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
	90115	A. BUILDING: ______ B. WING ______	C 11/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE MANOR	7 LAUREL AVENUE KEANSBURG, NJ 07734

(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) COMPLETE DATE
A 000	Initial Comments Initial Comments: TYPE OF SURVEY: COVID-19 and Complaint survey COMPLAINT #: NJ 00149798 Survey dates: 11/4, 11/5 Census: 119 11/15 and 11/16/21 ensure implementation of removal plan Census: 113 SAMPLE SIZE: 11 A Covid-19 Focused Infection Control Survey was conducted by the State Agency on 11/4, 11/5. On 11/15 and 11/16/21, the survey was continued to ensure implementation of the facility's removal plan. The facility was found not to be in compliance with the New Jersey Administrative Code 8:36 infection control regulations standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. The facility is not in substantial compliance with all of the standards in the New Jersey Administrative Code 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs. 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	A 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 02/07/22

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A 000	Continued From page 1 accordance with provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations.	A 000		
A 312	8:36-3.4(a)(3) Administration (a) The administrator or designee shall be responsible for, but not limited to, the following: 3. Ensuring that all personnel are assigned duties based upon their ability and competency to perform the job and in accordance with written job descriptions; This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility administrator failed to ensure that non-certified staff received adequate training and achieved and maintained competency in accordance with their responsibilities required in their job descriptions to safely feed residents who received Executive Order 26, 4.b. due to Executive Order 26 Executive Order 26, 4.b. for Exe of Execu residents reviewed for feeding, Resident Executi and Execu. It was determined the facility's non-compliance had the potential to cause serious injury, harm, impairment, or death to all residents. This deficient practice was evidenced by the following: 1. On 11/4/21 at 1:25 p.m., during tour of the facility, Housekeeper #2 explained to Surveyor	A 312		

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A 312	Continued From page 2 #2 that although she had fed residents she had not received training on how to safely feed residents who received therapeutic diets due to swallowing difficulty and/or needed assistance with eating. On 11/4/21 at 1:55 p.m., Surveyor #1 interviewed an unsampled Certified Nurse Aide (CNA) who stated that CNA's, Dietary Aides, and Housekeeping staff had always helped with serving meals and had fed residents since more residents were eating meals in their rooms. The CNA was not aware of any training for feeding of residents who were on therapeutic diets or required assistance to eat. The job descriptions of CNA's, Dietary Aides and Housekeepers did not include providing assistance to residents with eating, including those residents on therapeutic diets with swallowing difficulties. 2. On 11/5/21 at 9:30 a.m., a Nurse Aide (NA) informed Surveyor #1 that the Dietary Aide (DA) #1 had fed residents who required assistance with breakfast and that she would feed the residents lunch. At 9:35 a.m., DA #1 confirmed with Surveyor #1 and Surveyor #2 during interview, that she had fed Resident [redacted] and Resident [redacted] breakfast. DA #1 continued to tell the surveyors that she had not received any training on how to safely feed residents who had therapeutic diets due to swallowing difficulties and required feeding assistance. 3. On 11/5/21 at 10:30 a.m., Surveyor #1 and Surveyor #2 performed medical record reviews of Resident [redacted] and Resident [redacted] a. Review of Resident [redacted] medical record indicated that Resident [redacted] was admitted to the	A 312		

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A 312	Continued From page 3 facility on Executive Order with diagnoses which included Executive Order 26, 4.b.. According to Resident Executive Order 26, 4.b.'s Executive Order 26, 4.b. Plan" Executive Order dated Executive Order, Resident Executive Order was Executive Order 26, 4.b.. Further review of Resident Executive Order GSP revealed under the title "Diet:" that Resident Executive Order was on a Executive Order and Executive Order 26, 4.b. In addition, Resident Executive Order had to be fed all meals and was on Executive Order 26, 4.b. (Executive Order 26, 4.b.) and Executive Order 26, 4.b. Executive Order 26, 4.b. Executive Order 26, 4.b.) precautions. On page two of Executive Order 26, 4.b. Executive Order 26, 4.b. with Executive Order 26, 4.b. the surveyor identified a comment that Resident Executive Order had to be fed with caution. b. Review of Resident Executive Order's medical record indicated that Resident Executive Order was admitted to the facility on Executive Order with diagnoses which included Executive Order 26, 4.b.. According to Resident Executive Order's Executive Order 26, 4.b. Assessment note dated Executive Order, Resident Executive Order was Executive Order 26, 4.b.. Surveyor review of Resident Executive Order's GSP dated Executive Order indicated that Resident Executive Order required a Executive Order 26, 4.b. with Executive Order 26, 4.b. and required monitoring for Executive Order 26, 4.b. On 11/5/21 at 11:30 a.m., the surveyors interviewed the Registered Nurse (RN) regarding training of non-certified staff who had been feeding residents. The RN informed the surveyors that she was not aware of any training provided to Dietary Aides or Housekeeping staff on how to feed residents on Executive Order 26, 4.b. Executive Order 26, 4.b. precautions. This task was not included in the job description of the Dietary Aides or the Housekeeping staff. On 11/5/21 at 11:40 a.m., the Director of Nursing	A 312		

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A 312	Continued From page 4	A 312		

(DON) informed the surveyors that Housekeeping staff and other non-certified staff helped pass meal trays when needed. Further, the DON explained that the Dietary Aides were trained on diets and feeding by the RN and the DON. The surveyors asked the DON for documentation of this training and the DON stated that the training had been provided verbally and there was no documented evidence of such training.

The "Essential Job Responsibilities" of the Housekeeping Employees included:
"9. help with serving residents meals when needed." The job description for the Dietary Aide included, "Serve resident's meals in a timely manner and reset tables for next meal.": The job descriptions did not include feeding residents their meals including those residents receiving a therapeutic diet due to swallowing difficulty and monitoring for aspiration.

On 11/5/21 at 11:45 a.m., the surveyors interviewed the Executive Director (ED) regarding non-trained and uncertified staff providing feeding assistance to residents who required therapeutic diets and required monitoring for aspiration. The ED explained to the surveyors that the DA was dedicated to the unit and that the NAs were trained on feeding residents but there was no documentation of such training.

On 11/5/21 at 12 noon, the surveyors requested a removal plan from the Executive Director for the deficient practice of allowing untrained, non-certified staff to provide feeding assistance to residents who were on therapeutic diets and required monitoring for aspiration precautions.

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A 312	Continued From page 5 The ED provided the surveyors with an acceptable removal plan at 1:00 p.m. in which the facility immediately discontinued the use of all non certified staff from assisting residents with feeding until they were trained. On 11/15/21 at 10:45 a.m., Surveyor #1 and Surveyor #2 returned to the facility to conduct a revisit to ensure the removal plan was implemented. During interview, the ED and the RN reported that staff were trained on 11/11/21 by a licensed Speech Therapist and provided the surveyors with documentation to support that non certified staff had received the proper training to feed residents receiving therapeutic diets. On 11/15/21 at 11:30 a.m., the surveyors found that the removal plan had been successfully implemented.	A 312		
A1297	8:36-18.3(a)(4) Infection Prevention and Control Services (a) Written policies and procedures shall be established and implemented regarding infection prevention and control, including, but not limited to, policies and procedures for the following: 4. Surveillance techniques to minimize sources and transmission of infection; This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of pertinent facility documents on 11/4, 11/5, 11/15 and 11/16/21 it was determined that the facility	A1297		

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A1297	Continued From page 6 failed to implement its "Outbreak Response Plan" mitigation strategies to prevent the spread of COVID-19 in accordance with Centers for Disease Control's (CDC) guidelines by failing to follow infection control practices during COVID-19 outbreak that began on Executive Order 26 and continued throughout the survey. At the time of the survey on Executive Order 26, 4.b., Execu residents Executive Order 26, 4.b., 17 staff members tested positive, Exe residents Executive Order 26, 4.b.. At the time of the Executive Order 26, 4.b. survey, Exe more residents had Executive Order 26, 4.b. for a total of Execu residents 3 more staff members tested positive for a total of 20 staff members and Exe more residents Executive Order 26, 4.b. Executive Order 26, 4.b. experiencing a total of Executive Order 26, 4.b. Executive Order . It was determined the facility's failure to implement the strategies defined in the "Outbreak Response Plan" to prevent the spread of COVID 19 had the potential to cause serious injury, harm, impairment, or death to all residents. The deficient practice was evidenced by the following: Surveyor review of the facility policy and procedure titled, "Outbreak Response Plan" revealed: "An annual risk assessment is conducted as part of the infection control program to identify, track, trend, and implement prevention techniques to prevent and mitigate disease outbreaks. The Infection Control Preventionist (ICP) conducts ongoing surveillance for Healthcare Associated	A1297		

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A1297	Continued From page 7	A1297		

Infections (HAIs) and other epidemiologically significant infections that have substantial impact on potential resident outcomes and that may require transmission-based precautions and other preventative interventions."
The Outbreak Response Plan concluded by stating:
"Bayside contracted with an Infection Preventionist Consultant to assist the facility to review the infection control program and assist with outbreak prevention and management."
Though the first cases of COVID 19 were identified on Executive Order 26, 4.b., the ICP was not a part of the infection control mitigation until Executive Order 26, 4.b. after Execu residents and 17 staff had Executive Order 26, 4.b. with Executive Order 26, 4 Executive Order 26, 4.b..

Surveyor review of the ICP contract dated 12/15/2020 indicated, "Onsite assistance during NJDOHS surveys including COVID-19 surveys as requested and ongoing regulatory compliance." In addition, "... Consultant services will be provided onsite pursuant to a mutually agreed upon schedule."

On 11/4/21 at 10 a.m., the surveyor interviewed the Director of Nursing (DON)/ a Licensed Practical Nurse (LPN), the Executive Director/Owner #1, (ED/Owner #1) and the facility's Registered Nurse (RN) and inquired if there was a COVID-19 outbreak at the facility. The DON responded that the facility was experiencing a COVID-19 outbreak that began with one employee on 10/7/2021. The DON explained that the employee notified the facility on 10/7/21 and stated that she was not feeling well and had tested positive for COVID-19 after the employee performed a "Rapid test" at home.

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A1297	Continued From page 8 The DON told the surveyor that the facility began testing all residents and staff members for COVID-19 immediately. On 1 Executive Order 26, 4.b. facility testing revealed Execu residents and 15 staff members Executive Order 26, 4.b. The surveyor then requested the facility's line listing and the outbreak response plan policy. During the continued interview, the surveyor asked the DON (LPN) who was responsible for the infection control program at the facility. The DON stated that she assisted the facility's RN to provide in-services to staff which included infection control. The surveyor inquired if the facility had an Infection Control Preventionist (ICP) and if the ICP was available for interview. The ED/Owner #1 stated that the facility had entered into a contract with an ICP consultant on Executive Order 26, 4.b. ED/Owner #1 reported that the consultant last visited the facility "months ago" [could not recall month/date]. The ED/Owner #1 stated that the ICP was consulted as needed and was mostly available by telephone for guidance. In addition, the ED/Owner #1 confirmed that the ICP consultant had not visited the facility since the outbreak that began on Executive Order 26. The contracted ICP was not called to provide infection control services until 11/1/2021. On 11/4/2021 at the start of the survey, there were Execu residents and 17 staff members who Executive Order 26, 4.b. and Executive Order 26, 4 Executive Order 26, 4.b. The surveyor requested the ICP contract with the facility for review. At 3:20 p.m., the surveyor interviewed the ICP consultant by telephone regarding the COVID-19 outbreak at the facility. The ICP informed the surveyor that she received a telephone call from the facility on Executive Order 26 regarding the outbreak and	A1297		

