STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315514	A. BUILDING _____ B. WING _____	04/21/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EGG HARBOR CARE CENTER	6818 DELILAH ROAD EGG HARBOR TOWNSHIP, NJ 08234

(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 STANDARD SURVEY CENSUS: 122 SAMPLE SIZE: 19 +1 closed record A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of other facility documentation, it was determined	F 812	1. How the corrective action will be accomplished for those residents to have	4/26/21

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

Electronically Signed | 04/29/2021

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F 812	Continued From page 1 that the facility failed to handle potentially hazardous foods and maintain kitchen sanitation in a safe consistent manner designed to prevent food borne illness. This deficient practice was evidenced by the following: On 4/14/2021 from 9:08 to 9:54 AM the surveyor, accompanied by the Food Service Director (FSD), observed the following in the kitchen area: 1. On a top shelf of a multi-tiered rack in the walk-in freezer, a bag of frozen chopped collard greens was removed from its original container. The bag had no dates. When interviewed the FSD stated, "They should have put a date on it when they removed it from the original container." The FSD threw the frozen collard greens in the trash. On a middle shelf on top of a box of frozen lima beans, a frozen herb roasted chicken kosher dinner covered with clear plastic cellophane was removed from its original container. The frozen meal had no dates. The FSD stated, "That's a frozen kosher meal that we used for a previous resident we had here." The meal showed signs of freezer burn and excessive ice buildup on the meal surface. On interview the FSD stated, "I'm throwing it out." On an upper shelf a partially consumed sponge cake was on top of a cardboard box. The sponge cake was wrapped with plastic wrap; however, the plastic wrap was ripped, and the cake was exposed. The FSD threw the cake in the trash. 2. In the rear of the walk-in freezer under the refrigeration unit, a large box of previously opened Thomas' English Muffins was on top of a wheeled plastic pallet. The top of the box had a large build-up of ice in a cylindrical shape. The FSD stated, "That's going in the trash." The box	F 812	been affected by the deficient practice: The bag of chopped collard greens, the box of lima beans, frozen herb roasted chicken kosher dinner, the sponge cake, the English muffins, and the two boxes of exposed plastic wrap were all immediately disposed of in the trash. The Food Service Director immediately in serviced the staff on potentially hazardous foods and maintaining kitchen sanitation in safe consistent manner designed to prevent food borne illness and also having proper date and label and making sure plastic wrap top not being removed. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents residing in the facility have the potential to be affected by the deficient practice in potentially hazardous foods and maintaining kitchen sanitation in safe consistent manner designed to prevent food borne illness. 3. What measures will be put into place or systemic changes made to ensure the deficient practice will not recur: The Food Service Director has been re in-serviced by the Administrator on potentially hazardous foods and maintaining kitchen sanitation in safe consistent manner designed to prevent food borne illness which consisted of safely securing food and having the proper label and date. Also having plastic wrap top not being removed. The Food Service Director then in-serviced all of his staff again to re-educate on potentially	

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F 812	Continued From page 2 of English Muffins was thrown in the trash. On 4/20/2021 from 11:11 to 11:33 AM the surveyor, accompanied by the FSD, observed the following in the kitchen: 1. On lower shelf of a food preparation table and approximately 4 inches off the floor, 2 individual boxes of Foodservice Film (plastic wrap) were observed to have had their tops removed. The plastic wrap was exposed. The FSD instructed staff to not remove the tops of the plastic wrap boxes and then threw the 2 boxes that were exposed in the trash. The surveyor reviewed the undated facility Policy and Procedure titled "Purchasing and Inventory". Under the Procedure section at 3. "Dietary personnel will rotate all items; date all items according to State and Federal guidelines." NJAC 8:39-17.2(g)	F 812	hazardous foods and maintaining kitchen sanitation in safe consistent manner designed to prevent food borne illness and safely securing food and having the proper label and date. Also having plastic wrap top not being removed. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: The freezer is being audited daily by the Food Service Director or Designee to ensure that all products are safely secured and have the proper label and date. The plastic wrap is also being monitored daily by the Food Service Director of designee ensuring that the staff are not removing the top of the plastic wrap. The daily monitoring of both the freezer for safely secured items and label and dates and the plastic wrap will continue for 3 months or until no issues have been seen for one month past the 3 month original period of auditing. The Food Service Director will report any out of compliance findings to the administrator so the staff member can be disciplined. The Food Service Director will report findings of his audit to Quality Assurance Committee on a quarterly basis.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program	F 880		8/30/21

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F 880	Continued From page 3 designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (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	F 880		

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F 880	Continued From page 4 least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to 1.) remove personal protective equipment (PPE) gowns when exiting resident rooms on the Persons Under Investigation unit (PUI) and 2.) wear gloves when entering resident rooms on the PUI unit to minimize the potential spread of infection. The deficient practice was observed on 1 of 2 hallways designated for PUI for COVID-19 (a potentially deadly respiratory virus). The deficient practice was evidenced by the following: On 4/15/21 at 11:40 AM, the surveyor observed	F 880	Date of corrective action completion will be August 30th 2021. 1. How the corrective action will be accomplished for those residents who have been affected by the deficient practice: CNA#1 and CNA #2 were immediately reeducated on proper personal protective equipment (PPE) in Persons Under Investigation unit (PUI) and also were reeducated on proper donning and doffing proper personal protective equipment (PPE). A root cause was done and it was determined that staff were nervous due to	

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F 880	Continued From page 5 CNA (Certified Nurse Aide) #1 and CNA #2 passing lunch trays on the [redacted] Unit that included rooms [redacted]. The surveyor observed that there were COVID-19 Personal Protective Equipment for Healthcare Personnel signs outside each occupied room. The signs revealed that a gown, gloves, mask, and eye protection were to be used when entering the room. 1. The surveyor observed CNA #1 and CNA #2 wearing gowns, eye protection, and masks while in the hallway. They retrieved trays from the cart, entered rooms, and exited rooms without removing their gowns. 2. The surveyor observed that CNA #1 and CNA #2 did not have gloves on at any time when they entered rooms. During an interview with the surveyor on 4/15/21 at 12:26 PM, CNA #1 stated full PPE including facemasks, gowns, and gloves are to be worn when entering rooms on the [redacted]. CNA #1 informed the surveyor that they put PPE on when they enter the room and remove it when exiting the room. The surveyor asked if wearing the same gown from room to room was proper procedure. CNA #1 stated, "Typically no. I kind of slipped the gun when you were watching during lunch." During an interview with the surveyor on 4/21/21 at 9:09 AM, the Director of Nursing stated that wearing one gown for all rooms was the incorrect procedure. They should have removed gowns, gloves, and washed their hands when exiting rooms. They should not be wearing gowns in the hallways.	F 880	a state surveyor observing them. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents residing in the facility have the potential to be affected by the deficient practice. 3. What measures will be put into place or systemic changes made to ensure the deficient practice will not recur: All facility staff both clinical and non clinical have been re in-serviced on to 1.) remove personal protective equipment (PPE) gowns when exiting residents rooms on the Persons Under Investigation unit (PUI) and #2 wear gloves when entering the residents rooms on the unit to minimize the potential spread of infection. Topline staff and Infection Preventionist viewed Module 1 Infection Prevention & Control Program; Frontline staff viewed Keep Covid-19 Out; and all staff viewed Use PPE Correctly for Covid-19. Date of corrective action completion will be August 30th 2021. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur: The Director of Nursing or Designee will be doing weekly x4, then monthly x 2 audits on staff to ensure that all staff are wearing the proper PPR in the PUI unit. The Director of Nursing or designee will report audit findings to Quality Assurance Committee Quarterly x 2.	

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F 880	Continued From page 6 The facility's untitled policy, page 11 revealed "All recommended PPE should be worn during care of residents under observation; this includes use of an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face). Gloves, and gown." NJAC 8:39 - 19.4(a)	F 880	Date of corrective action completion will be August 30th 2021.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
315514	A. Building B. Wing	9/3/2021

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
EGG HARBOR CARE CENTER	6818 DELILAH ROAD EGG HARBOR TOWNSHIP, NJ 08234

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 F0812 Reg. # 483.60(i)(1)(2) LSC	Correction Completed 04/26/2021	ID Prefix F0880 Reg. # 483.80(a)(1)(2)(4)(e)(f) LSC	Correction Completed 08/30/2021	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	
4/21/2021	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO