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 _____	01/14/2022

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:1/14/2022 Census:96 Sample:5 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 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, 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;	F 880		3/4/22

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

Electronically Signed | 02/02/2022

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 §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. §483.80(f) Annual review.	F 880		

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F 880	Continued From page 2 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 other pertinent facility documentation, it was determined that the facility staff failed to wear the required personal protective equipment (PPE), specifically gowns, when entering 1 of 8 resident rooms under precautions for COVID-19 (a potentially deadly respiratory virus) that had posted signs indicating that gowns must be worn upon entering room. This deficient practice was evidenced by the following: On 1/14/2022 at 9:40 AM, during the initial tour of the facility the following: License Practical Nurse (LPN #1) entered Resident #1's room wearing a mask, gloves, and eye protection. LPN #1 was not wearing a gown. A sign on the door of the room indicated, "STOP: Special Droplet/Contact Precautions." The sign further revealed, "Everyone Must: including visitors, doctors, & staff gown and glove at door." During an interview with the surveyor at that time, LPN #1 said, "We should be" when asked if staff must wear gowns in Resident #1's room. At approximately 9:45 AM, the surveyor observed a housekeeper enter Resident #1's room wearing a mask, gloves, and eye protection without wearing a gown. At 9:50 AM, the surveyor observed LPN #2 enter room Resident #1's room wearing a mask, gloves, and eye protection. LPN #2 was not	F 880	1. All employees were re-educated on the use of required PPE when entering rooms for residents who are confirmed positive for Covid-19 or those considered PUI. The affected residents did not experience a decline related to the alleged deficient practice. 2. All residents have the potential to be affected by the alleged deficient practice. 3. Consistent with the DPOC, a root cause analysis was be completed to identify the reasons why the alleged deficient practice occurred as well as systemic changes that need to be taken to implement the solution. Based on this exercise, it was determined that although the staff understood the signage at the door and wore mask, gloves and eye protection, they were careless in recognizing the need to wear full PPE, including gowns. In addition, the facility provided in-service training as follows: Nursing Home Infection Preventionist Training Course Module 1 □ Infection Prevention & Control Program Training provided to: Topline staff and infection preventionist CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff: Keep	

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F 880	Continued From page 3 wearing a gown. During an interview with the surveyor at that time, LPN #2 replied, "Yes" when asked if a gown was needed to enter the room. A review of Resident #1's "Executive Order 26, 4.b." provided by the Director of Nursing (DON), revealed Resident #1 Executive Order 26, 4.b. Executive Order 26, 4.b. A review of a facility policy titled, "Coronavirus Infection Prevention Control and Recommendations" with an effective date of March 2020, revealed under "Duration of Isolation Precautions for PUI's (Person Under Investigation), New Admissions and Confirmed Covid 19 Patients" #6 "Health care personnel caring for residents in 14-day quarantine/observation should use all recommended PPE, including a respirator (or facemask if a respirator is not available), gown, gloves, and eye protection (i.e., contact and droplet precautions, in addition to standard precautions)." NJAC 8:39 - 19.4(a)	F 880	COVID-19 Out! Training provided to: Frontline Staff CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff: Sparkling Surfaces Training provided to: Frontline Staff CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff: Closely Monitor Residents Training provided to: Frontline Staff CDC COVID-19 Prevention Messages for Front Line Long-Term Care Staff: Use PPE Correctly for COVID-19 Training provided to: Frontline Staff Nursing Home Infection Preventionist Training Course Module 5 □ Outbreaks Training provided to: Topline staff and infection preventionist Nursing Home Infection Preventionist Training Course Module 4 □ Infection Surveillance Training provided to: Topline staff and infection preventionist Nursing Home Infection Preventionist Training Course Module 6A □ Principles of Standard Precautions Training provided to: All staff including topline staff and infection preventionist Nursing Home Infection Preventionist Training Course	

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F 880	Continued From page 4	F 880	Module 6B □ Principles of Transmission Based Precautions Training provided to: All staff including topline staff and infection preventionist 4. The Director of Nursing or designee will conduct monthly rounds with special focus to ensure that all staff caring for, or providing services to residents who require use of PPE are doing so properly. This will include observation of adequate supply of PPE, use of all required PPE as well as proper donning and doffing. Documentation of these rounds will be submitted to the QAPI committee for the next three months. Based on the results of these rounds, a decision will be made regarding the need for continued submission and reporting.	

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
315206 Y1	A. Building B. Wing Y2	3/14/2022 Y3

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

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 03/04/2022	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	
1/14/2022	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO