STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315213	A. BUILDING ______ B. WING ______	12/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW SPRINGS REHABILITATION AND HEALTHCARE CTR	**1049 BURNT TAVERN ROAD BRICK, NJ 08724**

(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: 12/20/2022 Census: 139 Sample: 28 + 3 closed records A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of medical records and other facility documentation, it was determined that the facility failed to accurately complete the Minimum Data Set (MDS) for two (2) of 29 residents reviewed Residents #114 and #112. This deficient practice was evidenced by the following: The surveyor reviewed the Admission Record for Resident #114 which reflected that the resident was admitted with diagnoses that included EX. Order 26.(4) B1 The surveyor reviewed the EX. Order 26.(4) B safety evaluation dated EX. Order 26.(4) B1, which indicated that Resident #114 currently EX. Order 26.(4) B	F 641	1. Residents #114 and #112 MDS corrected to accurately reflect their assessments. 2. All residents who smoke or on anti-depressant medication and incorrectly coded have the potential to be affected. Regional MDS conducted audits all Residents who EX. Order 26.(4) and all Residents who are on EX. Order 26.(4) B1 medication to verify correct coding of their MDS assessments. No further Residents found to be affected by this deficient practice. 3. The MDS coordinators have been educated on proper coding of EX. Order 26.(4) B1 The MDS coordinators have been	1/19/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 01/10/2023

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 641	Continued From page 1 The surveyor reviewed Resident #114's Admission MDS dated EX. Order 26.(4) B1. The section for current tobacco use was coded as EX. Order 26.(4) indicating that Resident #114 does not currently use EX. Order 26.(4). When interviewed on 12/19/2022 at 10:45 AM, the MDS Coordinator stated that she was unaware that Resident #114 was a EX. Order 26.(4). She stated that Resident #114's Admission MDS dated EX. Order 26.(4) B1, should have been coded as Resident #114 currently using EX. Order 26.(4) B1 When interviewed on 12/20/2022 at 10:41 AM, the Licensed Nursing Home Administrator (LNHA) acknowledged that the MDS for Resident #114 was coded incorrectly. The surveyor reviewed the Admission Record of Resident #112 which indicated that the resident was admitted with diagnoses which included EX. Order 26.(4) B1. The surveyor reviewed the Order Summary Report for Resident #112. Resident #112 had an order dated EX. Order 26.(4) B1 for EX. Order 26.(4) B1 milligrams by mouth one (1) time a day related to EX. Order 26.(4) B1 The surveyor reviewed Resident #112's two Quarterly MDS (s) dated for EX. Order 26.(4) B1 and EX. Order 26.(4) B1 On the MDS dated EX. Order 26.(4) B1, the section for EX. Order 26.(4) B1 medication was coded as six EX. Order indicating that Resident #112 received an EX. Order 26.(4) B1 medication during the last seven (7) days. The section for EX. Order 26.(4) B1 medication received was coded as a zero (0) indicating that Resident #112 did not receive an EX. Order 26.(4) B1 medication. On the MDS dated EX. Order 26.(4) B1 the	F 641	educated on proper coding of EX. Order 26.(4) B1. MDS coordinators will complete an audit of all Residents who EX. Order 26.(4) to ensure they are coded correctly in their MDS. MDS coordinators will complete an audit of all Residents on antidepressants to ensure they are coded correctly in their MDS. 4. The regional MDS or designee will audit 5 MDS a week X 4 weeks then monthly x4 months. The results will be reported to the Administrator at quarterly QAPI committee and determine if continuation of audits is required based on the results of the audits	

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F 641	Continued From page 2 section for EX. Order 26.(4) B1 medication received was coded as a zero (0) indicating that Resident #112 did not receive an EX. Order 26.(4) B1 medication. When interviewed on 12/19/2022 at 10:46 AM, the MDS Coordinator stated that both the EX. Order 26.(4) B1 and EX. Order 26.(4) B1 MDS (s) were coded incorrectly. She stated the EX. Order 26.(4) B1 and EX. Order 26.(4) B1 Quarterly MDS (s) should have reflected that Resident #112 received an EX. Order 26.(4) B1 When interviewed on 12/20/22 at 10:41 AM, the Licensed Nursing Home Administrator (LNHA) acknowledged that Resident #112's MDS (s) were coded incorrectly. NJAC 8:39-2(e)1	F 641		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized	F 761		1/19/23

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F 761	Continued From page 3 personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to a.) properly store medications, b.) maintain clean and sanitary medication storage areas, and c.) properly label opened multidose medications. This deficient practice was observed in 4 of 4 medication carts on 2 of 2 EX. Order 26.(4 and EX. Order 26) nursing units reviewed for medication storage and was evidenced by the following: On 12/9/22 at 10:17 AM, while observing medication administration, the surveyor observed Licensed Practical Nurse (LPN #1) place a EX. Order 26.(4) B1 injectable medication used to treat EX. Order 26.(4) B1 and EX. Order 26.(4) B1) with the needle still attached on Resident #70's tray table after administering the injection. LPN #1 then stated she needed to go to the medication storage room to obtain another medication to administer and left the resident's room, leaving the EX. Order 26.(4) B1 with EX. Order 26.(4 unsecured with the resident and their ambulatory roommate in the room. At 10:19 AM, LPN #1 returned with the newly obtained medication, administered it, and collected the EX. Order 26.(4) B1 with EX. Order 26.(4) brought the	F 761	It was identified that during the survey process that the facility Licensed nursing staff failed to properly store and label medications and failed to maintain clean and sanitary medication storage areas. Corrective action has been accomplished for this deficient practice. Staff immediately ensured all medication storage area were maintained clean and sanitary according to state and federal regulations. All open multi dose medication were reviewed to ensure they were appropriately labeled. Unlabeled or inappropriately stored items discarded. Education was provided to LPN #1, #2, #3, #4 and #5 regarding proper storage of medications, labeling of medications, disposal of medications, and importance of cleanliness of all medication storage areas. Policy Storage of Medications was reviewed and reinforced with (LPNs #1,#2,#3,#4,#5) by the Assistant Director of Nursing (ADON). Policy Administering Medications was reviewed and reinforced with (LPNs #1,#2,#3,#4,#5) by the Assistant Director of Nursing (ADON)	

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F 761	Continued From page 4 insulin to the medication cart EX. Order 26.(4) B1 side) situated outside the resident's room, discarded the needle into the sharps container (a container used to dispose of sharp medical waste and supplies), placed the EX. Order 26.(4 on top of the medication cart, then was called back into the resident's room by the resident. At this point, LPN #1 left the EX. Order 26.(4) B1 unsecured once more, this time on the medication cart in the hallway and entered the resident's room to answer the call and washed her hands in the restroom. During this time, another resident of the nursing unit walked by the medication cart with the EX. Order 26.(4) B1 sitting on top, unsecured. At 10:26 AM, LPN #1 returned to the medication cart at which point the surveyor interviewed LPN #1 regarding securing medication and the EX. Order 26.(4 to which LPN #1 replied she "should not have left the insulin in the room because someone can come by and use it." LPN #1 stated she "got flustered and realized I left it when I went away, I should not have left it in the room or on the cart, I'm sorry." On 10/12/22 at 9:15 AM, the surveyor in the presence of LPN #2 observed 'EX. Order 26.(4 nursing unit EEX. Order 26.(4) B1 medication cart which contained: one (1) open bottle of EX. Order 26.(4) B1 (EX. Order 26.(4) B1) which was not labeled or dated; one (1) open and used bottle of EX. Order 26.(4) B1 EX. Order 26.(4) B1) which was labeled with a pharmacy label for Resident #234 but placed in a plastic bag with a pharmacy labeled for Unsampled Resident #1's name, and two (2) loose medication pills of various colors and sizes in the bottom of the drawers. LPN #2 collected these pills as they were discovered, counted them, and disposed of these medications using the medication cart drug buster bottle. LPN #2 informed the surveyor that Resident #234 and	F 761	All residents have the potential to be affected by (this deficient practice). Director of Nursing or Designee will in-service all nurses on proper medication storage, labeling of medications, disposal of medications, and importance of cleanliness of all medication storage areas. All in- servicing will be completed by 1/19/23. All new staff hired will be in-serviced upon hire. The DON or designee will complete weekly audits to check all medication storage areas as well as medication carts for proper labeling and storage of medications and cleanliness/sanitation. DON or designee will complete audits of all medication storage areas weekly x 4 months to assure compliance in these areas. The results of audits will be brought to QAPI committee monthly for review. After completion of 4 months review of audit results, audits may be discontinued as long as the QAPI committee has determined substantial compliance.	

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F 761	Continued From page 5 Unsampled Resident #1 were both discharged, and she will dispose of the EX. Order 26.(4) B1. On 12/13/22 at 9:55 AM, the surveyor in the presence of LPN #3 observed EX. Order 26.(4) B1 nursing unit EX. Order 26.(4) B1 medication cart which contained: one (1) EX. Order 26.(4) B1 milligram (mg) EX. Order 26.(4) B1 medication used to treat EX. Order 26.(4) B1) which was confirmed by LPN #3 to have been opened and EX. Order 26.(4) B1 device not dated, two (2) EX. Order 26.(4) B1 microgram (mcg) and one (1) EX. Order 26.(4) B1 mcg EX. Order 26.(4) B1y medication used to treat EX. Order 26.(4) B1 opened with no name and not dated on the inhaler devices, and a total of three (3) loose medication pills of various colors and sizes in the bottom of the drawers. LPN #3 collected these medication pills as they were discovered, counted, and disposed of using the medication cart drug buster bottle. On 12/13/22 at 10:43 AM, the surveyor in the presence of LPN #4 observed EX. Order 26.(4) B1 nursing unit EX. Order 26.(4) B1 medication cart which contained: one (1) EX. Order 26.(4) B1 pen which LPN #4 confirmed had been opened and used contained in a plastic bag with an unsampled resident's last name written with black marker and had no label on the pen and not dated; one (1) EX. Order 26.(4) B1 EX. Order 26.(4) B1 medication used to treat EX. Order 26.(4) B1 not labeled, and a total of eighteen (18) loose medication pills of various colors and sizes in the bottom of the drawers. At this point, the surveyor informed LPN #4 that observation of the medication cart was complete, indicating LPN #4 can proceed with proper facility procedure to secure the medication cart and any medications needing to be disposed of (loose	F 761		

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F 761	Continued From page 6	F 761		

pills). LPN #4 then proceeded to lock the medication cart drawers, left the plastic cup containing the loose pills found in the cart, one EX. Order 26.(4) B1, and the unlabeled EX. Order 26.(4) B1 on top of the medication cart and proceeded to sit at a computer behind the nurses' station. LPN #4 did not return to dispose of or secure these medications until the surveyor asked if she was going to do so. At which point, LPN #4 returned to the medication cart, disposed of the loose pills using the medication drug buster bottle, disposed of the EX. Order 26.(4) B1 into the sharps container, and returned the EX. Order 26.(4) B1 EX. Order 26.(4) B1 back into the medication cart and resecured the cart.

On 12/13/22 at 11:24 AM, the surveyor interviewed the facility's Consultant Pharmacist (CP) regarding dating of respiratory inhalers and other multi-use medication. The CP stated if inhalers were not labeled properly and fell out of their labeled bag, it can cause confusion and cross contamination with germs from different residents. The CP also stated that there should not be any loose pills in medication storage areas as it could "cause confusion or medication diversion."

On 12/13/22 at 11:48 AM, the surveyor in the presence of LPN #5 observed EX. Order 26.(4) nursing unit EX. Order 26.(4) B1 medication cart which contained: two (2) opened EX. Order 26.(4) B1 bottles with no label or date, to which LPN #5 confirmed should be labeled and dated; and a total of eight (8) loose medication pills of various colors and sizes in the bottom of the drawers. At this time, LPN #5 stated that the nurses checked the medication carts for loose medications every shift and during medication pass and they were

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F 761	Continued From page 7	F 761		

expected to dispose of loose medication pills in the drug buster. LPN #5 informed the surveyor that all inhaler and multi-use devices should be labeled and dated on the device and not just on the packaging stating "this is how they should be labeled."

On 12/15/22 at 12:38 PM, the surveyor interviewed the Director of Nursing (DON), who informed the surveyor that medications in carts should be labeled and dated with residents' name and date opened, the DON further stated that there should not be any loose pills in storage or in medication carts, all medication should be secured and no medication should be unattended by nurses and unsecure as this is a "safety concern for a patient taking it wrongly." Furthermore, the DON stated that medication labeled for one resident should not be kept in a bag labeled for a different resident.

On 12/15/22 at 2:25 PM, the DON followed up with further information for the surveyor stating, "EX. Order 26.(4) B should have been labeled and dated with resident's name and date opened...for not mixing medications and devices between residents."

A review of the facility's undated "Storage of Medications" policy included: "2. drugs and biologicals are stored in the packaging, containers or other dispensing systems in which they are received ... 3. nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner.
4. drug containers that have missing, incomplete, improper, or incorrect labels are returned to the pharmacy for proper labeling before storing.

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F 761	Continued From page 8 Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed." A review of the facility's undated "Administering Medications" policy included: " ...17. [EX. Order 26.4] pens are clearly labeled with the resident's name or other identifying information. Prior to administering [EX. Order 26.] with an [EX. Order 26.4] pen, the nurse verifies that the correct pen is used for that resident ... 19. During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse or aide ... No medications are kept on top of the cart." N.J.A.C. 8:39-29.4	F 761		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional	F 812		1/19/23

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F 812	Continued From page 9 standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and review of facility documentation it was determined that the facility failed to a.) properly handle and store potentially hazardous foods in a manner that is intended to prevent the spread of food borne illnesses, b.) maintain equipment and kitchen areas in a manner to prevent microbial growth and cross contamination and c.) failed to maintain adequate infection control practices during food service in the kitchen. This deficient practice was observed and evidenced by the following: On 12/6/22 from 10:15 AM -11:13 AM, the surveyor toured the kitchen in the presence of the Food Service Director (FSD) and observed the following: 1. The FSD wore a hair net on the top of his head with the sides and back of his hair exposed. The FSD acknowledged his hairnet and stated hairnets were required to be worn in the kitchen. The FSD further stated that it was important that hairnets covered all of the hair to prevent food contamination. 2. In the walk-in refrigerator, there was an open box containing four frozen turkeys with no received or use by dates. The FSD acknowledged there was no sticker and stated that the box should have had a received or use by date. 3. In the coffee station, there was one opened box containing two clear plastic wrapped stacks	F 812	1. Regional Food Service Director insured all staff were wearing hairnets appropriately. Turkeys found in undated box discarded immediately . Exposed coffee lids, open box of filters discarded immediately . Open box of clear plastic wrap discarded immediately . Upper convection oven cleaned. Identified cutting boards discarded immediately and replaced. 2. All residents have the potential to be affected. 3. All dietary staff in-serviced on wearing hairnets appropriately by Assistant administrator. All dietary staff in-serviced on dating food Assistant administrator. All dietary staff in-serviced on proper storage Assistant administrator. All dietary staff in-serviced cleaning expectations (including time frames) and replacing if necessary Assistant administrator. Checking to ensure items are dated, properly stored, clean and in proper working order added to routine kitchen rounds. Rounds completed by administrator and/ or designee. 4. Administrator or designee will audit food	

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F 812	Continued From page 10 of disposable coffee lids that were opened and exposed to air. There was one open box containing clear plastic wrapped large coffee filters that were opened and exposed to air. The FSD acknowledged the exposed products and stated that they should have been covered to prevent contamination and maintain cleanliness. 4. On the bottom shelf of the metal spice rack, there was one open box containing clear plastic wrap that was uncovered and exposed to air. There was one roll of clear plastic wrap resting on the metal shelf that was uncovered and exposed to air. The FSD acknowledged that the rolls of clear plastic wrap should not have been stored uncovered and stated that it was "not a good thing" if crumbs and food were to contaminate the plastic wrap. The FSD removed the rolls of plastic wrap from the area. 5. On the upper convection oven, there was brown greasy residue on the inside of the doors and there was black debris on the oven floor. The FSD acknowledged the debris and stated it was "baked on splatter" and that the oven needed to be cleaned to prevent contamination. 6. On a metal shelf in the cook's prep area, there were three large white cutting boards each with black smudges, brown stains, and gouges. The FSD acknowledged the cutting boards should not be stained and stated that they should be clean to prevent contamination and then he removed the boards. The surveyor reviewed the facility policy, "Preventing Foodborne Illness-Employee Hygiene and Sanitary Practices," undated, which revealed, Policy Interpretation and Implementation: 12. Hair	F 812	service area three times a week for the next four weeks then monthly for 3 months to insure hairnets are worn appropriately. The results will be reported to the monthly QAPI committee and determine if continuation of audits is required based on the results of the audits Administrator or designee will audit the freezer weekly for the next four weeks then monthly for 3 months to insure all items are dated within acceptable time frame. The results will be reported to the monthly QAPI committee and determine if continuation of audits is required based on the results of the audits Administrator or designee will audit storage area weekly for the next four weeks then monthly for 3 months to insure all items are stored correctly. The results will be reported to the monthly QAPI committee and determine if continuation of audits is required based on the results of the audits Administrator or designee will audit cooking appliances weekly for the next four weeks then monthly for 3 months to insure appliances are cleaned appropriately. The results will be reported to the monthly QAPI committee and determine if continuation of audits is required based on the results of the audits	

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F 812	Continued From page 11	F 812		

nets or caps and/or beard restraints must be worn to keep hair from contacting exposed food, clean equipment, utensils, and linens.

The surveyor reviewed the facility policy, "Food Storage," adopted September 2021, which revealed, Procedure: 6. The Director of Culinary Services or designee will ensure that food is properly labeled and dated.

The surveyor reviewed the facility policy, "Food Receiving and Storage," undated, which revealed, Policy Interpretation and Implementation: 8. All foods stored in the refrigerator or freezer will be covered, labeled and dated ("use by" date).

The surveyor reviewed the facility policy, "Disposable Dishes and Utensils," undated, which revealed, Policy Interpretation and Implementation: 2. Single-service articles related to food services used by this facility will be stored in the original protective package or stored by using other means that provide protection from contamination until used ...

The surveyor reviewed the facility policy, "Sanitization," undated, which revealed, Policy Interpretation and Implementation: 1. All kitchens, kitchen areas and dining areas shall be kept clean ...2. All utensils, counters, shelves and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seams, cracks and chipped areas that may affect their use or proper cleaning ...3. All equipment, food contact surfaces and utensils shall be washed to remove or completely loosen soils ...7. Cutting boards (acrylic or hardwood) will be washed and sanitized between uses.

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F 812	Continued From page 12 The surveyor reviewed the facility's Week at a Glance, PARSLEY-Fall/Winter 2022/2023 Marquis Week 1 (Heart Healthy), Week 1 (Renal), Week 1 (CCHO), Week 1 (Puree), and Week 1 (Mech Soft) menus which all revealed sliced turkey on the Saturday lunch menu. NJAC 8:39-17.2(g)	F 812		
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; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:	F 880		1/19/23

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F 880	Continued From page 13 (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 IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 880		

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F 880	Continued From page 14 Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure a.) staff wore appropriate personal protection equipment (PPE) and performed appropriate hand hygiene in accordance with nationally accepted guidelines for infection prevention and control upon entering the rooms of residents (Resident #44, #59, #64, #76, #77, #80, #106, #108 #380) that were identified as EX. Order 26.(4) B1 and b.) ensure infection control practices were adhered during EX. Order 26.(4) care for one (1) of three (3) residents reviewed for EX. Order 26.(4) B1 (Resident #23). According to the U.S Centers for Disease Control and Prevention (CDC) guidelines, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic updated 09/23/22, included resources for Recommended Infection Prevention and Control (IPC) practices, specifically the Personal Protection Equipment (PPE). The guidelines included, "HCP [healthcare personnel] who enter the room of a patient with suspected or confirmed SARS-CoV-2 [COVID-19] infection should adhere to standard precautions and use a NIOSH-approved particulate respirator with N95 filters or higher, gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face.) This deficient practice was evidenced by the following: a.) On 12/12/22 at approximately 12:38 PM, the surveyor entered the EX. Order 26.(4) B1 wing of the EX. Order 26.(4) B1 Unit to observe the distribution of the lunch meal trays.	F 880	" The two CNAs and LPN identified as allegedly out of compliance were in-serviced on facility policy and acceptable standards of infection control practice according to the Centers for Disease Control and Prevention. The CNA and Activity aide also successfully completed competencies on hand hygiene. Resident□s #23, #44, #59, #64, #77, #80, #106, #108, #380 were monitored for s/s of infection and none was observed. " All residents have the potential to be affected. No other residents were affected. " IP will perform random weekly audits of 5 nurses & 5 CNAs performing hand hygiene procedure x 12 weeks, then 10 nurses & 10 CNAs monthly x 1 quarter. IP will perform random weekly audits of 5 nurses & 5 CNAs for proper use of PPE procedure x 12 weeks, then 10 nurses & 10 CNAs monthly x 1 quarter. 2 wound care observations will be conducted by ADON or Designee weekly x 4 weeks then monthly x 1quarter then annually thereafter. The results of audits will be brought to the QAPI committee monthly for review, based on results of audits QAPI committee will make recommendations regarding continued need for audits vs. discontinuation. " The findings will be reported to the QAPI committee to determine if satisfactory compliance has been reached/reevaluate and continued if needed. F880 SS=D	

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Continued From page 15

On 12/12/22 from 12:40 PM to 12:47 PM, the surveyor observed Certified Nursing Assistant (CNA #1) wearing an N-95 respirator mask and eye protection. CNA #1 performed hand hygiene with alcohol-based hand rub (ABHR) then removed a disposable meal tray off the meal truck and proceeded to the room of Resident #44 without donning (putting on) a gown and a pair of gloves. CNA #1 exited the room and performed hand hygiene with ABHR. CNA #1 then returned to the meal tray cart and repeated the same process of not donning a gown and pair of gloves while she distributed the lunch meal trays to Resident #59, #64, and #77.

On 12/12/22 from 12:41 PM to 12:48 PM, the surveyor observed CNA #2 wearing an N-95 respirator mask and eye protection. CNA #2 donned a yellow laundered gown from an isolation bin located in the hallway. She then removed a disposable meal tray from the meal truck and entered the room shared by Resident #108 and Resident #380 without donning a pair of gloves. CNA #2 set up the meal tray for Resident #380 and exited the room without performing hand hygiene. CNA #2 still wearing the same laundered gown removed the disposable meal tray for Resident #108. She did not perform hand hygiene or donned a pair of gloves and proceeded to set up the meal tray for Resident #108. CNA #2 again exited the room without performing hand hygiene and was still wearing the same yellow laundered gown. She went back to the meal truck and removed a disposable meal tray and entered the room of Resident #106 without performing hand hygiene or donning a pair of gloves. CNA #2 exited the room of Resident #106 and performed hand hygiene

F 880

CFR(s): 483.80 (1) (2) (4) (e) (f) Infection Prevention and Control

ROOT CAUSE ANALYSIS

1. EVENT: Annual Survey 12/12/22-12/20/22
2. TEAM FACILITATORS: Administrator, Director of Nursing, Infection Preventionist (IP)
GOVERNING BODY: Quality Assurance Performance Improvement (QAPI) Committee
3. PROBLEMS IDENTIFIED:
" Two CNAs and an LPN allegedly failed to appropriately perform hand hygiene and/or failed to wear appropriate personal protection equipment and/or failed to handle supplies according to facility and CDC guidelines.

4. CONTRIBUTING FACTORS:
" Two CNAs failed to wash her hands between patient contact and failed to ensure handwashing was performed according to policy and acceptable standards of infection control practice according to the Centers for Disease Control and Prevention.

" Two CNAs failed to wear/ and or change appropriate personal protection equipment according to facility and CDC guidelines.
" LPN failed to appropriately perform hand hygiene according to facility and CDC guidelines.
" LPN failed to appropriately handle supplies according to facility and CDC

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F 880	Continued From page 16 using ABHR. While still wearing the same yellow laundered gown, CNA #2 removed another disposable meal tray from the meal truck and without donning a pair of gloves, entered the room of Resident #80. CNA #2 then went into the resident's bathroom and performed hand hygiene at the sink. CNA #2 then exited the room still wearing the same yellow laundered gown, proceeded to redirect Resident #76 who was walking in the hallway. CNA #2 informed Resident #76 it was time for lunch and that she would be assisting them during their meal. CNA #2 then grabbed a pair of gloves that was located on the medication cart in the hallway and walked Resident #76 to his/her room. On 12/12/22 at 01:03 PM, the surveyor interviewed CNA #2 who stated she was a designated CNA for the EX. Order 26.(4) B1 wing. CNA #2 stated that when she distributed the meal trays, she was required to wear a gown, N-95 mask, and eye protection. CNA #2 further stated that the gloves were not required because she was "just going inside the room to drop off the meal trays". CNA #2 then explained that hand hygiene should be performed before and after meal tray set up and resident care. The surveyor informed CNA #2 of the observations. CNA #2 stated she thought she performed hand hygiene in between each resident but acknowledged she should have performed hand hygiene before and after each resident. On 12/12/22 at 01:06 PM, the surveyor interviewed Licensed Practical Nurse (LPN #1) who stated she was a designated nurse for the EX. Order 26.(4) B1 wing. LPN #1 stated that staff were required to wear eye protection, a gown, gloves, and an N-95 mask. She stated that staff should	F 880	guidelines. 5. ROOT CAUSES: " Need for re-education regarding when to perform hand hygiene, proper usage of personal protection equipment and wound care supply handling. " Employees stated that being observed by the surveyor made them nervous causing them to skip important steps of EX. Order 26.(care procedures and infection control practices (hand hygiene and PPE use). 6. CORRECTIVE ACTIONS: " The two CNAs and LPN identified as allegedly out of compliance were in-serviced on facility policy and acceptable standards of infection control practice according to the Centers for Disease Control and Prevention. The two CNAs and LPN aide also successfully completed competencies on hand hygiene. The two CNAs and LPN received training and successfully completed competencies wearing/ and or changing appropriate personal protection equipment according to facility and CDC guidelines. LPN received training on infection control and EX. Order 26.(4 care according to facility and CDC guidelines. " Facility Staff were re-educated on facility and CDC guidelines for hand hygiene. " Facility Staff were re-educated wearing/ and or changing appropriate personal protection equipment according to facility and CDC guidelines. 7. MONITORING/EVALUATIONS: IP will perform random weekly audits of 5	

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F 880	Continued From page 17 perform hand hygiene between each resident. LPN #1 stated the facility's policy was for staff to change their gowns and gloves after each resident. She further stated that the staff should not be walking in the hallway with their gowns on. LPN #1 concluded the same rules apply for when staff are passing the meal trays. On 12/12/12 at 01:09 PM, the surveyor interviewed CNA #1 who stated she assumed if she was just going inside the rooms to drop off the meal trays then she did not need a gown but should perform hand hygiene with ABHR or hand washing before and after each resident. She further stated that she donned a gown when she assisted a resident during meals or had direct resident care. On 12/12/22 at 01:16 PM, the surveyor interviewed Licensed Practical Nurse/Unit Manager (LPN/UM #2) who stated that staff were required to wear the full PPE which included a gown, gloves, N-95 mask and eye protection when entering the rooms of EX. Order 26.(4) B1 residents. LPN/UM #2 stated that the staff should have been wearing the full PPE even when they were distributing and setting up the meal trays. She further stated that the staff should have been performing hand hygiene before and after donning and doffing between each resident. LPN #2 emphasized that the staff should have worn the full PPE during the passing of the meal trays and that staff should have changed their gowns in between each resident. LPN/UM #2 explained that all staff were educated on donning and doffing and that the appropriate steps were also on their badges, which LPN/UM #2 showed the surveyor on her name badge.	F 880	nurses & 5 CNAs performing hand hygiene procedure x 12 weeks, then 10 nurses & 10 CNAs monthly x 1 quarter. IP will perform random weekly audits of 5 nurses & 5 CNAs for proper use of PPE procedure x 12 weeks, then 10 nurses & 10 CNAs monthly x 1 quarter. 2 wound care observations will be conducted by ADON or Designee weekly x 4 weeks then monthly x 1quarter then annually thereafter. The information will be brought to monthly QAPI committee for review. After completion of 4 months review of audit results, audits may be discontinued.	

