STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315174	A. BUILDING _______ B. WING _______	C 12/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEPTFORD CENTER FOR REHABILITATION AND HEALTHCARE	1511 CLEMENTS BRIDGE RD DEPTFORD, NJ 08096

(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 Complaint #: NJ149849, NJ150192 Census: 191 Sample Size: 6 The facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities based on this complaint survey. A COVID-19 Focused Infection Control Survey was conducted by the New Jersey Department of Health. The facility was found to not be in compliance with 42 CFR §483.80 infection control regulations and had not implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Survey date: 12/14/2021 - 12/15/2021	F 000		
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 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,	F 880		2/10/22

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 01/17/2022

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 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 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.	F 880		

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F 880	Continued From page 2 §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 observations, interviews, record reviews, and review of facility policies, it was determined the facility failed to ensure that staff developed and maintained an Infection Prevention and Control Program (IPCP) to help prevent the spread of infections including COVID-19 for 2 of 6 residents (Resident #1 and Resident #5) reviewed for NJAC 8:43E-2.1 and Exec Order 26, 4.... The facility failed to provide personal protective equipment (PPE) and isolation precaution signage outside the door of a resident's room on isolation (Resident #1) and failed to don PPE prior to going into a resident's room that was on isolation precautions (Resident #5). The deficient practice occurred during the COVID-19 pandemic. Findings included: 1. A review of Resident #1's face sheet revealed the facility admitted the resident with diagnoses NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1.	F 880	1. Resident #1's sign and PPE caddy were immediately replaced. C.N.A.#2 was immediately educated on wearing PPE when entering rooms of residents on COVID 19 precautions. 2. All residents have the potential to be affected by this deficient practice. 3. Corporate policies titles "COVID 19 Outbreak Management" and "Infection Control" were reviewed by facility administration and determined to be in compliance. The Regional Director of Clinical Operations held an Ad Hoc QAPI meeting in which a review of the deficiency occurred with a root cause analysis developed, and corrective actions developed including but not limited to audits. DIRECTED PLAN OF EDUCATION	

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

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F 880	Continued From page 3	F 880		

The quarterly Minimum Data Set (MDS), dated NJAC 8:43E-2.1 and Exec O, revealed that the resident scored NJAC 8: NJAC 8:43E-2.1 and E on the Brief Interview for Mental Status (BIMS), indicating the resident was NJAC 8:43E-2.1 and Exec NJAC 8:43E-2

The medical record for Resident #1 revealed that a NJAC 8:43E-2.1 and Exec Orde was NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. on NJAC 8:43E-2.1 and Exec O at 10:54 PM. The lab report was reviewed by Unit Manager (UM) #2 on 12/11/2021. A review of orders revealed that on 12/11/2021, an order was received for NJAC 8:43E-2.1 and E NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. An order for contact NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. (NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1.) was also started.

The surveyor interviewed Resident #1 on 12/14/2021 at 12:49 PM, and there was no signage noting contact precautions or availability of PPE for staff or visitors. PPE was required for entering the room.

On 12/15/2021 at 1:25 PM, Licensed Practical Nurse (LPN) #1 stated that Resident #1 had been on isolation precautions due to C. diff., but the PPE was gone so the medication must have been finished.

Resident #1 was interviewed on 12/15/2021 at 1:32 PM and stated that they had been diagnosed with NJAC 8:43E-2.1 about a week ago.

At 1:44 PM on 12/15/2021, during an interview with the Director of Nursing (DON) and Unit Manager (UM) #2, it was determined that

The Regional Consultant Board Certified in Infection Control/ designee educated all staff on deficiency, contributing factors, adherence to infection control practices specifically focusing on appropriate infection control precautions for MDRO and following COVID 19 precautions specifically focusing on donning PPE when entering a room on COVID 19 precautions.

The facility shall provide in-service training to appropriate staff and validated competency by the DON, medical director, or Infection Preventionist, as follows:

1. Nursing Home Infection Preventionist Training Course Module 1 - Infection Prevention & Control Program https://www.train.org/main/course/1081350/
Provide the training to: Topline staff and infection preventionist
2. CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff: Keep COVID-19 Out! https://youtu.be/7srwrF9MGdw
Provide the training to: Frontline staff
3. CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff: Closely Monitor Residents https://youtu.be/1ZbT1Njv6xA
Provide the training to: Frontline staff
4. CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff: Use PPE Correctly for COVID-19

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F 880	Continued From page 4 Resident #1 should still have been on NJAC 8:43E-2.1 and [redacted] PPE should have been outside the door, and a sign to see the nurse should also be on the door. UM #2 stated the cart was missing and sometimes residents would take the carts away. UM #2 was unsure why, but it had happened previously. UM #2 returned a few minutes later to inform the surveyor that the cart had been found in the shower room with the sign crumpled on top. UM #2 also informed the surveyor and the DON that the cart was returned to the resident's door with a new sign. The DON stated that it was expected that residents who were on isolation precautions were expected to remain on precautions for the entire time ordered. 2. On 12/14/2021 at 2:40 PM, the surveyor was interviewing Resident #4 and observed Certified Nursing Assistant (CNA) #2 walking into Resident #5's room without PPE. The CNA left the room, returned with a cup of water, and walked back into the room, again without donning PPE. After completing the interview, this surveyor interviewed CNA #2 on 12/15/2021 at 2:54 PM and asked why the cart with PPE was outside the room. CNA #2 stated that it was for residents who had fluid on their stomach COVID-19. CNA #2 stated that everyone should gown up before entering a room that contained a resident that was on precautions or isolation. CNA #2 went into the room to check on the resident and then went back with water without PPE. CNA #2 stated they did not gown up but should have before going into the room. UM #1 was interviewed on 12/14/2021 at 2:59	F 880	https://youtu.be/YYTATw9yav4 Provide the training to: Frontline staff 5. Nursing Home Infection Preventionist Training Course Module 4 - Infection Surveillance https://www.train.org/cdctrain/course/108 1802/ Provide the training to: Topline staff and infection preventionist only 6. Nursing Home Infection Preventionist Training Course Module 6A - Principles of Standard Precautions https://www.train.org/main/course/108180 4/ Provide the training to: All staff including topline staff and infection preventionist 7. Nursing Home Infection Preventionist Training Course Module 6B - Principles of Transmission Based Precautions https://www.train.org/main/course/108l80 5/ Provide the training to: All staff including topline staff and infection preventionist 4. The Infection Preventionist /designee will perform audits of residents on precautions and appropriate signage and PPE placed outside the room. The audits will focus on MDRO and appropriate infection control precautions. These audits of MDRO precaution requirements will be observed weekly x 4 weeks and then monthly until compliance is met. The results of these observations will be submitted at QAPI.	

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F 880	Continued From page 5 PM as the UM was donning PPE to go into Resident #5's room. UM #1 stated Resident #5 was NJAC 8:43E-2.1 and Exec Order 26, 4. b. 1. due to being a new admission and the resident was NJAC 8:43E-2.1 and Exec Order 26, NJAC 8:43E-2.1 and Exec Order 26 The UM stated staff must don PPE before entering the room and remove the gown and gloves prior to leaving the room. The Director of Nursing (DON) was interviewed on 12/15/2021 at 1:44 PM and stated that it was expected that all staff don PPE prior to entering all rooms with residents with isolation precautions. The Infection Preventionist (IP) stated in an interview on 12/15/2021 at 3:15 PM that staff were trained to use PPE for all residents who were on isolation precautions and that all isolation precautions were in effect the entire time the precautions were ordered. New Jersey Administrative Code § 8:39-19.4(a)1-6	F 880	The Infection Preventionist /designee will perform Covid-19 infection control rounds, including observation of adherence to COVID 19 requirements for donning PPE when entering a room on COVID 19 precautions. These audits of COVID 19 requirements will be observed weekly x 4 weeks and then monthly until compliance is met. The results of these observations will be submitted at QAPI The DON is responsible for the execution and oversite of this POC.	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 315174 Y1	MULTIPLE CONSTRUCTION A. Building B. Wing Y2	DATE OF REVISIT 2/16/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
DEPTFORD CENTER FOR REHABILITATION AND HEALTHCARE	1511 CLEMENTS BRIDGE RD DEPTFORD, NJ 08096

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 02/10/2022	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 12/15/2021	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO