STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315239	A. BUILDING _____ B. WING _____	10/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHILDRENS SPECIALIZED HOSPITAL MOUNTAINSIDE	150 NEW PROVIDENCE ROAD MOUNTAINSIDE, NJ 07092

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F 000	INITIAL COMMENTS Standard Survey: 10/6/21 Census: 43 Sample Size: 12+1 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=D	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, interviews, and review of documentation provided by the facility, it was	F 812	NJAC 1. At the time of survey there were three (3) residents who received food prepared	10/31/21

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

Electronically Signed | 10/22/2021

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F 812	Continued From page 1 determined that the facility failed to a) maintain proper kitchen sanitation practices and b) properly store dry and refrigerated foods in a safe and sanitary environment to prevent the development of foodborne illness. The deficient practice was observed and was evidenced by the following: On 09/22/21 at 10:17 AM, during the initial tour of the kitchen in the presence of the Dietary Supervisor (DS), the surveyors observed the following: 1. The ceiling vent located above the slicer had a heavy buildup of black and grayish material. 2. The ceiling vent located above the food prep area had a heavy buildup of black and grayish material. 3. The silver pole located between the slicer and the sink had a heavy buildup of black and grayish material where the pole connected to the ceiling. The DS stated that maintenance would clean the ceiling vents and the silver pole. She further stated they should be free of dust because dust could fall into the food and contaminate it. 4. The bracket that secured the pot/utensil holding rack to the ceiling, which was located above the food prep area, had a heavy buildup of black and gray material. The DS stated that it was the responsibility of the kitchen staff to keep clean. 5. Located under the food prep area on the coffee side, there were 4 screening pans and 8	F 812	or stored in the dietary department and six (6) who received formula prepared in dietary department. These residents have the potential to be affected by the deficient practice outlined in CMS-2567. 2. All current residents who may advance in their diets and any future residents who require nutrition and/or storage of food have the potential to be affected by this deficient practice. All residents who require nutrition and/or storage of food have the potential to be affected by this deficient practice. 3. On the day of finding, the following actions were taken: a. The ceiling vent above the slicer and food preparation area was cleaned b. The pole located between the slicer and sink was cleaned c. The bracket that secured the pot/utensils was cleaned d. All pans with a noted substance were discarded e. All expired spices were discarded. The spices rack policy was updated to include labeling of the date received, date of opening and expiration date. Inspection of the spice rack was added to the daily checklist f. The hanging pots on the holding rack were discarded. Staff were provided education to not hang clipboard on rack g. Beard nets were order h. All open dressing and sauce items were discarded A Food and Nutrition Team Meeting was held to review all findings from the survey tour and provided an in-service on the	

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F 812	Continued From page 2 sheet pans, nested on top of each other, that had a heavy buildup of black substance around the edges of the pans. The DS stated that they should have been scrubbed better and now they just needed to be replaced. 6. The seasoning rack contained the following opened spices: -16-ounce (oz) Curry Powder with a received by date of 9/21/20, the DS was unable to locate an opened date -16 oz whole mustard, the DS was unable to locate a received or an opened date, -16 oz celery seed with an opened date of 5/28/18 -16 oz container that contained an orange-colored seasoning that had the letters [redacted] handwritten on it. The DS confirmed that the container did not contain any dates. The DS stated it was taken from a larger container of [redacted] seasoning and put into the smaller container for use. The DS further stated it should have been more clearly marked and that it should have contained an opened date. The DS stated that it was important to label clearly so that you know when it comes in and when it expires. -16 oz whole sesame seed with an opened date of 6/23/2019 and a use-by date 6/23/21 -16 oz ground mustard with an opened date of 6/2018 and a use-by date of 6/2021 -12 oz poultry seasoning with an opened date of 5/28/2018 and a use-by of 5/2021 -13 oz ground oregano with a received on date of 11/2017 and an expiration date of 6/23/21 -14 oz ground cayenne pepper with a received on date of 4/1/2019, the DS was unable to locate an opened date	F 812	following items; a. Cleaning of areas that holds pots, pans, utensils and any cookware b. Cleaning of pots, pans, utensils and any cookware c. Labeling, dating and shelf life of spices d. Labeling, dating and shelf life of dressing and sauces. e. Overall cleanliness of the kitchen including the vents in the ceiling f. Need to discard broken or damaged cookware of utensils g. Need for hair nets/beard nets Compliance with Dietary Policies and Procedures will be validated through the Closing Checklist which is completed at the end of each shift. The checklist will be audited via visual inspection of the food service area by the Food Service Manager, Food Service Supervisor, or designee, daily until 100% compliance has been maintained for three (3) consecutive weeks. Then, three (3) times per week until 100% compliance has been maintained for three (3) consecutive months. Following completion of this frequency, compliance will be monitored weekly. 4. The Food Service Manager will report the audits to the QAPI committee on a quarterly basis. The report will include outcomes and any additional action plans implemented when deviations are noted.	

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F 812	Continued From page 3 -16 oz ground allspice with a received on date of 1/10/2018 and a date opened of 3/4/2018 -16 oz ground nutmeg with a received on date of 11/2009, the DS confirmed that there was not an opened date -11 oz spice white cloves with a received on date of 5/14/18 and an opened date of 6/15/2018 7. Hanging from the pot/utensil holding rack there was the following: -4 pans, the DS stated that they were 12 inch (") or 16" pans, that had a black nonstick protective coating on the inside of the pan that had multiple scrape marks and pieces of loose protective coating on the inside of the pan. - 2 6" sauté pans that had a black nonstick protective coating on the inside of the pan that had multiple scrape marks and pieces of loose protective coating on the inside of the pan. The DS stated that the pans were not usable because the scrapings could get in the food and contaminate it. -1 4 quart (qt) saucepot with a black substance in the bottom of the pot. The DS rubbed it off and stated it should not be there because it could contaminate food - 1 large sauté pan, the DS stated it was 18" or 20"pan, that had multiple deep grooves with a black substance in the grooves, on the inside of the pan. The DS stated it needed to be scrubbed off. - a brown clipboard that the DS identified as the cook's menu clipboard, was hanging on the rack touching the serving spoons 8. Two male kitchen staff members, a cook and a kitchen aid (KA) wearing surgical masks with	F 812		

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F 812	Continued From page 4	F 812		

facial hair exposed around the mask, exiting the kitchen area:

During an interview with the surveyor at that time, the cook stated that facial hair should be contained in a beard net, so hair doesn't fall into the food. He felt around his surgical mask and confirmed that all his facial hair was not contained in the surgical mask. The KA stated that he did not know the facility's policy on facial hair. The KA's facial hair was coming out below and around the sides of the surgical mask. The DS stated that a beard guard must be worn, and facial hair needs to be cut low to the face. The DS instructed both staff members to put beard guards on. They then came back to the DS to inform her that the facility does not have beard guards, so the DS instructed them to put hair nets on to cover their facial hair.

9. The walk-in refrigerator contained the following opened dressing and sauces:

-1-gallon honey mustard with a received on date of 12/2020 dated and an opened date of 12/10 no year, The DS stated that the dressings were good for 2 months after opening.
-1-gallon French dressing with a received on date of 12/2019 and 12-2 written (nothing else)
-1 gallon thousand island with a received on date of 3/15/21 and an opened date of 4/4/21
-1-gallon sweet pickle relish with a received on date of 3/5/21 and an opened date of 4/9/21
-1-gallon blue cheese dressing with two opened dates: 12/14/20 and 1/29/21 and a use-by date of 4/27/21
-1-gallon sweet pickle relish with a received on date of 3/15/21 and an opened date of 7/13/21

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F 812	Continued From page 5	F 812		

-4.5 pounds sweet and sour "ready to use" sauce with an opened date of 4/29/21, the DS confirmed that there was not a received on date. The DS stated that the sauces were good for 2 months after opening.
-20 oz caramel sundae syrup with an opened date of 7/12/20, no received on date. The DS stated that syrups were good for 2 months after opening.
-24 oz chocolate flavor syrup with an opened date of 4/17/21, no received on date.
-24 oz chocolate flavor syrup with an opened date of 2/15/21, no received on date.

A review of the facility's Policy and Procedure "Dietary Department", reviewed 8/20, Procedure-The Cooks Area to be cleaned includes these four areas, overhead rack area, stainless steel work area, drawers, and underneath stainless steel storage. Each area should be stripped of all its items and cleaned properly. Any items of questionable quality should be disposed of.

A review of the facility's Policy and Procedure "Labeling and Dating Spices", reviewed 10/20, Procedure: Whole spices, ground, and dried leaf spices have a shelf life up to three years. Spices will be labeled with receiving dates. To ensure freshness once spices have been open they will be dated with an opening date to ensure freshness and disposal of after three years.

A review of the facility's Policy and Procedure "WASHING of POTS, PANS, AND UTENSILS", reviewed 6/15, Doing one item at a time, you: 1. Use pot and pan agitator to loosen food, which is baked on. 2 Thoroughly scrub the inside and

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F 812	Continued From page 6 outside of all Pots and pans, using brush. A review of the facility's Policy and Procedure, "Sanitation Guidelines for Pantries", reviewed 8/20, 8. All counters and equipment must be cleaned thoroughly. 9. Silverware should be displayed and stored in such a way the person will only touch the handle and not the eating side. 13. Ceilings and walls must be cleaned and in good repair. A review of the facility's Policy and Procedure, "Personal Hygiene and Good Grooming", reviewed date 8/20, HAIR-Clean hair is an essential part of personal hygiene. All hair must be confined either in a cap or a hairnet. A review of the facility's Policy and Procedure, "Dietary Dress Code", reviewed 8/20, Procedure: 4. All men with facial hair must be cut close and wear bearded guard. A review of the facility's Policy and Procedure, "Salad Bar", reviewed 8/20, All dressing need to be label and date upon entering with a receiving and open date and discarded 60 days after opening. A review of the resident diet orders revealed that 2 out 34 residents were on diets provided by the kitchen. NJAC 8:39-17.1(a);17.2(g)	F 812		
F 886 SS=E	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including	F 886		12/15/21

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F 886	Continued From page 7 individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test.	F 886		

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F 886	Continued From page 8 §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of pertinent facility documents, it was determined that the facility failed to ensure 4 of 5 unvaccinated facility staff were tested for COVID-19 twice a week in accordance with the Interim Final Rule (IFC), CMS-3401-IFC, Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency related to Long-Term Care (LTC) Facility Testing Requirements; and nationally accepted guidelines for infection prevention and control, and the facility's testing schedules related to the high COVID-19 county positivity rate. The evidence was as follows:	F 886	1. No residents were found to have been affected by the deficient practice outlined in the CMS-2567. RN #1, RN#2, LPN and C.N.A. outlined in the CMS-2567 all tested for COVID-19 and tested negative. RN#1, RN#2, LPN and C.N.A. outlined in the CMS-2567 and all individuals entering the Long Term Care Unit are screened for signs and symptoms of COVID-19 and exposure to COVID-19. 2. All residents have the potential to be affected by this deficient practice outlined in the CMS-2567. 3. The Infection Preventionist, or	

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F 886	Continued From page 9 According to the U.S. Centers for Disease Control and Prevention (CDC) guidelines, Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 [COVID-19] Spread in Nursing Homes updated 9/10/21 included, "In nursing homes located in counties with substantial to high community transmission, unvaccinated HCP should have a viral test twice a week." According to the Interim Final Rule (IFC), CMS-3401-IFC, Additional Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency related to Long-Term Care (LTC) Facility Testing Requirements revised 9/10/21 included, "Routine testing of unvaccinated staff should be based on the extent of the virus in the community ...Facilities should use their community transmission level as the trigger for staff testing frequency ...Routine Testing Intervals by County COVID-19 Level of Community Transmission: Low (blue) testing frequency: not recommended; Moderate (yellow) testing frequency: once a week; Substantial (orange) testing frequency: twice a week; and high (red) testing frequency: twice a week." On 9/22/21 at 10:48 AM, during the Entrance Conference the Team Coordinator (TC) requested a list of facility staff who were unvaccinated for COVID-19 from the Licensed Nursing Home Administrator (LNHA). Later on that same date, the surveyor reviewed the level of community transmission via the CDC COVID-19 Integrated County View site which indicated the facility's level of community transmission was high and in the red.	F 886	designee, will review the County COVID-19 Level of Community Transmission and CALI score on a weekly basis. The testing cadence will follow the requirements outlined in New Jersey Department of Health Executive Directive 20-017 and any subsequent CMS of NJDOH directive. All not fully vaccinated team members have been educated to the COVID-19 testing requirements outline in New Jersey Department of Health Executive Directive 20-017. All not fully vaccinated team members have been informed if they are non-compliant with the COVID-19 testing program they will not be able to work. 4. The Administrator will oversee the testing program. In the Administrator□s absence the program testing program will be overseen by the Infection Preventionist or their designee. Compliance with COVID-19 testing will be audited by the Administrator, or designee, three times per week. This audit will continue until CMS and NJDOH no longer require routine COVID-19 testing. Audit reports will be submitted to the QAPI committee quarterly.	

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On 9/24/21 at 1:45 PM, the LNHA stated that staff who were not vaccinated were being tested for COVID-19 twice a week and their results were recorded in the electronic medical record for staff. He further stated that "the unvaccinated staff have to be checked one by one regarding their testing records and that supervisors were aware who should be tested before working."

On 9/27/21 at 10:01 AM, the surveyor selected five unvaccinated facility staff for COVID-19 testing. The surveyor identified that 4 of the 5 facility staff did not have evidence of twice a week COVID-19 testing in accordance with the aforementioned testing requirements. The following was revealed:

A review of a Registered Professional Nurse #1 (RN #1) work schedule revealed the RN #1 worked on the following dates: 9/5/21, 9/8/21, 9/10/21, 9/14/21, 9/18/21, 9/21/21, 9/22/21 and 9/25/21. The RN #1 was tested for COVID-19 via rapid antigen on 9/8/21, 9/14/21, 9/21/21 and 9/25/21.

A review of a Licensed Practical Nurse (LPN) work schedule revealed the LPN worked on 9/12/21, 9/15/21 and 9/20/21. The LPN was tested for COVID-19 via rapid antigen on 9/21/21.

A review of RN #2's work schedule revealed RN #2 worked on 9/20/21, 9/22/21, and 9/25/21. RN #2 was tested for COVID-19 via rapid antigen on 9/25/21.

A review of a Certified Nursing Assistant (CNA)

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F 886	Continued From page 11 work schedule revealed the CNA worked on 9/12/21, 9/17/21, 9/18/21, 9/19/21, 9/24/21, and 9/25/21. The CNA was tested for COVID-19 via rapid antigen on 9/24/21. On 9/27/21 at 12:20 PM, the surveyor interviewed the LNHA who stated that the staff should have been tested twice a week and could not speak to why the aforementioned unvaccinated staff were not tested twice a week. On 9/28/21 at 9:10 AM, the LNHA provided the surveyor a copy of the SARS-CoV-2 [COVID-19] Pandemic Plan Long-Term Care Practices for All Phases at All times which included, "Ongoing weekly testing of all staff until guidance from the NJDOH changes based on epidemiology and data about the circulation of virus in the community." He stated, "this is our policy regarding staff testing and we follow the CDC guidelines with CALI report." NJAC 8:39-5.1(a)	F 886		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
315239		12/23/2021

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CHILDRENS SPECIALIZED HOSPITAL MOUNTAINSIDE	150 NEW PROVIDENCE ROAD MOUNTAINSIDE, NJ 07092

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 10/31/2021	ID Prefix F0886 Reg. # 483.80 (h)(1)-(6) LSC	Correction Completed 12/15/2021	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	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO
10/5/2021	