirmed that all current Covid-19 positive residents had acquired the infection at the facility. When questioned about contact tracing, the DON/IP stated that they did not conduct contact tracing because it was the Local Health Department (LHD) that conducts contact tracing. Upon further inquiry during the entrance conference, the LNHA stated that they did contact tracing but did not document it anywhere. The LNHA stated that the facility did not implement Transmission Based Precaution (TBP)	F 880	Response (ICAR) was conducted as required by the DPOC. Directed in-service training videos will be completed by the DON/Infection Preventionist/Nursing Supervisors and facility/frontline staff as required by the DPOC. All staff were educated by the DON/ Designee regarding transmission-based precautions to include the use of N95 respirator, gowns, gloves and eye protection. Transmission-based precautions are in place for all residents residing in the facility. Isolation carts are available in all hallways. All residents exposed, suspected or positive are on transmission-based precautions. 4.Corrective actions will be monitored to ensure the deficient practice will not recur: Unit Manager/Designee will conduct a daily audit for 14 days, then weekly times 2 weeks and monthly times 3 months to validate that transmission-based precautions are being followed on all residents (as applicable). Discrepancies will be reported to the DON with follow up actions as necessary. The DON will analyze and trend Audit findings and report outcomes of each to the QAA Committee quarterly for recommendations, as necessary.	

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F 880	Continued From page 15 because the facility did not have Covid-19 positive residents at the time CNA #1 tested positive. The CRN, DON/IP and the LNHA stated again that they did not write down their discussions but that they talked about the Covid-19 positive CNAs during their morning meetings. The LNHA also acknowledged that the facility did not implement TBP in a timely manner. The DON/IP stated that the facility had three residents units - [redacted] and [redacted] Units. She added that the facility quarantined residents in place in their rooms for both Covid-19 positive residents and for Persons Under Investigation (PUI), which includes residents with potential exposure to Covid-19 positive staff. The DON/IP stated that the facility did not have the physical capacity to designate separate areas for Covid-19 positives residents and PUIs and that was why they quarantined in place as directed by their Local Health Department. During a follow-up interview with the Administrative team on 01/05/21 at 3:05 PM, the DON/IP stated that CNA #1 and CNA #2 "worked everywhere throughout the facility." The surveyor questioned again if a facility -wide TBP was initiated after CNA #1 and CNA #2 tested positive. The DON/IP responded that they did not feel they needed to initiate TBP at that time. The LNHA stated that the first in-house COVID-19 positive resident (Resident [redacted]) was in a private room, and that they initiated TBP for Resident [redacted] upon receipt of the resident's test results on [redacted] The LNHA further stated that they discussed as a team and felt that facility- wide TBP did not need to be initiated at that time.	F 880	Part B: 1. LPN #1 was re-educated on not wearing soiled gowns in the hallways and doffing the soiled gown in the residents room per facility protocol. 2. All residents have the potential to be affected. Facility conducted an audit to ensure appropriate infection control protocols were being followed when doffing soiled gowns. No deficient areas were found. All rooms were audited to ensure they had marked bins for soiled gowns. 3. All staff were re-educated by the DON/IP or designee about doffing of soiled gowns in the residents room and not wearing the soiled gown in the hallway. Competencies were also completed. 4. DON/IP or designee will complete random observation rounds 2X a week X 2 weeks. Then weekly X 2 weeks, then monthly X3 months, to validate that the facility staff is following PPE competency on doffing soiled isolation gown. The DON/IP will report the results to the QAA committee for the next 2 Quarters to ensure education and oversight was effective.	

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The surveyor then requested a timeline and any investigations they completed related to the 11/23/20 and 11/30/20 positive Covid-19 of two CNAs.

Both the LNHA and the DON/IP stated that the facility was in constant communication with the LHD and that the LHD did not direct them to implement TBP.

The DON/IP then handed the surveyor a line listing for staff and residents and the facility team members left the conference room. The facility did not provide any other document regarding contact tracing or time line during day one of the survey.

