STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315206	A. BUILDING _____ B. WING _____	12/22/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANAHAWKIN CONV CTR	1211 RT 72 WEST MANAHAWKIN, NJ 08050

(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: 12/22/2020 Census: 93 Sample: 5 A COVID-19 Focused Infection Control Survey was conducted by the New Jersey Department of Health. The facility was found not to be in compliance with 42 CFR §483.80 infection control regulations and has implemented 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 facility assessment conducted according to §483.70(e) and following	F 880		1/27/21

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

Electronically Signed | 12/31/2020

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F 880	Continued From page 1 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. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880		

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F 880	Continued From page 2 §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, medical record review and review of other facility documentation, it was determined that the facility failed to: 1.) follow appropriate infection control practices in a manner to prevent the potential spread of infection and/or cross-contamination and post appropriate Transmission-Based Precaution (TBP) signs outside rooms/cohort areas for residents under investigation for COVID-19, and 2. the facility failed to adhere to the Executive Directive No, 20-013 issued by the New Jersey Commissioner in response to the COVID-19 Pandemic by failing to report a positive case of COVID-19 infection. This deficient practice was identified for 1 of 1 cohort units (TBP unit) and [redacted] of [redacted] sampled residents (Resident [redacted]) and was evidenced by the following: 1. On 12/22/2020 at 9:20 AM during an entrance conference with the Regional Corporate Clinical Coordinator (RCCC) the surveyor was informed that the facility currently had [redacted] residents on their TBP isolation unit. The TBP unit was described by the RCCC as "Residents who were not exposed but left the facility for dialysis treatments, regular medical appointments or were new admissions or readmissions to the facility." On further interview the RCCC stated that residents who are new admissions or readmissions were required to have a negative COVID-19 test within 72 hours of admission and would be tested in the facility for COVID-19 within 5 to 7 days. Residents	F 880	F-880 1. The Infection Preventionist (IP) immediately posted signs to identify the [redacted] unit as the type of unit for Transmission Based Precautions(TBP). The staff member who failed to practice the correct protocol for Transmission Based precautions was given individual counseling by the Infection Preventionist as to the proper techniques and policies for the Transmission Based Precautions. The RCCC was immediately in-serviced by the Infection Preventionist (IP)on the proper signage needed to be posted on the Transmission Based Precaution Unit. The Director of Nurses was given individual counseling by the Regional Corporate Consultant as to the proper reporting protocols and policies required by the Department of Health in regards to testing of residents and staff and the reporting of these results. 2. All residents and staff have the potential to be affected by this deficient practice when policies and procedures are not followed to prevent the spread of COVID-19 virus. 3. All staff were in-serviced on 12/23/2020 by the Infection Preventionist on the policies and protocols for infection	

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F 880	Continued From page 3 are required to quarantine for 14 days on the TBP unit before being relocated to another area of the facility. In addition, the RCCC stated that the personal protective equipment (PPE) required to enter the TBP unit consisted of "Full PPE, N95 mask, gown, gloves, and face shield." On 12/22/2020 at 12:03 PM the surveyor entered the [redacted] on the [redacted] floor of the facility, which contained the TBP isolation unit. The surveyor observed a plastic, 6 drawer PPE bin. The PPE bin contained disposable gloves, KN95 masks, disposable gowns, plastic trash bags, plastic face shields and eye goggles. The TBP unit was separated from the rest of the [redacted] Wing by a plastic barrier. No signage was observed to be posted at the entrance to the unit, including the walls or plastic barrier, to identify what PPE was required to enter the unit and what type of infection control precautions were in place. The surveyor entered the TBP unit at 12:06 PM and did not observe any signage posted indicating that the residents in rooms [redacted], [redacted] were on any type of transmission-based precautions. The surveyor did observe a sign posted on the wall between rooms [redacted] which detailed how to properly donn and doff (put on/take off) PPE. During tour of the TBP isolation unit the surveyor observed a female staff member enter the TBP unit through the plastic barrier at 12:13 PM. The staff member was observed to donn a surgical type mask only. The staff member proceeded to knock on the door and then enter room [redacted] while donning a surgical mask and no other PPE. The surveyor observed the staff member in room [redacted] through the open door. The staff was observed to	F 880	prevention in regards to the COVID-19 virus. On 12/23/2020, all staff were in-serviced by the Infection Preventionist(IP)on the proper donning and doffing of PPE equipment when entering and exiting the Transmission Based Unit. On 12/28/2020 a Root Cause Analysis (RCA) was conducted by the Administrative Staff to identify the cause of the event and to develop corrective actions. Module #1 was viewed by the topline staff. The regulation video was viewed by all staff. The outcome of the Root Cause Analysis (RCA) was successful. The cause of F-tag 880 was due to the lack of compliance with infection control policies and procedure in regards to Transmission Based Precautions with the COVID-19 virus and the lack of compliance with reporting positive COVID-19 cases to the local department of health (LDH). The Regional Corporate Consultant will monitor all reporting requirements weekly. 4. The Infection Preventionist and the Director of Nurses will choose 3 employees daily,then 2 employees weekly x 30 days going in and out of the Transmission Based Unit for proper technique for donning and doffing PPE equipment. The Administrator will monitor daily x 30 days the posting of signs for designated Transmission Based areas. The Regional Corporate Consultant will monitor weekly x 30 days then monthly x 60 days all reporting requirements. All information will be reviewed at the Quality Assurance meeting x 3 quarters.	

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F 880	Continued From page 4 practice social distancing (6 feet or greater) while speaking with Resident [redacted]. The surveyor observed the staff member adjust the residents bed height utilizing a crank under the footboard of the resident's bed. The staff member exited room [redacted] at 12:16 PM and immediately performed hand hygiene with alcohol-based hand rub. Resident [redacted] was a [redacted] placed on transmission based precautions for 14 days and had been [redacted] in the [redacted] to facility. On 12/22/2020 at 12:17 PM the surveyor interviewed the staff member who identified herself as a Behavior Monitor Assistant (BMA). The BMA described her job duty as "monitoring the fall risk residents" and she does not perform resident care. On interview the BMA told the surveyor that the required PPE to enter the TBP isolation unit consisted of "gown, gloves, KN95 mask and eye protection." On further interview the BMA stated that she doesn't normally enter the TBP isolation unit but, "the call light was on for awhile and I just came down here to answer it. I need to wear the full PPE like everybody else." On 12/22/2020 at 1:08 PM the surveyor interviewed the Licensed Practical Nurse (LPN) who was assigned to the TBP unit on 12/22/2020 and had observed the BMA enter the TBP unit without proper PPE. On interview the LPN stated, "The requirement to be on the TBP unit is full PPE upon entering the unit. The BMA should have donned full PPE upon entering the unit." On 12/22/2020 at 1:20 PM the surveyor interviewed the Licensed Practical Nurse/Unit Manager (LPN/UM) for the [redacted] and	F 880		

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F 880	Continued From page 5 [redacted]Wings. On interview the LPN/UM stated, "My expectation is staff will have gown, gloves, KN95 mask and face shields on the TBP unit." The surveyor asked the LPN/UM why there was no signage posted on the TBP unit to indicate proper PPE or what transmission-based precautions were in place on the unit. The LPN/UM stated "We need to be on all precautions, contact, droplet and airborne. We do not have signage posted on the unit." On 12/22/2020 at 2:09 PM the surveyor conducted an interview with the RCCC. The surveyor questioned the RCCC as to why no signage was posted on the TBP unit. The RCCC stated "I need to make one of those. I'm not sure how long the unit has been up. There should be a sign by the isolation setup on how to donn and doff PPE, maybe it fell down." On further interview the RCCC stated "I would expect staff to donn full PPE to enter the TBP unit. It would be the same as entering a COVID unit, you need full PPE." The surveyor reviewed the facility policy titled "Infection Control Guidelines for Mandatory Health Alerts", revised 3/19/20. Under the "Guidelines for Providing Care" heading, the policy stated the following at 3.(a): "Before providing care to a resident diagnosed or suspected to have COVID-19 virus the employees that provide care or visit with a resident must wear the appropriate PPE required (sic). This includes gown, mask, gloves, shoe booties and eye protection." The policy also revealed under the heading "Identifying Assessing and Procedure", at 4. "Implement transmission-based precaution signage to include Contact and Droplet unless community is capable	F 880		

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F 880		F 880		

Continued From page 6
of Airborne Isolation."

2. Resident [redacted] was admitted to the facility with [redacted].

A review of a weekly SARS-CoV-2 (COVID) lab test with a collection date of [redacted] and report date of [redacted] revealed [redacted] Subsequent [redacted] with collection date of [redacted] and report date of [redacted] revealed [redacted]." Further Covid testing dated [redacted] and [redacted] also reported [redacted]. A review of the [redacted] completed on [redacted] at the facility indicated Resident [redacted] was [redacted]

During an interview with the Director of Nursing (DON) on 12/22/20 at 9:03 AM, the DON said Resident [redacted] for [redacted] on [redacted] and that she found out on [redacted] when the Local Health Department (LHD) called and told her Resident [redacted] was [redacted]. The DON further stated that on [redacted] Resident [redacted] received [redacted] at the facility as well as [redacted] all of which were [redacted]. The DON went on to say that she assumed this was a [redacted] as there was no reason for Resident [redacted] to be positive as he/she had not been out and was [redacted] The DON said Resident [redacted] roommate was also tested and was [redacted] and both residents were placed on PUI status for 14 days. The DON said the LHD called and told her she had to report the positive test and received an "[redacted] (outbreak) and had to put Resident [redacted] on a line list.

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F 880	Continued From page 7 During an interview with the Regional Corporate Clinical Coordinator Nurse (RCCC) on 12/22/20 at 11:55 AM, the RCCC said the lab notifies the LHD of positive results of test. The RCCC further stated the DON did not report this and you are supposed to report all positive tests even if they are inconclusive. During an interview with the DON on 11/22/20 at 12:15 PM, the DON said she was not aware of needing to do a line listing and she did not call her LHD about Resident [redacted] Executive Order 26, 4.b.. The DON said she spoke to the LHD a few weeks ago and told the LHD I thought this was a [redacted], but the LHD did not get back to me until 12/16/20 telling me to report it. The DON said the LHD educated her on how to do the line listing and she sent this to the LHD. The DON further said yes I should have reached out to the LHD, but I didn't know I was supposed to notify them. During a telephone interview with the LHD on 12/22/20 at 12:48 PM, the LHD revealed she was notified of through a contact tracer on [redacted] that Resident [redacted] had tested Executive Order 26, 4.b. on [redacted]. The LHD went on to say she notified the facility on [redacted] and told the DON they had to report this. The LHD said no one had reached out to her from the facility about this [redacted] case. NJAC 8:39-19.4(a) (f) (2)(c)	F 880		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT
315206 Y1	Y2	1/6/2021 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 01/06/2021	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 12/22/2020	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			