STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315333	A. BUILDING ______ B. WING ______	07/06/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COMPLETE CARE AT ARBORS	1750 ROUTE 37 WEST TOMS RIVER, NJ 08757

(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 out of compliance with 42 CFR §483.80 infection control regulations and had not implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Survey date: 07/07/2020 Census: 59	F 000		
F 880 SS=F	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	F 880		9/24/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 07/17/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 880	Continued From page 2 by: Based on staff interviews and record review, it was determined that the facility failed to adequately monitor residents, staff and visitors for signs and symptoms of COVID-19. This affected 59 of 59 residents in the facility during the COVID-19 pandemic. This deficient practice was evidenced by the following: A review of the Centers for Disease Control's (CDC) guidelines titled, "Preparing for COVID-19 in Nursing Homes," last updated 06/25/2020, indicated, "Actively monitor all residents upon admission and at least daily for fever (T (temperature) [greater than/equal to] 100.0 (degrees) [Fahrenheit]) and symptoms consistent with COVID-19. Ideally, include an assessment of oxygen saturation via pulse oximetry." According to the CDC, symptoms of COVID-19 include fever or chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, and diarrhea. On 07/06/2020 at 9:45 AM, an interview was completed with the Administrator. The Administrator said the receptionist checked temperatures of staff as they came to work. The receptionist came to work about 7:45 AM, but the day shift started at 7:00 AM, and a few of the kitchen staff came in at 5:45 AM. If the receptionist wasn't in, staff would go to a nurse to get a temperature check, "then come back up, usually at their first break, and fill out the kiosk." The kiosk was a tablet set up to answer screening questions about symptoms.	F 880	Residents affected by deficient practice: All residents were affected by staff being screened by a nurse on the unit for temperature upon coming to work then completing the screening questions at the kiosk during hours that receptionist was not working. All residents were affected by not having a covid-19 screening in addition to having vital signs taken at each shift. Identifying other Residents who could be affected by the deficient practice: All residents Measures or systemic changes to ensure that the deficiencies will not recur: All Receptionist and staff have been re-educated on the screening process. All staff regardless of the time of entering the facility will go directly to the reception area to take their temperature and complete the kiosk for screening. A thermometer was chained to the kiosk to be available to all staff. Nursing department initiated a COVID screening process to be completed for residents every shift. All nursing staff was immediately educated on the new screening process. Monitoring the continued effectiveness of the systemic change: The Director of Nursing and department heads completed re-education of all staff regarding review of Screening Process.	

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F 880	Continued From page 3 On 07/06/2020 at 12:10 PM, an interview was completed with Nursing Assistant (NA) #1. NA #1 said, "They take our temperature when we come in. If no one is up front, we will get the nurse to take it. There is a kiosk up front we fill out. If no one is there, we would go get our temperature checked then go right back to the kiosk or wait until our break (to fill out the symptoms questionnaire at the kiosk)." An interview was completed with Nurse #1 on 07/06/2020 at 12:30 PM. Nurse #1 said when staff arrive, they get a temperature check. If no one was at the reception desk, they would find the nursing supervisor, get a temperature check, then return to the kiosk to answer screening questions. She also reported that residents were being screened with vital signs taken every shift; but were not asked about symptoms. "We don't do any questions for the residents. They don't go anywhere to be exposed." On 07/06/2020 at 12:45 PM, an interview was completed with the Director of Nursing (DON). The DON reported that for screening residents, vital signs were being completed each shift. She acknowledged that there were no screening questions as part of the resident screening. For staff screening, the DON said, "If the receptionist isn't here, they (staff) would go get temped (temperature check) by a nurse, then go back and fill out the kiosk." She said staff may wait until they have a break, after the shift starts, to go back to answer screening questions at the kiosk. NJAC: 8:39-13.1 (c)	F 880	Educated was provided to all staff for proper screening of visitors and employees. Education was provided to the nursing staff for proper screening of residents. The Director of Nursing or designee will complete an audit of All Screening Processes for residents, visitors, and employees 3 times weekly x 4 weeks then monthly x 3 months. Results of audit will be reviewed at the Monthly Quality Assurance Meeting and Quarterly over the duration of the audit process. Root cause analysis Initially the infrared thermometer was removed from the front kiosk site when the receptionist left for the day. This caused the staff who arrived off hours to proceed to the entrance of the Rosewood unit and ring for a nurse to take their temperatures then proceeded to the kiosk to record their information. Staff education using the Keep Covid-19 out with a test has been implement for all staff LTC infection control self-assessment was completed by Director of Nursing The Infection Prevention and Intervention Plan has been implemented which addresses CDC guidelines for preparing for Covid-19 for Nursing Homes	
F 885 SS=F	Reporting-Residents,Representatives&Families CFR(s): 483.80(g)(3)(i)-(iii)	F 885		7/17/20

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F 885	Continued From page 4 §483.80(g) COVID-19 reporting. The facility must— §483.80(g)(3) Inform residents, their representatives, and families of those residing in facilities by 5 p.m. the next calendar day following the occurrence of either a single confirmed infection of COVID-19, or three or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other. This information must— (i) Not include personally identifiable information; (ii) Include information on mitigating actions implemented to prevent or reduce the risk of transmission, including if normal operations of the facility will be altered; and (iii) Include any cumulative updates for residents, their representatives, and families at least weekly or by 5 p.m. the next calendar day following the subsequent occurrence of either: each time a confirmed infection of COVID-19 is identified, or whenever three or more residents or staff with new onset of respiratory symptoms occur within 72 hours of each other. This REQUIREMENT is not met as evidenced by: Based on staff and resident interviews, it was determined that the facility failed to develop a process for notifying residents, their representatives and families by 5 PM the next calendar day each time a confirmed COVID-19 test result was identified, or whenever three or more residents or staff with new onset of respiratory symptoms occur within 72 hours of each other. There were no weekly cumulative updates on COVID-19 cases being issued to residents or families. The deficiency occurred during the COVID-19 pandemic.	F 885	Residents affected by deficient practice: Residents #1 was affected by the deficient practice. Identifying other Residents who could be affected by the deficient practice: All alert and oriented not listed as their own responsible party have the potential to be affected. Measures or systemic changes to ensure	

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F 885

Continued From page 5

This deficient practice was evidenced by the following:

On 07/06/2020 at 9:45 AM, an interview was completed with the Administrator. The Administrator said that notifications of new COVID-19 positive cases or staff or residents with new COVID-19 symptoms were given to all residents except those who have identified a "primary contact." She confirmed that the notification may not be given to an alert and oriented resident if they have someone marked as a primary contact.

A follow up interview was completed with the Administrator on 07/06/2020 at 1:00 PM. The Administrator said that notification letters go "to whoever is listed as the Responsible Party." She confirmed that an oriented resident may not get the letter. The Administrator also said there was a posting placed on the reception desk that was updated daily to reflect the current status of COVID-19 cases, recoveries and tests, but there was no weekly update that was given to residents or families if there were no increases in cases or symptoms.

On 07/06/2020 at 1:10 PM, an interview was completed with Resident #1. Resident #1 reported she was not informed of COVID-19 updates; that her son would be notified.

During an interview on 07/06/2020 at 1:20 PM, the Administrator verified that any COVID-19 notification announcements would be sent to Resident #1's family member, but not to Resident #1.

NJAC: 8:39-13.1 (c)

F 885

that the deficiencies will not recur:
Resident #1 was provided with weekly written update.
All residents able to receive notification regarding Covid-19 updates were immediately provided most recent updated and will receive written covid-19 updates in accordance with reporting time of a new occurrence or suspected cases. Residents will also receive weekly written notification when there are no covid-19 related changes.

Monitoring the continued effectiveness of the systemic change:
The Activities Director and department heads completed re-education on proper weekly notification of residents on Covid-19 cases. The notification process will be audited by Activities Director or designee weekly x 4 weeks then monthly x 3 months. Results of audit will be reviewed at the Monthly Quality Assurance Meeting and Quarterly over the duration of the audit process.