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On 12/13/22 at 11:18 AM, the surveyor interviewed the Licensed Practical Nurse/Infection Preventionist (LPN/IP) who stated that he was responsible for conducting the infection control in-services which included hand washing and donning and doffing PPE. The LPN/IP stated that the staff on the [EX. Order 26.(4) B1] wing were required to wear the full PPE that was also specified on the signage on all the doors. He explained for the [EX. Order 26.(4] precautions the PPE included a gown, gloves, N-95 mask and eye protection. He further explained that the full PPE should have been worn anytime the staff went into a covid positive room. The LPN/IP stated that according to their policy staff should have worn a gown, gloves, N-95 mask and eye protection during passing of the meal trays. In addition, the staff should have changed their gown in between the residents. The LPN/IP stated that the staff should have removed their gown upon exiting the resident's room. He further stated that the gowns should not have been worn in the hallway. The LPN/IP concluded that the staff should have applied hand sanitizer in between each resident and after the third resident then the staff should have performed hand washing with soap and water.

On 12/13/22 at 12:43 PM, the Licensed Nursing Home Administrator (LNHA) in the presence of survey team stated that based on their current policy staff should have donned and doffed PPE after each resident. He further stated that staff should have performed hand hygiene before and after each resident. The LNHA emphasized that all staff had been educated on infection control.

A review of Resident #44's medical record reflected the resident tested [EX. Order 26.(4)] for

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F 880	Continued From page 19 EX. Order 26.(4) B1 on EX. Order 26.(4) B1 A review of Resident #59's medical record reflected the resident tested EX. Order 26.(4) for EX. Order 26.(4) B1 on EX. Order 26.(4) B1 A review of Resident #64's medical record reflected the resident tested EX. Order 26.(4) for EX. Order 26.(4) B1 on EX. Order 26.(4) B1 A review of Resident #76's medical record reflected the resident tested EX. Order 26.(4) for EX. Order 26.(4) B1 on EX. Order 26.(4) B1 A review of Resident #77's medical record reflected the resident tested EX. Order 26.(4) B for EX. Order 26.(4) B1 on EX. Order 26.(4). A review of Resident EX. Order 2 medical record reflected the resident tested EX. Order 26.(4) B for EX. Order 26.(4) B1 on EX. Order 26.(4) B1. A review of Resident #106's medical record reflected the resident tested EX. Order 26.(4) for EX. Order 26.(4) B1 on EX. Order 26.(4) B1. A review of Resident #108's medical record reflected the resident tested EX. Order 26.(4) B for EX. Order 26.(4) B1 on 12/EX. Order 26. A review of Resident #380's medical record reflected the resident tested EX. Order 26.(4) B for EX. Order 26.(4) B1 on EX. Order 26.(4) B1 On 12/20/22 at 10:38 AM, the LNHA in the presence of the Director of Nursing (DON), the Regional LNHA, the Regional Director of Clinical Services and the survey team, acknowledged that the staff should have worn the appropriate PPE	F 880		

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and performed appropriate hand hygiene while they were passing out the meal trays on the COVID-19 wing.

A review of the handwashing and PPE education dated EX. Order 26.(4) B1, reflected the proper steps for handwashing, the proper steps for donning and doffing PPE for EX. Order 26.(4 precautions and that staff must change PPE between each room. The in-service further reflected LPN #1, CNA #1, and CNA #2 were in attendance.

A review of the facility's policy CDC [Centers for Disease Control and Prevention] Guidance - Personal Protective Equipment revised September 2022, reflected "The facility will review and implement recommendations by the CDC. Regulatory guidance and/or directives provided by the State and/or CMS may supersede the CDC recommendations ...HCP who enter the room of a resident with suspected or confirmed SARS-CoV-2 [COVID-19] infection should use a NIOSH-approved N95 or equivalent or higher-level respirator, gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face."

A review of the facility's Handwashing/Hand Hygiene policy revised 07/18/22, reflected ..."7. Use an alcohol-based hand rub (ABHR) containing at least 62% alcohol; or alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: ...n. Before and after entering isolation precaution settings; o. Before and after eating or handling food; p. Before and after assisting a resident with meals ...."

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WILLOW SPRINGS REHABILITATION AND HEALTHCARE CTR	1049 BURNT TAVERN ROAD BRICK, NJ 08724

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F 880	Continued From page 21 b.) On 12/06/22 at 11:32 AM, the surveyor observed Resident #23 in their room resting with their eyes closed in bed on EX. Order 26.(4) B1 fully EX. Order 26.(4) B1s (a EX. Order 26.(4) s used to reduce the risk of EX. Order 26.(4) B1 also known as EX. Order 26.(4) B1 The resident had a sign on their room door indicating "Enhanced Barrier Precautions" and instructing the requirement to perform hand hygiene prior to entering and exiting the room and the use of PPE including gloves and gown when performing personal care for the resident or in contact with the resident. The surveyor reviewed the medical record for Resident #23. A review of the Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility in EX. Order 26.(4) B1, with diagnosis which included EX. Order 26.(4) B1 or EX. Order 26.(4) B1 A review of the active Order Summary Report (OSR) reflected physician's orders (PO) dated EX. Order 26.(4) B1 for EX. Order 26.(4) B1 care, PO (s) dated EX. Order 26.(4) B1 1.) to apply EX. Order 26.(4) B1 (a medication topical which EX. Order 26.(4) B1 healing) to EX. Order 26.(4) B1 topically every day shift for EX. Order 26.(4) B1 topically every day shift for EX. Order 26.(care, and a PO dated EX. Order 26.(4) B1 to apply EX. Order 26.(4) B1) (ointment used to prevent and EX. Order 26.(4) B1	F 880		

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F 880	Continued From page 22 EX. Order 26.(4) B1 topically every shift for prevention. Another PO dated EX. Order 26.(4) B1 for enhanced barrier precautions - to clean hands with sanitizer before entering and when leaving the room, and wear gloves and gown for dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs, or assisting with toileting, device care, or use - EX. Order 26.(4) B1, EX. Order 26.(4) B1 EX. Order 26.(4) B1 care every shift for EX. Order 26.(4) B1. On 12/19/22 from 11:14 AM to 11:34 AM, the surveyor observed LPN #2 perform the EX. Order 26.(4) B1 and skin treatment to Resident 23's buttock/sacral region: LPN #2, without performing hand hygiene and with bare hands began to gather wound care supplies from the EX. Order 26.(4) B1 care treatment cart in the clean supply closet located across from the nurse's station. The supplies gathered consisted of a box of gloves, a full package of clean 4x4 gauze, two (2) clean plastic drinking cups, a bottle of sterile saline solution, a newly opened full tube of EX. Order 26.(4) B1, and a single packaged sterile towel drape. LPN #2 then brought all these supplies down the hallway to Resident 23's room and without cleaning or sanitizing the surface, placed them directly onto the resident's tray table which had unidentified particles dispersed on the surface along with other belongings of the resident. LPN #2 then washed her hands, exited the resident's room to obtain a washable isolation gown from the isolation gown bin outside the resident's room door, donned (put on) the gown, entered the room, and donned clean gloves. At that point, a second staff member entered the resident's room to assist LPN #2 with turning the resident during the procedure. The second staff member entered	F 880		

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F 880	Continued From page 23 the room with a clean isolation gown on and washed her hands and donned clean gloves while LPN #2 opened and laid the sterile towel drape on the uncleaned tray table and arranged the procedure supplies on top of the drape. She then brought over a bedside tray table to the resident's bedside and without changing gloves or performing hand hygiene, proceeded with the skin care. After cleaning the resident's buttock with clean EX. Order 26.(4) B1 and EX. Order 26.(4) B1 directly from the bottle of EX. Order 26.(4) B1, LPN #2, using the same gloves reached back to the package of 4x4 gauze for more gauze and patted the area dry. LPN #2 then disposed of the dirtied gauze and doffed (took off) her gloves, and without performing hand hygiene, donned clean gloves, picked up the tube of EX. Order 26.(4) B1 dispensed an amount of the medication directly onto her left hand and applied the medication to the resident's buttock. LPN #2 then doffed her gloves, and without performing hand hygiene or donning new gloves, wrapped up the soiled gauze and unused plastic cups into the towel drape and disposed of them in the trash bin. She then washed her hands, doffed her isolation gown and placed it in the dirty gown bin in the room, and without performing hand hygiene or donning clean gloves, collected the unused package of EX. Order 26.(4) B1 EX. Order 26.(4) B1 bottle, and medication tube and walked it back to the clean supply closet. LPN #2 then dated the medication and saline containers and without disinfecting any outside surfaces of supplies, placed all the unused supplies from the procedure back into the clean treatment supply cart. At that time, the surveyor interviewed LPN #2 who acknowledged that normally she would only bring in a "hand full" of EX. Order 26.(4 in a plastic cup to	F 880		

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F 880	Continued From page 24 the resident's room, and she "should have" wiped down the tray table prior to setting up the clean supplies, but she stated "I had a lot in my hands" as the reason to which she did not. LPN #2 also stated, "I didn't forget, I didn't know I should wash hands between glove changes." Regarding bringing the supplies back to the clean supply room, LPN #2 stated, "I shouldn't have brought the rest of the gauze back because it can contaminate the rest, I'm going to have to throw that out." On 12/19/22 at 11:45 AM, the surveyor interviewed the LPN/IP who stated that nurses should only bring in the amount of packaged EX. Order 26 needed to perform the treatment and not the entire package into resident rooms. Any unused supplies that remained after the treatment were to be discarded. The LPN/IP stated that supplies should always be placed on a clean/sanitized surface, and staff should change gloves and perform hand hygiene in between glove changes, dispensing of treatment medication should be a small amount to be used for the treatment into a container prior to the procedure, and gloves should be worn when used treatment supplies are handled and disposed. Review of the facility provided policy dated 07/18/22, titled "Dressing, Dry/Clean" included the following steps: " ...Steps in the Procedure 1. Disinfect overbed table. 2. Perform hand hygiene ... 4. Prepare supplies on the lean field using clean technique ....9. Remove soiled dressing and discard into designated container. 10. Remove gloves and perform hand hygiene. 11. Put on clean gloves ... 18. Discard disposable items into designated container. Remove gloves and discard. 19. Perform hand hygiene. 20.	F 880		

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F 880	Continued From page 25 Disinfect reusable supplies as indicated (i.e., outside of containers that were touched by unclean hands, scissor blades, etc.). Return reusable supplies to treatment cart. Review of further facility provided policy dated 07/18/22 and titled "Hand Washing/Hand Hygiene" included: " ...7. Use an alcohol-based hand rub (ABHR) containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations:" ..." g. Before handling clean or soiled dressings, gauze pads, etc.; h. Before moving from a contaminated body site to a clean body site during resident care; ... n. Before and after entering isolation precaution settings." ... "10. 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. 11. 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." NJAC 8:39-19.4(a)(b)(c)(d); 27.1(a)	F 880		
F 888 SS=D	COVID-19 Vaccination of Facility Staff CFR(s): 483.80(i)(1)-(3)(i)-(x) §483.80(i) COVID-19 Vaccination of facility staff. The facility must develop and implement policies and procedures to ensure that all staff are fully vaccinated for COVID-19. For purposes of this section, staff are considered fully vaccinated if it has been 2 weeks or more since they completed	F 888		1/19/23

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F 888	Continued From page 26	F 888		

a primary vaccination series for COVID-19. The completion of a primary vaccination series for COVID-19 is defined here as the administration of a single-dose vaccine, or the administration of all required doses of a multi-dose vaccine.

§483.80(i)(1) Regardless of clinical responsibility or resident contact, the policies and procedures must apply to the following facility staff, who provide any care, treatment, or other services for the facility and/or its residents:
(i) Facility employees;
(ii) Licensed practitioners;
(iii) Students, trainees, and volunteers; and
(iv) Individuals who provide care, treatment, or other services for the facility and/or its residents, under contract or by other arrangement.

§483.80(i)(2) The policies and procedures of this section do not apply to the following facility staff:
(i) Staff who exclusively provide telehealth or telemedicine services outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section; and
(ii) Staff who provide support services for the facility that are performed exclusively outside of the facility setting and who do not have any direct contact with residents and other staff specified in paragraph (i)(1) of this section.

§483.80(i)(3) The policies and procedures must include, at a minimum, the following components:
(i) A process for ensuring all staff specified in paragraph (i)(1) of this section (except for those staff who have pending requests for, or who have been granted, exemptions to the vaccination requirements of this section, or those staff for

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F 888	Continued From page 27 whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations) have received, at a minimum, a single-dose COVID-19 vaccine, or the first dose of the primary vaccination series for a multi-dose COVID-19 vaccine prior to staff providing any care, treatment, or other services for the facility and/or its residents; (iii) A process for ensuring the implementation of additional precautions, intended to mitigate the transmission and spread of COVID-19, for all staff who are not fully vaccinated for COVID-19; (iv) A process for tracking and securely documenting the COVID-19 vaccination status of all staff specified in paragraph (i)(1) of this section; (v) A process for tracking and securely documenting the COVID-19 vaccination status of any staff who have obtained any booster doses as recommended by the CDC; (vi) A process by which staff may request an exemption from the staff COVID-19 vaccination requirements based on an applicable Federal law; (vii) A process for tracking and securely documenting information provided by those staff who have requested, and for whom the facility has granted, an exemption from the staff COVID-19 vaccination requirements; (viii) A process for ensuring that all documentation, which confirms recognized clinical contraindications to COVID-19 vaccines and which supports staff requests for medical exemptions from vaccination, has been signed and dated by a licensed practitioner, who is not the individual requesting the exemption, and who is acting within their respective scope of practice as defined by, and in accordance with, all	F 888		

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F 888	Continued From page 28 applicable State and local laws, and for further ensuring that such documentation contains: (A) All information specifying which of the authorized COVID-19 vaccines are clinically contraindicated for the staff member to receive and the recognized clinical reasons for the contraindications; and (B) A statement by the authenticating practitioner recommending that the staff member be exempted from the facility's COVID-19 vaccination requirements for staff based on the recognized clinical contraindications; (ix) A process for ensuring the tracking and secure documentation of the vaccination status of staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations, including, but not limited to, individuals with acute illness secondary to COVID-19, and individuals who received monoclonal antibodies or convalescent plasma for COVID-19 treatment; and (x) Contingency plans for staff who are not fully vaccinated for COVID-19. Effective 60 Days After Publication: §483.80(i)(3)(ii) A process for ensuring that all staff specified in paragraph (i)(1) of this section are fully vaccinated for COVID-19, except for those staff who have been granted exemptions to the vaccination requirements of this section, or those staff for whom COVID-19 vaccination must be temporarily delayed, as recommended by the CDC, due to clinical precautions and considerations; This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and review of pertinent facility documentation, it was	F 888	It is the intent of this facility to follow Centers for Disease control and	

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F 888	Continued From page 29 determined that the facility failed to ensure that mitigation measures were followed to prevent the potential spread of COVID-19, a contagious respiratory infection. This deficient practice was identified for 1 of 2 unvaccinated staff on [EX. Order 26] Unit and was evidenced by the following: On 12/6/22, during entrance conference, the facility was asked to provide a list of the COVID-19 staff vaccination status for all of their staff, which was provided by the Licensed Nursing Home Administrator (LNHA) on 12/7/22. On 12/12/22, the surveyor reviewed the list which revealed five staff members that were granted exemption from the COVID-19 vaccination. On 12/12/22 at 12:56 PM, on the [EX. Or. Order] Unit, the surveyor observed a COVID-19 exempted staff member exiting a resident's room wearing a surgical mask and a face shield. During an interview at that time, the temporary nurse aide (TNA) stated that he provided personal care (bathed, dressed, toileted) to the residents, assisted with meal tray pass, and fed the residents if needed. The TNA stated that the required personal protective equipment (PPE, equipment designed to protect the wearer's body from injury or infection) in the facility was a face shield, an N95 respirator mask (a filtering facepiece respirator that filters at least 95% of airborne particles), and a surgical mask. The TNA acknowledged that he was only wearing a surgical mask and stated that he thought he did not have to wear an N95 respirator mask because there were no COVID-19 residents on the [EX. Order 26] Unit. On 12/13/22 at 12:20 PM, the surveyor	F 888	Prevention (CDC)guidance during a pandemic and ensure staff who were not COVID-19 vaccinated wear proper personal Protective Equipment (PPE) while in the facility performing direct and indirect care. Corrective action taken: The unvaccinated staff member was provided proper PPE on 12/12/22. Immediate education was provided to the TNA regarding PPE required for unvaccinated staff including face shield and NIOSH-approved particulate respirator with N95 filter or higher when performing direct and indirect care. This education was initiated on 12/12/22 by the Infection Preventionist. All residents assigned to the identified TNA have the potential to be affected by (this deficient practice). No further residents were found to be affected by this deficient practice. The Infection Preventionist in-serviced the identified TNA immediately on 12/12/22. An audit was completed on 12/12/22 to ensure all other unvaccinated staff were wearing the appropriate PPE. All other staff were in-serviced starting on 12/12/22 by the Infection Preventionist regarding PPE required for Vaccinated staff and PPE required for Unvaccinated staff. Any staff who fail to comply with the points of the in-service will be further educated and/or progressively disciplined as needed. DON or Designee will monitor staff for appropriate PPE in accordance with	

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F 888	Continued From page 30 interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM) on [EX. Order 26.4] Unit who stated that all staff members are required to have the COVID-19 first dose, second dose, and booster vaccination. The LPN/UM was unable to speak of the vaccination process for exempted staff and stated that she was not made aware of staff vaccination exemptions due to the Health Insurance Portability and Accountability Act (HIPAA) laws. The LPN/UM further stated that the required PPE on [EX. Order 2]r Unit was a face shield or goggles and a surgical mask. On 12/13/22 at 12:57 PM, in the presence of the Director of Nursing (DON) and LNHA, the surveyor interviewed the LPN/Infection Preventionist (LPN/IP), who stated that staff members had received the COVID-19 first dose, second dose, and booster vaccinations and that the exempted staff members had religious or medical exemptions that were approved by the corporate office. The surveyor presented the COVID-19 Vaccine Declination and Exemption Request Form that the TNA had signed on 5/26/22, which the LPN/IP acknowledged. The LPN/IP stated that he was responsible for the vaccination exemption education and that exempted staff wore an N95 respirator mask at all times while in the building. The LPN/IP was made aware that the surveyor observed the TNA who wore a surgical mask and face shield with no N95 mask. The LPN/IP acknowledged that the TNA did not wear the appropriate PPE and that he should have worn an N95 mask and face shield to prevent the transmission and spread of COVID-19 or any respiratory illness. On 12/20/22 at 10:05 AM, during a follow up interview with the surveyors, the LPN/IP stated	F 888	vaccination status 5 days a week x 6 weeks, 3 days a week for x 4 weeks, 2 days a week x 2weeks. The information will be brought to QAPI committee monthly for review. After completion of 3 months review of audit results, audits may be discontinued	

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that the LPN/IP, Assistant Director of Nursing (ADON) and the DON were responsible for ensuring the exempted staff wore the required N95 respirator mask while in the building and that it was important to have worn the appropriate PPE to reduce the risk of exposure and spread of infection. The LPN/IP further stated that it was important to keep track of the PPE that each staff member wore to prevent the transmission of COVID-19.

The surveyor reviewed the facility policy, "COVID-19 Health Care Staff Vaccination Policy," updated June 2022, which revealed, "Staff" refers to individuals who provide any care, treatment, or other services for the facility and/or its residents, including employees; licensed practitioners; adult students, trainees, and volunteers ...Additional Precautions and Contingency Plans for Unvaccinated Staff ...While in the facility, unvaccinated or not fully vaccinated staff will wear source control in accordance with CDC guidance ...

The surveyor reviewed the Centers for Disease Control and Prevention (CDC) guidance for "Types of Masks and Respirators," updated September 8, 2022, which revealed, Summary of Recent changes: Clarified that "surgical N95s" are a specific type of respirator that should be prioritized for healthcare settings ...Masks and respirators (i.e., specialized filtering masks such as "N95s") can provide different levels of protection ...well-fitting NIOSH-approved respirators (including N95s) offer the highest level of protection ...What to know about NIOSH-approved respirators: When worn consistently and properly, they provide the highest level of protection from particles,

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F 888	Continued From page 32 including the virus that causes COVID-19. Additionally, they contain your respiratory droplets and particles so you do not expose others. NJAC 8:39-5.1(a)	F 888		

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S 000	Initial Comments The facility is not in compliance with the Standards in the New Jersey Administrative Code, Chapter 8:39, Standards for Licensure of Long Term Care Facilities. The facility must submit a plan of correction, including a completion date, for each deficiency and ensure that the plan is implemented. Failure to correct deficiencies may result in enforcement action in accordance with the Provisions of the New Jersey Administrative Code, Title 8, Chapter 43E, Enforcement of Licensure Regulations.	S 000		
S 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on interview and review of other facility documents, it was determined that the facility failed to maintain the required minimum direct care staff-to-resident ratios for the day shift as mandated by the State of New Jersey. This was evident for fourteen (14) of 14 day shifts as follows: Findings include: Reference: New Jersey Department of Health (NJDOH) memo, dated 01/28/2021, "Compliance with N.J.S.A. (New Jersey Statutes Annotated) 30:13-18, new minimum staffing requirements for nursing homes," indicated the New Jersey Governor signed into law P.L. 2020 c 112, codified at N.J.S.A. 30:13-18 (the Act), which	S 560	No Residents were identified in 2567 SOD to be affect by this defiant practice. All Residents of the facility have the potential to be affected. Director of Nursing, Staffing Coordinator and Administrator will meet daily during the week to review recruitment efforts, staffing for next day, and staffing for upcoming week. Director of Nursing, Staffing Coordinator and Administrator will review projected staffing trends to accurately identify any potential shifts that will not met minimum staffing requirements. Bonus will be offered to existing staff and all contracted agencies	1/19/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/10/23

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	061518	A. BUILDING: ______ B. WING ______	12/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW SPRINGS REHABILITATION AND HEALTHCA	1049 BURNT TAVERN ROAD BRICK, NJ 08724

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S 560	Continued From page 1 established minimum staffing requirements in nursing homes. The following ratio(s) were effective on 02/01/2021: One (1) Certified Nurse Aide (CNA) to every eight (8) residents for the day shift. One (1) direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be CNAs, and each direct staff member shall be signed in to work as a CNA and shall perform nurse aide duties: and One (1) direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a CNA and perform CNA duties. As per the "Nurse Staffing Report" completed by the facility for the weeks of 11/20/2022 through 11/26/2022 and 11/27/2022 through 12/03/2022, the staffing-to-resident ratio that did not meet the minimum requirement of one CNA to eight residents for the day shift is documented below: -11/20/22 had thirteen (13) CNAs for 142 residents on the day shift, required 18 CNAs. -11/21/22 had eleven (11) CNAs for 140 residents on the day shift, required 17 CNAs. -11/22/22 had fourteen (14) CNAs for 139 residents on the day shift, required 17 CNAs. -11/23/22 had fourteen (14) CNAs for 139 residents on the day shift, required 17 CNAs. -11/24/22 had thirteen (13) CNAs for 139 residents on the day shift, required 17 CNAs.	S 560	will be contacted in an effort to fill the shifts . The facility has developed a Culture Committee focused on recruitment. and retention of staff along with customer service and the employee experience. The facility has implemented the Care Champion Program to mentor new employees which has been proven to raise retention rates. The facility participates in an interdisciplinary Quality Care Resource call to review open positions, recruitment tactics, and changes to improve outcomes. Contract staff utilization is reviewed bi- weekly to identify trends and opportunities. The facility has contracts in place with multiple staffing agencies as an effort to provide additional staff when needed. The facility has implemented a multifaceted approach for recruitment and retention of employees, Job fairs, Flexible scheduling, Increased utilization of PRN staff, Implementation of OnShift, Multimedia advertisements, Partnership with schools, Sign on bonuses, Referral bonuses, Pick-up shift bonuses, Boomerang campaign to rehire staff that have resigned, Rate adjustments, Benefit adjustments, Contract staff utilization, Text message campaigns. The administrator/designee will review the minutes from resident council to determine whether any concerns regarding care and services are identified monthly for two months and then quarterly. The results of Resident Council minutes as well as recruitment data will be reviewed by the Administrator or designee at the quarterly QAPI meeting.	

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S 560	Continued From page 2	S 560		

-11/25/22 had eleven (11) CNAs for 139 residents on the day shift, required 17 CNAs.

-11/26/22 had ten (10) CNAs for 139 residents on the day shift, required 17 CNAs.

-11/27/22 had eleven (11) CNAs for 139 residents on the day shift, required 17 CNAs.

-11/28/22 had eleven (11) CNAs for 139 residents on the day shift, required 17 CNAs.

-11/29/22 had eleven (11) CNAs for 139 residents on the day shift, required 17 CNAs.

-11/30/22 had eleven (11) CNAs for 141 residents on the day shift, required 18 CNAs.

-12/01/22 had fourteen (14) CNAs for 141 residents on the day shift, required 18 CNAs.

-12/02/22 had thirteen (13) CNAs for 141 residents on the day shift, required 18 CNAs.

-12/03/22 had thirteen (13) CNAs for 142 residents on the day shift, required 18 CNAs.

On 12/06/22 at 10:48 AM, the Team Coordinator (TC) conducted the entrance conference with the Director of Nursing (DON) and the License Nursing Home Administrator (LNHA). During the entrance conference, the DON stated the facility used agency staffing. The LNHA concluded he felt they had adequate staffing to provide care to the residents.

NJAC 8:39-5.1(a)

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S 720	Continued From page 3	S 720		
S 720	8:39-7.3(d) Mandatory Resident Activities (d) Resident activities shall be scheduled for seven days each week, and during at least two evenings per week. Religious services shall be considered resident activities for purposes of complying with this requirement. This REQUIREMENT is not met as evidenced by: Based on interview and review of pertinent facility documentation it was determined the facility failed to provide residents with activities seven (7) days per week. This deficient practice was identified for two (2) of three (3) months reviewed for activities, November 2022 and December 2022 and was evidenced by the following: On 12/12/22 at 10:56 AM, the surveyor held a Resident Council meeting with five (5) residents from the facility, Resident #3, #4, #56, #70, and #83. During the meeting, all five (5) of the residents told the surveyor that the facility did not have any activities on the weekend. The surveyor asked if the facility offered evening activities and the residents told the surveyor that bingo was offered in the evening. On 12/12/22 at 01:00 PM, the surveyor reviewed the November activity calendar. On November 6, 2022 and November 20, 2022, both Sundays, the calendar said, "No group activities available for this date". Review of the December 2022 calendar showed that on December 10, 2022 and December 14, 2022, both Saturdays showed the same, "No group activities available for this date". Further review of December showed there were no group activities for December 4th, 11th, 18th, and 25th of 2022, which were all Sundays.	S 720	1. Daily and weekly staffing meeting will occur with Administrator, Activities Director, and Human Resources A review for the past 90 days was completed to accurately establish staffing patterns and barriers. 2. All Residents have the potential to be affected. 3. The Activities Director and supporting staff have been educated on expectations for their department, including activities seven days a week. Upcoming schedule planning meeting have been established to ensure activities seven days a week. Memory Care Director was hired for additional support on Applewood. 4. The Admin or designee will interview 5 Residents a week X 4 weeks then monthly x4 months and to review if activities were held daily preferences have been provided. The results will be reported to the monthly QAPI committee and determine if continuation of audits is required based on the results of the	1/19/23

New Jersey Department of Health

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S 720	Continued From page 4 On 12/13/22 at 11:45 AM, the surveyor interviewed the Activity Director (AD) regarding weekend activities for the residents. The AD told the surveyor that the calendar was completed by the memory care coordinator and herself. The AD stated they have had recent struggles hiring activity aides, but the schedule should change soon. On 12/13/22 at 12:00 PM, the surveyor reviewed the policy titled, "Activities Program", an undated policy. Under the section Policy Interpretation and Implementation, number six stated that activities are scheduled seven (7) days a week and residents are given an opportunity to contribute to the planning, preparation, conducting, clean-up, and critique of the programs. NJAC 8:39-7.3 (d)	S 720	audits. The Admin or designee will review staffing patterns weekly. The results will be reported to the monthly QAPI committee and determine if continuation of audits is required based on the results of the audits. Admin or designee will review weekly if activities calendar accurately reflect the activities provided . The results will be reported to the monthly QAPI committee and determine if continuation of audits is required based on the results of the audits	