Review of the facility's line listing reflected the following:

As indicated by the symptom/testing onset date on the line list, the facility's current out break started on [redacted], which was the day CNA #1 tested positive for Covid -19 and had symptoms of coughing and dizziness.

The Line list also showed that CNA #2 tested positive for Covid-19 on 11/30/2020.

Resident [redacted] who resided on [redacted] Unit, [redacted] for [redacted] on [redacted].
Resident [redacted] who resided on [redacted] unit, [redacted] for [redacted] on [redacted].
Resident [redacted] who resided on [redacted] Unit, [redacted] for [redacted] on [redacted].
Resident [redacted] who resided on [redacted] unit, [redacted] for [redacted] on [redacted].
Resident [redacted] who resided on [redacted] unit, [redacted]

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F 880	Continued From page 17 Executive Order 26 for Executive Order 26, 41 on [redacted]. Resident [redacted] who resided on [redacted] unit Executive Order Executive Order 26 for Executive Order 26, 41 unit on [redacted] The daily assignment sheets showed that CNA #1 worked on [redacted] on [redacted] and that CNA #2 worked on [redacted] units on [redacted] The surveyor then conducted a full review of the daily assignment sheets. The assignment showed that CNA #1 worked on 11/23/20 on 7:00 AM to 3:00 PM shift on [redacted] unit and provided direct care to [redacted] residents (Residents [redacted]). The surveyor reviewed the 11/21/20 and 11/22/20 daily assignment sheet which was the 48 hour look back period that preceded CNA #1's positive test on 11/23/20. The Assignment sheet showed that CNA #1 worked 7:00 AM to 3:00 PM shift on [redacted], [redacted] and [redacted] units, and provided direct care for additional [redacted] residents for a combined total of [redacted] residents (Residents [redacted], [redacted] and [redacted]) from [redacted]. During a telephone interview with the DON/IP on 1/11/20 at 2:30 PM, she confirmed that CNA #1 worked on [redacted] and [redacted] Units on Executive Order 26, 41, two days before she tested positive for Covid-19. Review of the 11/30/20 daily assignment sheet showed that CNA #2 worked the 7:00 AM to 3:00 PM shift on [redacted] and [redacted] Units and cared for [redacted] residents, (Residents [redacted]).	F 880		

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F 880	Continued From page 18 Review of 11/28/20 and 11/29/20 daily assignment sheet which was the 48 hour look back period that preceded CNA #2's positive test on 11/30/20, showed that CNA #2 worked the 7:00 AM to 3:00 PM shift on 11/29/20, on [redacted] and [redacted] units, and provided direct care for the same [redacted] residents as on [redacted] (Residents [redacted] and [redacted]. The surveyor reviewed an email communication dated 12/7/2020, which was provided by the DON/IP. This communication reflected that the facility increased the cleansing of high touch areas. The surveyor interviewed the Director of Housekeeping (DH) on 1/5/21 at 1:25 PM. He stated that he started working at the facility approximately two and half weeks ago and that he did not know when facility-wide TBP was initiated. The DH also stated that he had not implemented new infection prevention interventions in the house keeping department since he started. He then provided the surveyor with a document titled: " Housekeeping job description" and stated housekeeping staff followed this job description daily. There was no indication on the document for an increased cleaning of high touch areas. During interview with CNA #2 on 1/5/21 at 1:20 PM, she stated that she was sent home after testing positive for Covid-19 and that she quarantined for 14 days following her positive test. She added that she returned to work on 12/21/20 and that facility-wide TBP was in place	F 880		

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when she returned and that she did not know when TBP was initiated.

The surveyor interviewed unit Licensed Practical Nurse (LPN #2) on 1/5/21 at 1:05 PM. She stated that they don full PPE (gown, gloves, N95 mask and face shield) when they provided care for all residents. She stated that she was not sure when TBP was started.

On 01/6/21, at 10:50 AM, the surveyor went to the DON/IP's office to inquire about the requested documents. The DON/IP informed the surveyor that she was still typing up the information. The CRN stated that someone was completing the contact tracing on CNA #1 and CNA #2 and that they would provide the information shortly.

On 1/6/2021 at 11:30 AM, the Corporate Registered Nurse (CRN) provided the surveyor with a typed document dated 1/7/2021, which reflected the following:
"11/2/2020 met with all staff on 7-3 to make aware of 2 staff members testing positive for Covid19...."
"12/6/2020 transmission based precautions were instituted for the entire building. Supplies were provided and in-servicing done with staff.."

On 1/6/2020 at 2:30 PM. the CRN provided the survey team with a typed document titled: "Timeline." The Timeline reflected that the facility were aware that CNA #1 was tested for Covid -19 on 11/23/20 and that the facility received the result of test on 11/25/20. The Timeline showed that the facility notified CNA #1 and the LHD. The document showed that LHD directed the facility

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to conduct weekly testing for two weeks.

The Timeline also showed that the facility were made aware that CNA #2 tested positive for Covid-19 on 11/30/2020. The Timeline indicated that the facility notified CNA#2 and the LHD of the positive results.

The Timeline showed that the facility were made aware of Resident [redacted] result on [redacted] Executive Order 26, 4.b.

During interview on 1/5/2020 at 3:30 PM, the surveyor inquired about the interventions and preventive measure the facility implemented following their receipt of positive test results of Covid19 for CNA #1, CNA #2 and Resident [redacted]
The LNHA stated that the facility purchased trash cans for isolation rooms, started fit testing of staff members for N 95 masks, and purchased extra blood pressure cuffs.

The DON/IP stated that they tested residents weekly and that she informed the Local Health Department of the positive Covid-19 for CNA #1 and CNA #2. The DON/IP further stated that she was not be able to provide any documentation regarding facility -wide TBP. The DON reiterated that TBP was initiated on 12/06/2020.
The LNHA insisted that the facility followed all the CDC/NJDOH guidance

The facility did not provide an explanation for why they waited from 11/23/2020 to 12/6/2020 before implementing TBP in accordance with CDC/NJDOH guidelines.

Review of Center for Disease Control and

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Prevention (CDC) guidance dated April 30, 2020 and titled; "Responding to Coronavirus (COVID-19) in Nursing Homes" indicated the following:
The facility should identify which residents received care from a Health Care Professional (HCP) diagnosed with Covid-19 who worked with symptoms, restrict those residents in their rooms and utilize all recommended Covid-19 Personal Protective Equipment (PPE) until 14 days after last exposure. The guidance also reflected to maintain TBP on all residents on the units at least until there were no additional clinical cases for 14 days.

Documentation on the facility' line list showed that CNA#1, who tested positive for Covid-19 on 11/23/2020, had symptoms of coughing and dizziness.

The New Jersey Department of Health (NJDOH) guidance dated October 29, 2020 indicated that upon the facility's identification of Covid-19 positive staff and/or residents, priority actions should be taken including but not limited to: "identify close contacts including 48 hours prior to symptom onset/date of specimen collection of associated case. "

The surveyor reviewed the facility's Outbreak Response Plan (OBRP) dated 9/23/2020. The OBRP indicated that the facility would implement all appropriate TBP to mitigate, reduce and or eliminate infection control concerns.

Review of facility's Covid-19 Guidance Policy dated 03/2020 showed that the facility would follow any guidance from LHD/NJDOH/CDC,

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F 880	Continued From page 22 including following all updated guidelines. The IJ was identified on 1/6/2021, the LNHA, DON/IP and the CRN were notified of the IJ at 4:45 PM. A removal plan was accepted on 1/7/2021 which included that residents who were identified as having been exposed to a known Covid-19 positive person, would be placed on TBP. All licensed staff were re-inserviced on TBP. On 1/8/2021 at 10:31 AM, the surveyors toured all three units of the facility and verified through observations, interviews with facility staff, and review of in-service education and revised facility infection control policy; that the Removal Plan had been implemented. The implementation of the removal plan was verified on-site on 1/8/2021. Part B: F880 remains a deficiency, at a scope and severity level of a D based on the following: Based on observation, interview and record review, it was determined that the facility failed to follow appropriate infection control protocols regarding doffing of soiled isolation gown, in accordance with facility protocols. This deficient practice was identified for 1 of 2 nursing staff (LPN #1) observed for donning and doffing PPE and was evidenced by the following: On 1/5/2021 at 09:35 AM, the survey team entered the facility lobby and stood near the nurses' station for observation of staff on the	F 880		

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F 880	Continued From page 23 units. At that time, the surveyor observed as LPN #1 walked out of room [redacted] and onto the hallway of the [redacted] unit. Room-[redacted] was situated not far from the nurses's station and the whole hallway was in clear view of the surveyors from the nurses' station. The surveyor noted that LPN #1 wore a yellow isolation gown as she walked past two other rooms down the hallway. LPN #1 then turned around and walked back to the front of room [redacted], doffed/removed the isolation gown and placed it in a dirty linen bin which was by the entrance of room [redacted]. The surveyor noted that room [redacted]s front entrance was covered with a clear plastic curtain while room [redacted] was not. At 09:40 AM, the surveyor invited LPN #1 to the lobby for an interview. When asked about the clear plastic curtain in front of room [redacted], LPN #1 stated that the facility quarantined Covid-19 positive residents in place in their rooms and that the rooms with clear plastic curtains housed Covid-19 positive residents. She also confirmed that the residents in room [redacted] were positive for Covid-19. When questioned about the protocol for removing used isolation gowns and other PPE, LPN#1 stated that there was no soiled linen bin in room [redacted] and that she did not know why there was no bin in room [redacted]. She added that there should be a soiled linen bin in a Covid-19 positive room or right outside the room. At 1:56 PM, the surveyor interviewed LPN #1 again. She stated that she should not have worn the isolation gown outside the Covid-19 positive room and into the hallway. LPN #1 also stated that she should not have placed the used isolation gown into the bin in room [redacted]. When asked if room [redacted] was a Covid-19 room, she	F 880		

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F 880	Continued From page 24 stated that room[redacted] was not a Covid-19 room because Covid-19 precautions was discontinued for room-[redacted] "this morning"([redacted]) She added that the residents in room-[redacted] were recovered Covid-19 residents. During a follow-up interview with the Administrative team on 01/05/21 at 3:05 PM, the DON/IP stated that staff were required to wear full PPE (N95 mask, face shield or goggles, gown and gloves) prior to entering residents' rooms on the Covid Unit. The DON/IP added that staff were supposed to remove their gown and place them in the bin located inside the resident's room before exiting the resident's room. The DON/IP stated it was the responsibility of the nursing staff to make sure that all residents' rooms had bins for the used reusable gowns. At 11:10 AM, the surveyors inspected other rooms and noted that they had bins for soiled reusable gowns. At 1:20 PM, the surveyor interviewed CNA #2 who stated that staff were supposed to remove their gown in a resident's room and place it in the bin located in the resident's room or right outside the room. According to a document provided by the facility dated 12/7/2020, and titled In-service description: Transmission Based Precautions. Dirty disposable gowns should be doffed at the residents doorway, and placed in a plastic bag and into a garbage bin. An in-service document dated 12/4/2020, indicated that staff should follow the	F 880		

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TOWER LODGE CARE CENTER	**1506 GULLY ROAD WALL, NJ 07719**

(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 25 Transmission Based Precautions Guidelines. Another in-service document dated 12/11/2020 titled: procedure for using Non-disposable isolation gowns indicated that washable isolation gowns were to be removed properly before leaving the room, place them in a marked container inside the room, so they can be sent out for laundry. NJAC 8:39-19.4 (a)(b)(c)(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 (Y2)	DATE OF REVISIT (Y3)
315069	A. Building B. Wing	4/28/2021

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER LODGE CARE CENTER	1506 GULLY ROAD WALL, NJ 07719

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 F0835 Reg. # 483.70 LSC	Correction Completed 03/15/2021	ID Prefix F0880 Reg. # 483.80(a)(1)(2)(4)(e)(f) LSC	Correction Completed 03/15/2021	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	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

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	
1/8/2021	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO