STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315196	A. BUILDING ______ B. WING ______	08/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT MANCHESTER	1770 TOBIAS AVENUE MANCHESTER, 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 Survey Date: 8/24/21 Census: 138 Sample: 7 A COVID-19 Focused Infection Control Survey was conducted by the New Jersey Department of Health. The facility was found to be not in compliance with 42 CFR §483.80 infection control regulations as it relates to the implementation of the CMS and Centers for Disease Control and Prevention (CDC) recommended practices for COVID-19.	F 000		
F 880 SS=E	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	F 880		11/9/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 09/10/2021

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

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F 880	Continued From page 1	F 880		

facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(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.

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F 880	Continued From page 2 Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documents, it was determined that the facility failed to: a) implement transmission-based precautions for all residents in a timely manner for 1 of 3 resident care units Executive Order 26, 4.b. with evidence of known COVID-19 transmission when Executive Order 26, 4.b. Executive Order 26, 4.b. Executive Order 26, 4.b. for source control in accordance with nationally accepted guidelines for infection prevention and control; b) ensure residents were afforded an opportunity to perform hand hygiene upon service of the lunch meal for 1 of 3 resident care units (Executive Order 26, 4.b. c) ensure hand hygiene was performed between three consecutive rounds of COVID-19 testing; d) ensure a Certified Nursing Aide assigned to the COVID-19 positive unit removed personal protective equipment (PPE) in the proper sequence and location to prevent transmission; and, e.) ensure an open garbage bag of used PPE on the COVID-19 positive unit was separated from the clean linen cart. This deficient practice was evidenced by the following: 1. According to the U.S. Centers for Disease Control and Prevention (CDC) of Infection Control for Nursing Homes, updated 3/29/2021	F 880	A: 1. Facility reviewed CDC guidance and communicated with Local Health Department. Will continue to work with Local Health Department for any future outbreak to ensure appropriate cohorting practices. 2. All residents could potentially be at risk. 3. Facility conducted education on cohorting in case of future outbreak. 4. Facility will ensure clarified guidance is followed when completing outbreak checklist should a new outbreak occur. Outbreak checklist would be reviewed in QAPI/Infection Control committee meeting as appropriate when needed to ensure compliance. RCA conducted: Facility misinterpreted the LHD guidance. Completed contact tracing and determined cohorts that were needed, however after round 1 of testing showed more positive cases, facility then placed the whole unit on cohort 2. Moving forward, any future outbreak of one patient, whole unit will be placed on cohort 2. Cohort education completed and an outbreak checklist will be followed.	

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F 880	Continued From page 3 included guidelines for how to address a New Infection in Healthcare Personnel or Resident with COVID-19 in nursing homes. The guidelines included, "Because of the high risk of unrecognized infection among residents, a single new case of SARS-CoV-2 [COVID-19] infection in any HCP [Health Care Personnel] or a nursing home-onset SARS-CoV-2 infection in a resident should be evaluated as a potential outbreak...HCP should care for residents using an N95 or higher-level respirator, eye protection (i.e., goggles or a face shield that covers the front and sides of the face), gloves, and gown. Residents should generally be restricted to their rooms and serial SARS-CoV-2 testing performed...Recommended precautions should be continued for residents until no new cases of SARS-CoV-2 infection have been identified for at least 14 days." On 8/24/21 from 9:39 AM to 11:00 AM, the surveyor conducted an entrance conference and Infection Control interview with the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) who reported that she (the DON) and another Licensed Practical Nurse (LPN) were currently filling in as the role of Infection Preventionist (IP), as the facility's designated IP no longer worked at the facility. The DON confirmed that the facility was in a current COVID-19 outbreak that began on Executive Order 26. The DON stated that when they became aware of the first resident who tested positive for COVID-19 during a hospitalization on Executive Order 26, they immediately conducted rapid antigen testing for COVID-19 on all the residents in the facility residing on all three floors. According to the outbreak line list, six (6) more residents tested	F 880	B: 1. Hand hygiene provided for all residents following surveyors observation. Education provided for CNA #1 and CNA #2. 2. All residents could potentially be at risk. 3. Facility wide education on hand hygiene related to meal service was initiated. Individual hand wipes were ordered and are being placed on all resident trays by dietary staff. Staff assisting with meal set up will encourage use of/assist with wipes by residents. Residents that refuse will be educated on the benefits. Activities staff will encourage hand hygiene for residents during communal dining. 4. Weekly audits will be done by facility educator/designee weekly to ensure compliance with updated policy. This will include presence of hand wipes and the encouragement of hand hygiene. Results of audits will be reported to QAPI by facility Educator/designee for three months followed by redetermination of needed frequency. RCA conducted: Staff was unable to confirm hand hygiene protocol and who was fully responsible. Hand sanitizer wipes were not readily accessible. Individual hand wipes were ordered for each resident tray and hand sanitizer wipes are readily accessible in all areas where food is served. Education completed. C: 1. Education was immediately provided to	

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F 880	Continued From page 4 positive on [Executive Order 26, 4.b.] all of which resided on the [Executive Order 26, 4.b.]. The line list reflected that three of the residents that had Executive Order 26, 4.b. were [Executive Order 26, 4.b.] for the [Executive Order 26, 4.b.] The DON stated that contact tracing for all positive cases began right away but often took "hours" to complete. She continued to explain that all residents who tested positive using the rapid antigen test would then be treated as though they were positive with all necessary PPE (including the use of a gown, gloves, N95 respirator mask, and eye protection upon entering the room). She stated that those residents have follow-up PCR COVID-19 testing that same day, and the turn-around time for the PCR results would be 24 to 48 hours maximum. The DON stated that while the facility was awaiting the PCR results, they performed the contact tracing, and any exposed roommates were placed on transmission-based precautions (TBP) and were quarantined to their room. The surveyor inquired when they placed the remaining residents residing on the [Executive Order 26, 4.b.] on TBP to mitigate the potential for further spread of COVID-19 on the [Executive Order 26, 4.b.]. The DON replied in the presence of two additional surveyors that it wasn't until [Executive Order 26, 4.b.]1 (nearly five days after the first known case of [Executive Order 26, 4.b.] on the unit on [Executive Order 26, 4.b.]) that they decided to place all the residents on the [Executive Order 26, 4.b.] on [Executive Order 26, 4.b.] The DON confirmed that between 8/14/21 and 8/19/21, two additional facility staff members also tested positive for COVID-19 on 8/16/21, one of which was a Certified Nursing Aide (CNA) who worked on the [Executive Order 26, 4.b.]. The surveyor asked why there was a delay in placing all the residents on TBP when there was suspecting evidence of known transmission of [Executive Order 26, 4.b.] on the [Executive Order 26, 4.b.] on [Executive Order 26, 4.b.] and again on [Executive Order 26, 4.b.] when a CNA who	F 880	receptionist. Reception area was fully disinfected. Receptionist competency completed on antigen tested including infection control practice. Testing area reevaluated and changed to another area. This designated area will include full PPE and disinfectant equipment. Staff assigned to this task will have necessary competencies completed. 2. All residents, staff, and visitors have potential to be affected. 3. Facility wide education on new process and area for testing completed. 4. Weekly audits will be completed by the Infection Preventionist or designee during swabbing to ensure that the correct infection control procedures are being followed including utilization of PPE. Results of audits will be reported to QAPI committee monthly by Infection Preventionist/designee for three months followed by redetermination of needed frequency. RCA conducted: Receptionist did not follow proper protocol for swabbing and use of proper PPE. Competency was on file for her however, proved ineffective. Testing area was moved to a different location with proper supplies, re-competencies completed on any staff designated as a tester. D/E: 1. Education was immediately provided to CNA #3 on PPE use and disposal, location of disposal receptacles, and clean linen cart infection control practices.	

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F 880	Continued From page 5 worked on the Executive Order 26, 4.b. Executive Order 26, 4.b. for Executive Order 26, 4.b. The DON replied that they were trying to balance the "dignity" and "rights" of the residents by not requiring them to stay in their rooms for those first few days. She confirmed that while they isolated the residents who they believed had a known exposure, it was a decision at the time that they had made not to put the other residents on TBP. The surveyor requested any guidance from their Local Health Department (LHD) and any Centers for Disease Control (CDC) guidelines they were following in regards to the implementation of TBP. A review of the Resident and Staff Outbreak Line List initiated on Executive Order 26 reflected that seven (7) total residents Executive Order 26, 4.b. for Executive Order 26, 4.b. on Executive Order 26. All residents resided on the Executive Order 26, 4 at the time of their Executive Order 26, 4.b.. The Line List also revealed that transmission-based precautions were initiated on Executive Order 26 for any residents that Executive Order 26, 4.b. on the Executive Order 26, 4 from Executive Order 26, 4.b. The DON confirmed to the surveyor that the Executive date of 8/19/21 for the Executive Order 26, 4 residents was reflective of the date that all the residents on the Executive Order 26, 4.b were ultimately placed on Executive. On 8/23/21, from approximately 9:40 AM to 10:15 AM, two surveyors toured the resident care unit on the Executive Order 26, 4. The surveyors observed that all the residents on the unit were on TBP and were either designated as cohort 1 (COVID-19 positive) or cohort 2 (persons under investigation [PUI] for COVID-19). The surveyors observed hanging PPE storage carts over the door of each resident room and observed staff donning and doffing the PPE upon entry and exit of the rooms,	F 880	Competency completed on donning/doffing PPE, disposal, and hand hygiene. Administration audited to ensure all disposal receptacles for PPE were still in place on Covid unit. Linen carts checked to ensure compliance with infection control practices. 2. All residents have the potential to be affected. 3. Facility wide training on PPE donning/doffing, disposal, hand hygiene, and handling of clean linen completed. 4. Weekly audits on donning/doffing PPE, disposal, hand hygiene, and compliance with infection control practice with regard to clean linen with facility staff as well as agency staff. Results of audits will be reported to QAPI Committee monthly by Infectionist Preventionist/designee for three months followed by redetermination of needed frequency. RCA conducted: CNA #3 did not follow proper PPE, handling of dirty PPE which was found hanging on a clean linen cart. CNA also failed to use hand hygiene. A competency was on file for CNA #3, however proved ineffective. CNA #3 no longer working in facility. Education completed. Facility participated with Infection Control Assessment and Response (ICAR) COVID-19 Containment Assessment on 8/27/2021. Facility also participated with Quality Improvement Organizations (QIO/IPRO) on 9/10/2021. Facility review of recommendations for implementation.	

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F 880	Continued From page 6 respectively. A review of the Community Activity Level Index (CALI) scores for COVID-19 for the week prior to 8/14/21 for the facility's county revealed that the COVID-19 transmission rate was listed as "high." On 8/24/21 at 2:30 PM, two surveyors interviewed the LPN/Supervisor, who stated that she was the supervisor working on 8/14/21 and was also assisting in the Infection Preventionist (IP). The LPN/Supervisor noted that although they did not consistently document in each resident's medical record when TBP was started, she stated that any roommates of residents that tested positive for COVID-19 were put on TBP on 8/14/21, or any other residents that may have been exposed and identified through the contact tracing process. She confirmed that all the remaining residents on the [Executive Order 26, 4.b] were not placed on [Executive Order] until [Executive Order 26]. She confirmed this was a period of five days. The surveyor requested any additional documentation that TBP were started for residents who had initially tested negative during facility-wide testing on 8/14/21, specifically on the [Executive Order 26, 4.b]. The LPN/Supervisor confirmed in the presence of the DON that there were gaps in some of their documentation regarding when TBP started for each resident, and the dates differed until [Executive Order 26] when all residents on the [Executive Order 26, 4] were put on [Executive Order] The surveyors, DON, and LPN/Supervisor reviewed communication emails from the Local Health Department (LHD), including an email dated 8/18/21 for guidelines the facility was to follow for the outbreak. The guidance reflected to "if positive cases are located on more than 1 unit,	F 880	Required Education : Infection Control Prevention and Program Module 1- all top line staff CDC Covid-19 Prevention Clean Hands https://you.tube/xmYMUly7qiE- all staff including top line and front line staff COVID-19 Prevention Modules- all staff including top line and frontline CDC CoOVID-19 prevention messages for frontline LTC staff/Keep COVID out https//youtube/7srwrF9MGdw- all staff including top line and frontline staff Nursing Home Infection Preventionist Training Course Module 4- all staff including top line and front line Nursing Home Infection Preventionist Training Course Module 5- all staff including top line and front line staff Nursing Home Infection Preventionist Training Course Module 7- all staff including top line and front line staff Nursing Home Infection Preventionist Training Course Module 6A- all staff including top line and front line staff Nursing Home Infection Preventionist Training Course Module 6B- all staff including top line and front line staff	

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implement the use of full transmission-based precautions on all units for the care of all residents." At that time, the DON indicated that the reason the facility did not implement [Executive Order 26, 4.b.] for all residents on the [Executive Order 26, 4.b.] on [Executive Order 26, 4.b.] was because they interpreted the guidance to mean that only if there were cases on more than one floor, and since it was confined to one floor, they did not implement it until [Executive Order 26, 4.b.]

The DON stated that staff were wearing universal N95 respirator masks and eye protection since 8/9/21, and she provided an in-service education of their policy change at that time. She confirmed that gowns and quarantining the negative and non-exposed residents on the [Executive Order 26, 4.b.] were not implemented until [Executive Order 26, 4.b.] She confirmed the reason [Executive Order 26, 4.b.] was the date to implement full [Executive Order 26, 4.b.] for all the residents on the [Executive Order 26, 4.b.] because an [Executive Order 26, 4.b.] resident from the [Executive Order 26, 4.b.] tested Executive Order 26, 4.b.

At 3:26 PM, two surveyors interviewed the DON and the LNHA. No additional documentation was provided that reflected that all residents on the [Executive Order 26, 4.b.] were placed on [Executive Order 26, 4.b.] on [Executive Order 26, 4.b.] when seven residents (six of them on the current census) were identified as Executive Order 26, 4.b. with evidence of active transmission from an identified source at the time.

A review of the facility's Outbreak Response Plan initiated on 5/28/2020 included to "evaluate and initiate isolation precautions as necessary..."

2. On 8/24/21 at 12:06 PM, two surveyors toured the Executive Order 26, 4.b., which was identified to be a

Provider's Plan of Correction (F 880):

CDC COVID-19 Prevention Closely Monitor Residents-all staff including top line staff and frontline staff

CDC COVID-19 Prevention Use PPE Correctly for COVID-19- all staff including top line and front line staff

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F 880	Continued From page 8 non-ill, non-exposed to Executive Order 26, 4.b. of the facility. At 12:29 PM, the surveyors observed two Certified Nursing Aides (CNA's) pushing a meal truck down the hallway and passing out lunch trays to the residents on the unit. The surveyors observed that there were no hand wipes for residents to use on each lunch tray to perform hand hygiene prior to eating. At that time, the surveyor observed CNA #1 enter a Executive Order 26, 4.b. room of Resident #1. CNA #1 set up the resident's lunch tray by removing the lids and opening a drink carton, and the resident began to pick up their food and eat it independently in their room. CNA #1 then exited the resident's room and returned to the meal truck to obtain another lunch tray without offering Resident #1 hand hygiene prior to the lunch service. At that time, the surveyor interviewed CNA #1, who confirmed that there were no hand wipes on the resident trays. The surveyor asked if residents on the unit were afforded an opportunity to wash their hands before the meal, and CNA #1 stated that "We do it." The surveyor asked him when they do it, and he replied that he assisted Resident #1 to the bathroom about one hour ago and that he/she washed their hands then. He stated that the preferred method of hand hygiene was for soap and water at the sink, as opposed to hand wipes so he would have all the residents wash their hands at the sink or he would provide a basin of soapy water for each resident if they were unable to get to the bathroom for various reasons. He stated that "hand sanitizer is good, but it only sanitizes them and doesn't wash them." He acknowledged that it was possible that Resident #1 could have touched various objects within	F 880		

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their bathroom and room since the one hour in which he/she had washed their hands after toileting.

From 12:22 to approximately 12:35 PM, the surveyor observed CNA #2 enter the room of other residents on the [Executive Order 26, 4.b]. CNA #2 set up each resident's lunch tray but did not offer the residents an opportunity to perform hand hygiene. CNA #2 confirmed there were no wipes on the meal trays for residents to wash their hands. She did not speak to how the residents washed their hands prior to meal service.

At 12:40 PM, the surveyor interviewed the LPN/Supervisor, who confirmed that she was a supervisor and was responsible for overseeing aspects of the Infection Prevention and Control Program at the facility. She stated that "the activities [department] can wash hands with wipes, and we all can do it." She continued to state that CNAs can also perform hand hygiene during care. The surveyor asked who was responsible for the hand hygiene that day, and the LPN/Supervisor stated that she did not do it today and that maybe it was the Activity Assistant, but she couldn't be sure. She stated that everyone participates in it. She confirmed that there were no wipes on the trays.

At 12:42 PM, the surveyor interviewed the Activities Assistant assigned to the [Executive Order 26, 4.b]. She stated that she would usually offer hand hygiene to residents when they would eat in the dining room but that they weren't eating in the dining room right now due to COVID-19 restrictions at the facility. She stated that she was not responsible for hand hygiene for residents

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F 880	Continued From page 10 today. At 3:00 PM, the surveyor discussed the findings with the DON and the LNHA. They confirmed that there were no wipes on the meal trays. All staff were responsible for ensuring hand hygiene was performed before the lunch service using the containers of hand sanitizer wipes that are available throughout each unit. They could not speak to who offered the residents on the Executive Order 26, 4.b. an opportunity to perform hand hygiene prior to the lunch service that day on Executive Order 26 if the Activities Assistant, the CNA's, and the LPN/Supervisor denied having done it that day. They acknowledged that there was no assigned staff member responsible for offering wipes before the lunch service on a standard day but that it was always a group effort. They confirmed that it was difficult to determine if hand hygiene was offered to the residents or not if there was no designated staff member or members that day assigned to assist in that task. 3. Reference: A review of the US CDC's guidelines titled "Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens from Persons for Coronavirus Disease 2019 (COVID-19)" updated on 2/26/21, included "Collecting and Handling Specimens Safely. For healthcare providers collecting specimens or working within 6 feet of patients suspected to be infected with SARS-CoV-2, maintain proper infection control and use recommended personal protective equipment (PPE), which includes an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection, gloves, and a gown, when collecting specimens."	F 880		

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	315196	A. BUILDING ______ B. WING ______	08/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 11 According to the US CDC's "Interim Infection Prevention and Control Recommendations for HCP During the Coronavirus Disease 2019 (COVID-19) Pandemic" updated 2/23/21 included "Collection of Diagnostic Respiratory Specimens" which specified that, "Clean and disinfect procedure room surfaces promptly as described in the section on environmental infection control ....Ensure that environmental cleaning and disinfection procedures are followed consistently and correctly." On 8/24/21 at approximately 8:49 AM to 9 AM, upon entry to the facility, the surveyor, in the presence of two (2) surveyors and the Director of Nursing (DON), observed the Receptionist (RC) perform three (3) consecutive COVID-19 rapid antigen tests at the front reception desk area. The RC was wearing an N95 mask and goggles and donned (put on) a pair of gloves to perform the tests. The RC had not performed hand hygiene prior to donning the gloves and had not donned a personal protective gown. The RC placed the test cards on the reception desk area that had not been disinfected prior. Then, the three (3) surveyors consecutively performed a nasal swab on themselves and handed the nasal swab with the collected sample to the RC to insert into the test card that the RC had prepared. The RC had not changed gloves in between handling each surveyor's nasal swab and had not performed hand hygiene. In addition, during the RC performing the COVID-19 rapid antigen tests, the RC had handled the reception desk telephone to answer a phone call with the same gloved hands.	F 880		

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F 880	Continued From page 12 On 8/24/21 at 8:55 AM, after completing the Executive Order 26, 4.b., the surveyor interviewed the RC, who stated that performing Executive Order 26, 4.b. was her responsibility and had been trained by the former Infection Preventionist (IP). On 8/24/21 at approximately 9:00 AM, the DON stated that the RC would receive additional training regarding infection control issues when performing the COVID-19 rapid antigen tests. A review of the instructions for use for the BinaxNow COVID-19 AgCard reflected for specimen collection and handling to refer to the CDC "Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens from Persons for Coronavirus Disease 2019 (COVID-19)." 4. On 8/24/21 at 12:45 PM, the surveyor, toured the facility's Cohort 1 (COVID-19 positive) unit located on the Executive Order 26, 4. The surveyor observed CNA #3 exit the room of Resident #2 and Resident #3, who were both on Executive related to Executive Order 26, 4.b.. CNA #3 was wearing an N95 respirator mask, eye protection, a gown, and gloves. CNA #3 closed the resident's door behind him, wearing the full PPE. While standing in the hallway outside the resident's closed door, he proceeded to remove his long-sleeve, single-use gown first with force by breaking the ties. One of the broken ties fell to the floor, and he picked it up. After removing the gown, he crumpled it up with the loose tie that fell on the floor with his gloved hands, and without containing the used gown, he walked it to the end of the Cohort 1 (COVID-19 positive) hallway where there was a	F 880		

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F 880	Continued From page 13	F 880		

clear plastic bag secured to the rail of a covered clean linen cart. The surveyors observed CNA #3 place the used gown in the clear plastic bag secured to the covered clean linen cart, remove his gloves, and place them in the same clear plastic bag. The bag was filled with used PPE.

At that 12:48 PM, two surveyors interviewed CNA #3, who stated that he had just finished assisting Resident #3 in their room. He had to discard his PPE and place it in this bag because there was only one small trash can in the resident's room, and that he didn't want to put his used PPE in that, so he stated there was a bag to place all his PPE, and he pointed to the bag secured to the covered clean linen cart. The surveyor observed towels, draw sheets, fitted sheets, and resident gowns folded on the clean linen cart. The surveyor asked CNA #3 about the sequence in which he removed his PPE, and he stated that he always removed his gown first so that he could use his gloves to throw away the gown and then remove the gloves to discard them. He further stated that he was only assigned residents on the Cohort 1 (COVID-19 positive) unit.

At 12:50 PM, the surveyor interviewed the Licensed Practical Nurse (LPN) assigned to Cohort 1. He stated that gloves were supposed to be the first piece of PPE that was removed because it was considered the most contaminated of the PPE. He said then the disposable gown should be removed after the gloves, and it was to be discarded in the resident's trash can. He could not speak to the size of the trash can in the room of Resident #2 and Resident #3 but confirmed that it should be a covered trash can and that all PPE should be

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F 880	Continued From page 14	F 880		

contained in a secured bag before transporting it. The LPN acknowledged that the bag of used PPE that was secured to the covered clean linen cart should not have been there. He confirmed it was filled with used PPE and that it was likely from the CNA #3, who he stated was from a staffing agency. The LPN continued that if he had seen the CNA #3 place PPE in that bag, he would have corrected him.

At approximately 2:45 PM, the DON informed the survey team that the CNA #3 was from a staffing agency and that the facility did not do a PPE competency on him, nor did they maintain records of any of his PPE competencies that the staffing agency had completed but that they just reached out to the staffing agency for his competency records. The DON confirmed that CNA #3 should follow the appropriate sequencing of removing PPE in accordance with CDC guidelines and the education he had received.

At 3:00 PM, the surveyor discussed the findings with the Licensed Nursing Home Administrator and the DON. They acknowledged that there should not have been a bag of used PPE secured to the covered clean utility cart and that all PPE should be contained before transporting it down a hallway. They acknowledged that they didn't retain evidence that CNA #3 had passed all competencies related to COVID-19 prior to the surveyor's inquiry. The LNHA stated that they would email the competency to the surveyor once it becomes available to them from the agency.

According to an email provided by the Licensed Nursing Home Administrator dated 8/25/21 at

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F 880	Continued From page 15 9:58 AM reflected that on 6/14/21, CNA #3 had passed a competency on doffing (removing) PPE conducted by the staffing agency. The competency reflected that when doffing PPE, gloves were removed first and "discard gloves in the appropriate receptacle." It then indicated to remove the gown after the gloves have been removed and "discard gown in the appropriate receptacle." The staffing agency signed the competency that CNA #3 was competent in the task and able to perform it independently and without supervision at that time. According to the US CDC guidelines, "Using PPE" updated 8/19/2020 included to remove gloves to ensure it does not cause additional contamination of hands. Remove gown by "untie all ties (or unsnap all buttons). Some gown ties can be broken rather than untied. Do so in a gentle manner, avoiding a forceful movement ...rolling the gown down and away from the body. Dispose in the trash receptacle. Healthcare Personnel may not exit patient room. Perform hand hygiene ..." According to US CDC guidelines, a second method of safely removing PPE included to remove PPE prior to exiting the resident room, except the respirator if worn. The guidelines included to remove the PPE in the following sequence: " ...While removing the gown, fold or roll the gown inside out into a bundle. As you are removing the gown, peel off your gloves at the same time, only touching the inside of the gloves and gown with your bare hands. Place the gown and gloves into a waste container." NJAC 8:39-19.4(a)	F 880		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315196 (Y1)	A. Building B. Wing (Y2)	11/10/2021 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
ARISTACARE AT MANCHESTER	1770 TOBIAS AVENUE MANCHESTER, NJ 08759

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0880 Reg. # 483.80(a)(1)(2)(4)(e)(f) LSC	Correction Completed 11/09/2021	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
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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	
8/24/2021	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO