STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315298	A. BUILDING _____ B. WING _____	07/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRESTWOOD MANOR	50 LACEY ROAD WHITING, NJ 08759

(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 A COVID-19 Focused Infection Control Survey was conducted at this facility. The facility was found to be not in compliance with 42 CFR §483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Survey date: 07/09/2020 Census: 46	F 000		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880		7/31/20

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

Electronically Signed | 07/28/2020

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F 880	Continued From page 1 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review.	F 880		

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F 880	Continued From page 2 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 observations, staff interviews, and review of pertinent documentation, it was determined that facility staff failed to perform hand hygiene between resident rooms during the meal tray delivery. These failures occurred during a COVID-19 pandemic. This deficient practice was evidenced by the following: During a continuous observation of Nurse Aide (NA) #1 on 07/09/2020 at 12:28 PM, the NA assisted a resident with setting up a meal tray in Room [redacted], including adjusting the bedside table. NA #1 left the room without washing her hands or using hand sanitizer. NA #1 then went to the meal cart, retrieved a meal tray for the resident in Room [redacted] and sat the meal tray on the bedside table, unopened. NA #1 left the room, retrieved a meal tray for the Resident in Room [redacted] and sat the tray on the bedside table for the resident. NA #1 positioned the table, opened all of the resident's food and utensils and left the room. NA #1 was called to another room and used a sanitizer wipe at that time. On 07/09/2020 at 12:43 PM, an interview was conducted with NA #1 who stated she was supposed to wash her hands before and after leaving a resident's room and she did not use hand sanitizer while passing the resident trays. NA #1 stated she had no answer for why she did not sanitizer her hands. On 07/09/2020 at 12:53 PM, an interview was	F 880	1. How the corrective action will be accomplished for those residents affected by the deficient practice. No residents were affected by the deficient practice. Resident [redacted] was tested for COVID- 19 on [redacted] and [redacted] with negative results. This resident did not have any other signs or symptoms of a communicable disease or infection. Resident 132#2 was admitted to the hospital on [redacted] with a diagnosis of [redacted] and resident did not have any other signs or symptoms of communicable disease or infection. Resident [redacted] was tested for COVID-19 on [redacted] with negative results and was discharged to an [redacted] on [redacted] and did not have any signs or symptoms of a communicable disease or infection. Resident [redacted] expired on [redacted] the primary cause of death was [redacted] This resident did not have any signs or symptoms of a communicable disease or infection. In summary, the deficient practice did not result in any adverse affect such as communicable disease or infection. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents have the potential to be	

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F 880	Continued From page 3 conducted with the Director of Nursing (DON). The DON stated she would expect staff to wash their hands if they were dirty or before and after resident care, but she would not expect staff to sanitize their hands when passing trays between residents that were not on isolation. On 07/09/2020 at 2:43 PM, an interview was conducted with the Administrator, who stated she did not have expectations of staff to wash their hands between setting up meal trays between residents. A review of the facility's "Handwashing/Hand Hygiene" policy, revised on 07/18/2018, specified to use an alcohol-based hand rub, or alternatively, soap and water for the following situations: After contact with objects...in the immediate vicinity of the resident; Before and after eating or handling food; Before and after assisting a resident with meals. NJAC: 8-39:13.1 (c)	F 880	affected by the deficient practice. 3. Measures or systemic changes to ensure that the deficient practice will not recur. In-servicing was conducted to all staff, with regard to the hand washing policy. Random weekly staff observations of adherence to the hand washing policy will occur. 4. Monitoring the continued effectiveness of the systemic change. The DON or designee will conduct random weekly staff observations of adherence to the hand washing policy. The DON or designee will keep a log of all random observations. The DON or designee will submit a monthly report to be reviewed by the Administrator at the QAPI meeting monthly for 6 months. 5.Each deficiency is assigned only one completion date. The compliance date for this POC is July 31, 2020.	