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A1297	Continued From page 9 that she provided the DON and her staff "remote guidance." In addition, the ICP stated that she provided the facility education and reviewed infection control practices which included contact tracing, cohorting residents/staff to affected units, personal protective equipment (PPE) requirements, PPE supplies, visitations, food services, dining and activities on the affected units. The DON told the surveyor that the staff had been provided this education verbally but there was no documented evidence to substantiate that in-service education had been provided to the staff on 11/1/2021. The DON did provide documented evidence of an in service provided on donning and doffing PPE and handwashing which was provided on 10/28/2021, prior to the telephone meeting with the ICP. On 11/15/21 at 3:25 p.m., the surveyor conducted a second interview with the ICP consultant by telephone regarding criteria for determining when on site visitation by the ICP consultant would be indicated. The ICP stated that she spoke with the facility on 11/4/21 at the start of the survey and provided guidance on continued cohorting, screening, testing, use of PPE/adequate PPE supply, no communal dinning, visitations and proper contact tracing/form. The ICP stated that she provided more remote assistance than on site visitation due to high risk exposure. She added that there was no criteria as to when an on site visit was indicated and that it was left up to the facility's discretion to request an on site visit(s). On 11/15/2021 at 9:30 a.m., the RN informed the surveyor that there were Executive Order 26 residents, 2 more staff and Executive Order 26, 4.b. in the facility related to Executive Order 26, 4.b. for a total of Executi residents, 19 staff members and Executi deaths Executive Order 26, 4.b. since the survey	A1297		

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A1297	Continued From page 10 began on Executive Order 26, 4.b. The facility was unable to provide documented evidence that they had provided contact tracing to identify and limit exposure to the virus in accordance with the ICP information obtained on 11/1/2021. The surveyor asked the RN if the facility knew how the three additional residents contracted COVID and if contact tracing was completed. The RN stated that the facility contacted Resident Execut Responsible Party (RP) on 11/10/21 to notify him/her that the resident was Executive Order 26, 4.b. Executive Order 26, 4.b. The RN told the surveyor that the RP informed the facility that Executive Order 26, 4.b. had Executive Order 2 and had visited the resident last week Executive Order 26, 4. The RN stated that neither she nor the DON performed contact tracing. The DON was not available for interview and was on vacation. The facility had no documented evidence requiring visitors to report to the facility if they were exposed to or contracted At 10:15 a.m., the surveyor interviewed the ED/Owner #1 who stated that he had a telephone meeting with the ICP consultant, the DON and RN on 11/4/21. He stated that they discussed ways to keep the outbreak under control and that the facility followed the ICP recommendations and that the ICP consultant had not been scheduled to be onsite. At 12:30 p.m., the surveyor requested a removal plan from the ED/Owner #1 for the failing to implement contact tracing to identify and minimize exposure to COVID-19, failing to require visitors to report exposure or illness from COVID-19 to the facility, failing to utilize consultant ICP services in a timely manner during an outbreak in an attempt to decrease the spread	A1297		

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A1297	Continued From page 11 of COVID-19. ED/Owner #1 provided the surveyors with an acceptable removal plan at 2:30 p.m., in which the facility immediately contacted the ICP consultant for an onsite visits scheduled on 11/17/21 and 11/22/21. This request for ICP on site visit was made after Execu residents, 20 staff and Execu residents Executive Order 26 during this Executive Order 26, 4.b. On 11/22/21 at 9:15 a.m., post survey, the surveyor interviewed the DON regarding contact tracing and notification to the facility by family members/visitors when they test positive for COVID-19. The DON stated that she did not have a set standard for performing contact tracing and that she quarantined residents if a staff member or a resident tested positive in assigned the area. Further, she stated that there was no guideline on family/visitors notification to facility and that if there was, it would be stated on the visitor's screening form. The DON reviewed the "... COVID-19 Self Screening Form" over the phone and confirmed that the form did not include notifying the facility if a visitor was exposed or tested positive for COVID-19. The facility failed to consult with the ICP when an outbreak was first identified on 10/7/2021, failed to provide documented evidence that contact tracing was conducted and failed to provide the surveyor a policy on visitor notification to the facility when the visitor was positive for COVID-19. The facility failed to maintain documented evidence that the information obtained by the ICP on 11/1/2021 was provided and implemented to facility staff in an effort to control the outbreak.	A1297		

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
90115 (Y1)	A. Building B. Wing (Y2)	3/17/2022 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BAYSIDE MANOR	7 LAUREL AVENUE KEANSBURG, NJ 07734

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A1297 Reg. # 8:36-18.3(a)(4) LSC	Correction Completed 11/30/2021	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
11/16/2021	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix A0312 Reg. # 8:36-3.4(a)(3) LSC	Correction Completed 12/15/2021	ID Prefix A1297 Reg. # 8:36-18.3(a)(4) LSC	Correction Completed 11/30/2021	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 11/16/2021	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			

State of New Jersey
DEPARTMENT OF HEALTH
PO BOX 367
TRENTON, N.J. 08625-0367

www.nj.gov/health

PHILIP D. MURPHY
Governor

SHEILA Y. OLIVER
Lt. Governor

JUDITH M. PERSICHILLI, RN, BSN, MA
Commissioner

December 3, 2021

Mr. Anthony Cappadona, Administrator
Bayside Manor
7 Laurel Avenue
Keansburg, NJ 07734

Dear Mr. Cappadona:

Thank you for your courtesy and cooperation extended during our Complaint/COVID Survey visit to your facility, which was conducted on November 16, 2021.

Your SOD will be e-mailed to you. Please reply to each deficiency on an item-by-item basis in your POC and include the date you expect the correction to be completed. All responses should be numbered to correspond with the numbers on your deficiency statement. Then email the POC back to Opunne Odulana at **HFEL.POCAL@doh.nj.gov** within ten (10) business days from receipt of this letter. **Please do not mail the POC.**

The POC should be a narrative and must include:

1. How the corrective action will be accomplished for those residents found to have been affected by the deficient practice.
2. How the facility will identify other residents having the potential to be affected by the same deficient practice.
3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.
4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes.

Sign and date the first page of the Statement of Deficiencies, and email it back as instructed in paragraph three within ten (10) business days from receipt of this letter.

Please be advised that one or more of the deficiencies cited in the enclosed survey report have been referred to the Office of Program Compliance (OPC) for enforcement. If OPC imposes a penalty, you will be advised at a later date and under separate cover from OPC regarding the type of penalty and your appeal rights.

N.J.A.C. 8:43E-2.3 provides facilities the option to challenge factual survey findings by requesting Informal Dispute Resolution (IDR) with Department representatives. Facilities wishing to challenge only the assessment of penalties are not entitled to IDR review, but may request a formal hearing at the Office of Administrative Law. IDR requests must be made in writing within ten (10) business days from

3. A weekly meeting shall be held between the Director of nursing, Assistant Director of nursing and administrator to review and discuss Infection Control Preventionist recommendations/or guidance for the week.
4. Weekly Meeting between Director of Nursing, Assistant Director of nursing and administrator shall occur to discuss any and all Infection Control Preventists reports.

A1297 Facility failed to provide policy on visitor notification to the facility when the visitor was positive for Covid-19

1. October 7th, 2021 the facility created a policy that all visitors entering the facility shall notify the Administrator, Director of nursing or Assistant Director of nursing if they have had exposure to or tested positive for Covid-19 infection.
2. All visitors and staff entering the facility shall complete a covid-19 screening. The screening process shall include a written notification submitted to all entering the building on reporting exposure to, or illness from covid to the facility
3. All visitors and staff entering the facility shall receive a written notification signature sheet at time of screening process informing them on protocol for reporting any exposure or covid related illness to Administrator , Director of nursing, or Assistant Director of Nursing.
4. All visitors shall sign off on Covid Screening form prior to admission into the facility. All screening forms with written protocol for reporting exposure or illness related to covid-19 will go to the Director of Nursing for review to assure notification is passed on to all visitors daily.

BAYSIDE
MANOR
ASSISTED
LIVING
Welcome to the family, Make yourself at home

A1297 Facility failed to implement contact tracing to identify and minimize exposure to Covid-19

1. On 11/17/21 Facility ADON, and Administrator met with Infection control and reviewed protocol for contact tracing. Contact tracing for all residents, and staff that tested positive for Covid-19 was initiated and completed by November 30th, 2021.
2. Contact tracing shall be conducted by the Director of nursing, and Assistant Director of nursing immediately for all individuals who have tested positive for Covid-19.
3. A contact tracing form has been developed, and will proceed all positive covid reports on all individuals who test positive for Covid-19.
4. A weekly meeting shall be held between the administrator, Nursing Director, and Assistant Director of Nursing to review, discuss, and confirm proper documentation is available for all individuals that tested positive for covid-19.

A1297 Facility failed to consult ICP Services in a timely manner.

1. November 17th, 2021, and November 24, 2021 an onsite meeting between Infection Control Preventionist (ICP), nursing and administration to review covid-positive cases, and improve the facility response to the current Covid-19 Outbreak.
2. Any new positive covid-19 cases shall be immediately reported to the infection Control Preventionist (ICP).The Nursing Director, or Assistant Director shall communicate daily five days per week, through emails or phone conversation with Infection Control preventionist Report shall include a copy of the facilities daily line list.

7 Laurel Avenue
Keansburg, NJ 07734
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Anthony@BaysideManor.com
BaysideManor.com

New Jersey Department of Health

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A 000	Initial Comments Initial Comments: TYPE OF SURVEY: COVID-19 and Complaint survey COMPLAINT #: NJ 001149798 Survey dates: 11/4, 11/5 Census: 119 11/15 and 11/16/21 ensure implementation of removal plan Census: 113 SAMPLE SIZE: 11 A Covid-19 Focused Infection Control Survey was conducted by the State Agency on 11/4, 11/5. On 11/15 and 11/16/21, the survey was continued to ensure implementation of the facility's removal plan. The facility was found not to be in compliance with the New Jersey Administrative Code 8:36 infection control regulations standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. The facility is not in substantial compliance with all of the standards in the New Jersey Administrative Code 8:36, Standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs. 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	A 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE owner (X6) DATE 2/7/2022

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A 000	Continued From page 1 accordance with provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations.	A 000		
A1297	8:36-18.3(a)(4) Infection Prevention and Control Services (a) Written policies and procedures shall be established and implemented regarding infection prevention and control, including, but not limited to, policies and procedures for the following: 4. Surveillance techniques to minimize sources and transmission of infection; This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of pertinent facility documents on 11/4, 11/5, 11/15 and 11/16/21 it was determined that the facility failed to implement its "Outbreak Response Plan" mitigation strategies to prevent the spread of COVID-19 in accordance with Centers for Disease Control's (CDC) guidelines by failing to follow infection control practices during COVID-19 outbreak that began on 10/7/21 and continued throughout the survey. At the time of the survey on [Executive Order 26, 4.b.], [Executive Order 26, 4.b.] residents [Executive Order 26, 4.b.] 17 staff members tested positive, [Executive Order 26, 4.b.] residents [Executive Order 26, 4.b.] At the time of the [Executive Order 26, 4.b.] survey, [Executive Order 26, 4.b.] more residents had [Executive Order 26, 4.b.] for a total of [Executive Order 26, 4.b.] residents 3 more staff members tested positive for a total of 20 staff members and	A1297		

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A1297	Continued From page 2	A1297		

Exec more residents Executive Order 26, 4.b. Execut with the facility experiencing a total of Executive Order 26, 4.b.

It was determined the facility's failure to implement the strategies defined in the "Outbreak Response Plan" to prevent the spread of COVID 19 had the potential to cause serious injury, harm, impairment, or death to all residents.

The deficient practice was evidenced by the following:

Surveyor review of the facility policy and procedure titled, "Outbreak Response Plan" revealed:
"An annual risk assessment is conducted as part of the infection control program to identify, track, trend, and implement prevention techniques to prevent and mitigate disease outbreaks. The Infection Control Preventionist (ICP) conducts ongoing surveillance for Healthcare Associated Infections (HAIs) and other epidemiologically significant infections that have substantial impact on potential resident outcomes and that may require transmission-based precautions and other preventative interventions."
The Outbreak Response Plan concluded by stating:
"Bayside contracted with an Infection Preventionist Consultant to assist the facility to review the infection control program and assist with outbreak prevention and management."
Though the Executive Order 26, 4.b. were identified on 10/7/2021 and 10/8/2021, the ICP was not a part of the infection control mitigation until 11/1/2021 after Executive residents and 17 staff had tested positive for COVID with Exec deaths associated with the outbreak.

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A1297	Continued From page 3	A1297		

Surveyor review of the ICP contract dated 12/15/2020 indicated, "Onsite assistance during NJDOHS surveys including COVID-19 surveys as requested and ongoing regulatory compliance." In addition, "... Consultant services will be provided onsite pursuant to a mutually agreed upon schedule."

On 11/4/21 at 10 a.m., the surveyor interviewed the Director of Nursing (DON)/ a Licensed Practical Nurse (LPN), the Executive Director/Owner #1, (ED/Owner #1) and the facility's Registered Nurse (RN) and inquired if there was a COVID-19 outbreak at the facility. The DON responded that the facility was experiencing a COVID-19 outbreak that began with one employee on 10/7/2021. The DON explained that the employee notified the facility on 10/7/21 and stated that she was not feeling well and had tested positive for COVID-19 after the employee performed a "Rapid test" at home. The DON told the surveyor that the facility began testing all residents and staff members for COVID-19 immediately. On 10/11/2021 facility testing revealed [redacted] residents and 15 staff members tested positive for COVID-19. The surveyor then requested the facility's line listing and the outbreak response plan policy.

During the continued interview, the surveyor asked the DON (LPN) who was responsible for the infection control program at the facility. The DON stated that she assisted the facility's RN to provide in-services to staff which included infection control. The surveyor inquired if the facility had an Infection Control Preventionist (ICP) and if the ICP was available for interview. The ED/Owner #1 stated that the facility had entered into a contract with an ICP consultant on December 15, 2020. ED/Owner #1 reported that

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A1297	Continued From page 4 the consultant last visited the facility "months ago" [could not recall month/date]. The ED/Owner #1 stated that the ICP was consulted as needed and was mostly available by telephone for guidance. In addition, the ED/Owner #1 confirmed that the ICP consultant had not visited the facility since the outbreak that began on 10/7/21. The contracted ICP was not called to provide infection control services until 11/1/2021. On 11/4/2021 at the start of the survey, there were Execut residents and 17 staff members who tested positive and Executiv Executive Order 26, 4.b. The surveyor requested the ICP contract with the facility for review. At 3:20 p.m., the surveyor interviewed the ICP consultant by telephone regarding the COVID-19 outbreak at the facility. The ICP informed the surveyor that she received a telephone call from the facility on 11/1/21 regarding the outbreak and that she provided the DON and her staff "remote guidance." In addition, the ICP stated that she provided the facility education and reviewed infection control practices which included contact tracing, cohorting residents/staff to affected units, personal protective equipment (PPE) requirements, PPE supplies, visitations, food services, dining and activities on the affected units. The DON told the surveyor that the staff had been provided this education verbally but there was no documented evidence to substantiate that in-service education had been provided to the staff on 11/1/2021. The DON did provide documented evidence of an in service provided on donning and doffing PPE and handwashing which was provided on 10/28/2021, prior to the telephone meeting with the ICP. On 11/15/21 at 3:25 p.m., the surveyor conducted a second interview with the ICP consultant by	A1297		

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A1297	Continued From page 5 telephone regarding criteria for determining when on site visitation by the ICP consultant would be indicated. The ICP stated that she spoke with the facility on 11/4/21 at the start of the survey and provided guidance on continued cohorting, screening, testing, use of PPE/adequate PPE supply, no communal dinning, visitations and proper contact tracing/form. The ICP stated that she provided more remote assistance than on site visitation due to high risk exposure. She added that there was no criteria as to when an on site visit was indicated and that it was left up to the facility's discretion to request an on site visit(s). On 11/15/2021 at 9:30 a.m., the RN informed the surveyor that there were 3 more residents, 2 more staff and Executive Order 26, 4.b. in the facility related to COVID-19 for a total of 38 residents, 19 staff members and Executive Order 26, 4.b. associated with COVID-19 since the survey began on 11/4/2021. The facility was unable to provide documented evidence that they had provided contact tracing to identify and limit exposure to the virus in accordance with the ICP information obtained on 11/1/2021. The surveyor asked the RN if the facility knew how the three additional residents contracted COVID and if contact tracing was completed. The RN stated that the facility contacted Resident 9's Responsible Party (RP) on 11/10/21 to notify him/her that the resident was positive for COVID-19. The RN told the surveyor that the RP informed the facility that his/her sibling had COVID and had visited the resident last week [11/4/21]. The RN stated that neither she nor the DON performed contact tracing. The DON was not available for interview and was on vacation. The facility had no documented evidence requiring visitors to report to the facility if they were exposed to or contracted COVID-19.	A1297		

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A1297	Continued From page 6 At 10:15 a.m., the surveyor interviewed the ED/Owner #1 who stated that he had a telephone meeting with the ICP consultant, the DON and RN on 11/4/21. He stated that they discussed ways to keep the outbreak under control and that the facility followed the ICP recommendations and that the ICP consultant had not been scheduled to be onsite. At 12:30 p.m., the surveyor requested a removal plan from the ED/Owner #1 for the failing to implement contact tracing to identify and minimize exposure to COVID-19, failing to require visitors to report exposure or illness from COVID-19 to the facility, failing to utilize consultant ICP services in a timely manner during an outbreak in an attempt to decrease the spread of COVID-19. ED/Owner #1 provided the surveyors with an acceptable removal plan at 2:30 p.m., in which the facility immediately contacted the ICP consultant for an onsite visits scheduled on 11/17/21 and 11/22/21. This request for ICP on site visit was made after 38 residents, 20 staff and Executive Order 26, 4.b. during this COVID-19 outbreak. On 11/22/21 at 9:15 a.m., post survey, the surveyor interviewed the DON regarding contact tracing and notification to the facility by family members/visitors when they test positive for COVID-19. The DON stated that she did not have a set standard for performing contact tracing and that she quarantined residents if a staff member or a resident tested positive in assigned the area. Further, she stated that there was no guideline on family/visitors notification to facility and that if there was, it would be stated on the visitor's screening form. The DON reviewed the "... COVID-19 Self Screening Form" over the	A1297		

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A1297	Continued From page 7 phone and confirmed that the form did not include notifying the facility if a visitor was exposed or tested positive for COVID-19. The facility failed to consult with the ICP when an outbreak was first identified on 10/7/2021, failed to provide documented evidence that contact tracing was conducted and failed to provide the surveyor a policy on visitor notification to the facility when the visitor was positive for COVID-19. The facility failed to maintain documented evidence that the information obtained by the ICP on 11/1/2021 was provided and implemented to facility staff in an effort to control the outbreak.	A1297		