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WARREN HAVEN REHAB AND NURSING CENTER	350 OXFORD ROAD OXFORD, NJ 07863

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F 000	INITIAL COMMENTS FOOO During an Onsite COVID-19 Focused Infection Control Survey conducted on 4/22/2020, an Immediate Jeopardy was identified in the area of infection control F 880 at S/S "K" The facility was not in substantial compliance with 42 CFR §483.80 (Infection Control), Subpart-B-Requirements for Long Term Care Facilities. The facility was not following infection control safety practices and guidance recommended by CMS and the Centers for Disease Control and Prevention (CDC), during a COVID-19 pandemic. The census was 82. The Director of Nursing (DON), Administrator, and Chief Operating Officer were made aware that Immediate Jeopardy existed on April 22, 2020 at 7:50 PM. Immediate Jeopardy was identified at: CFR 483.80 at tag F880 at a scope and severity of "K." The Immediate Jeopardy situation began on April 22, 2020 and was removed on April 24, 2020 after onsite verification of the Removal Plan. COVID-19 (Coronavirus Disease 2019), is a disease caused by the coronavirus SARS -CoV-2. COVID-19 is thought to spread mainly from person to person, mainly through respiratory droplets produced when an infected person coughs or sneezes.	F 000		
F 880 SS=K	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		4/25/20

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

Electronically Signed | 05/15/2020

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F 880	Continued From page 1 §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; §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	F 880		

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F 880	Continued From page 2 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. 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 a review of facility documentation, it was determined that the facility failed to ensure a.) appropriate transmission-based precautions and infection control practices were implemented and practiced by staff providing caring for residents on a unit that contained COVID-19 positive and COVID-19 negative residents, b.) used gowns were continuously worn by staff assigned to provide care for residents that were confirmed	F 880	F880 1. The assignments for the nursing staff on the COVID-19 unit were reviewed. The COVID-19 unit now only contains confirmed COVID positive residents and/or persons under investigation (PUI). The facility staff assigned to the COVID unit were immediately directed to the additional PPE stored on the unit and	

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F 880	Continued From page 3 positive for COVID-19 and residents that were non-ill, Asymptomatic, c.) staff practiced appropriate hand hygiene to prevent the spread of infection according to the Center for Disease Control and Prevention, d.) staff working at the facility had knowledge of the residents who were pending COVID-19 testing results, and e.) available gowns were easily accessible to nursing and housekeeping staff. This deficient practice was observed during a tour of 3 of 3 operating nursing units [redacted] conducted on 4/22/20. The residents identified in the deficient practice included; Resident #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, #15, #16, #17, #18, #19, #20, #21, #22, #23, and Resident #24, 24 residents who were COVID-19 positive, pending COVID testing results, or Asymptomatic out of the 82 residents who resided in the facility on 4/22/20. A review of the facility's COVID-19 Summary Report dated 4/22/20 and timed at 10:00 AM indicated that there was a total of 34 residents on the line list, 20 of the residents had been confirmed COVID-19 positive. Out of the 20 residents that had been confirmed COVID-19 positive, eleven residents resided in the facility on 4/22/20. Six residents were pending COVID-19 testing results. A total of six residents had also been hospitalized. A further review of the facility's COVID-19 Summary Report indicated that 14 staff members were included on the line list, and seven of those staff members had tested positive for COVID-19. Surveyor observation and interview revealed that nursing and housekeeping staff were provided one re-usable washable gown and one N-95	F 880	PPE was changed as required. The residents were placed on separate wings of the unit. In-servicing was provided to staff related to the changing of PPE (gowns, gloves, surgical masks and face shields) as they moved from the Non-COVID wing and back. Color coded signage was put in place (with staff in-servicing) : Blue- Droplet precautions (for residents testing negative but exposed to COVID positive resident), Yellow -for PUI (persons under investigation) and Red for COVID-19 positive. 2. The facility recognizes that all residents have the potential to be affected by this deficient practice. All current residents in the facility have been re-assessed and identified as COVID positive, PUI, and non-ill. The facility policy: Novel-Coronavirus Prevention and Response, was reviewed and revised. The facility policy on use of PPE during a public health emergency was reviewed and revised further to include the specific CDC guidelines on PPE usage during a pandemic. Separate wings on the unit were dedicated to COVID positive residents and Persons under investigation (PUI). Color-coded signs were placed on the doorways of residents as well to further clarify the resident's status. All staff were issued gowns and educated as to when these gowns must be changed. Staff were educated where to find additional PPE (on the linen carts and back-up in the treatment room).	

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F 880	Continued From page 4 respiratory mask at the start of their shift and that gowns were not easily accessible on the units where residents who were confirmed and presumed positive for COVID-19 resided. During the tour on the designated COVID-19 unit [redacted], it was identified that a Certified Nursing Aide (CNA) and a Licensed Practical Nurse (LPN) shared an assignment. This assignment consisted of a mix of confirmed positive COVID-19 residents and Asymptomatic COVID-19 negative residents. The CNA was observed wearing the same yellow gown and not performing appropriate infection control practices while going from COVID-19 positive to COVID-19 negative resident rooms. Further observation and interview revealed that staff were unaware of residents who were pending COVID testing results and were entering the symptomatic [pending results of COVID-19]. The staff identified above wore the same washable yellow gown and did not perform appropriate infection control practices between symptomatic [having signs and symptoms] and non-ill, Asymptomatic residents who resided on that unit ([redacted]). The interviews conducted with multiple staff members throughout the facility confirmed that staff were continuously wearing the same washable yellow gown while caring for Asymptomatic (non-ill), symptomatic (pending results and COVID-19), and positive COVID-19 residents throughout their shift. The surveyor further observed inappropriate hand hygiene practices by the housekeeping staff on the unit ([redacted]. Facility provided documentation dated 4/22/20, identified that 3 out of 20 residents (6.7 %) who were confirmed positive for COVID-19 had expired between 4/10/20 to 4/15/20.	F 880	Each staff member was provided with N95 masks (to be changed every 5 shifts worked or if soiled/damaged). Staff was educated on the use of surgical masks/covers and when these are required to be changed: whenever going from a COVID-19 room or a PUI room as well as if soiled or damaged. Each staff member was provided a washable face shield. Education was provided in the care of these face shields: to be cleaned with a disinfectant wipe when leaving a COVID positive room as well as exiting a PUI room and leaving the COVID-positive unit. Protocols for Routine and Terminal COVID-19 room cleaning are in place and Housekeeping staff trained to follow them. Housekeeping staff were included in hand-hygiene in-servicing. Non-Ill residents are located on a COVID-19 free unit. They remain confined to their rooms. Staff wear isolation gowns, N95 masks, surgical mask covers and gloves when in any and all resident care areas. 3. All staff currently on the schedule have been re-educated on the process of PPE usage and handwashing with return demonstration . Education of all staff will continue prior to their next scheduled shift until 100% compliance is achieved. All staff currently on the schedule have been educated on the identification method being used to identify the COVID status of each resident in the facility. This education will continue prior to their next scheduled shift until 100%	

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F 880	Continued From page 5 The facility's failure to ensure that proper infection control practices were implemented and adhered to resulted in the exposure of a virulent virus, Covid-19, during an outbreak. It was determined that the provider's noncompliance with one or more requirements of participation has caused, or was likely to cause, serious injury, harm impairment or death to residents. The Immediate Jeopardy (IJ) was related to §480.80 Infection Control. The Director of Nursing (DON), Administrator, and Chief Operating Officer were made aware the IJ existed for the residents who resided in the facility on 4/22/20, at 7:50 PM. The immediacy was removed on 4/23/20 on 4:45 PM based on an acceptable removal plan that was implemented by the facility and verified during an on-site revisit survey conducted on 4/24/20. The evidence was as followed: On 4/22/20 at 10:00 AM to 10:30 AM, the surveyor conducted the entrance conference with the Director of Nursing (DON) in the presence of the Administrator and Chief Operating Officer. The DON stated that the facility currently had eleven residents that were COVID-19 positive (C19+) and one C19+ resident in the hospital. The DON told the surveyor that all the C19+ residents were located on the long hallway on 2 East. The DON further stated that six residents altogether were pending COVID- 19 testing results, four of the residents resided in the facility, and two of the residents were currently in the hospital. The DON stated that there were three resident deaths related to COVID-19. The DON further stated that fourteen staff members	F 880	compliance is achieved. All facility staff currently on the schedule have been educated on the identification method being used to identify the COVID status of each resident n the facility through the use of color coding: RED= positive COVID; YELLOW=suspected COVID and BLUE= Droplet Precautions. Education of all remaining staff will be completed prior to their next scheduled shift until 100% compliance is achieved. The DON/designee will audit the availability of PPE supplies on the unit and the signage for identification of residents, daily. The Director of Nursing/designee will complete weekly audits of direct care staff with hand washing and the use of PPE. 4. The results of these audits will be reviewed and reported upon by the DON/Designee, as well as up-dates and reporting on staff in-service education, at the quarterly Quality Assurance Committee meeting. Any trends and/or patterns will be identified and the Committee will determine the corrective action. This will be an on-going QAPI (Quality Assurance/Performance Improvement) project. Date of Completion: 4/25/2020	

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presented with possible signs and symptoms of COVID-19, they were all tested, and seven of them came back positive for the virus.

The surveyor asked the DON what Personal Protective Equipment (PPE) the facility was utilizing. The DON told the surveyor that the facility currently had an adequate amount of PPE (gowns, gloves, N95 masks, surgical masks, and face shields). The DON stated that the facility had 450 washable PPE gowns that were in circulation. She stated that the staff would receive one at the beginning of their shift and return it at the end of their shift to be laundered. The DON stated that the staff received N95 masks, which they would put in a brown paper bag at the end of their shift, and the N95 masks would be used for five to seven days depending upon how frequently the staff member worked. The surveyor asked what the staff would do if they needed more PPE equipment. The DON stated that they could come to her or an Administrator for a replacement. She stated, "They know the procedure. If it becomes soiled, ripped, or damaged, it is replaced."

On 4/22/20 at 11:44 AM, the surveyor entered the first-floor locked dementia unit. The surveyor observed the 7:00 AM -3:00 PM Licensed Practical Nurse (LPN)#1 pull her medication cart into Resident #1 and Resident #2's room to make space for staff transporting Resident #3 in his/her bed from the unit. The surveyor observed that Resident #3 was wearing a surgical mask placed over his/her face, and the surgical mask was covering the resident's mouth, leaving the residents nostrils exposed.

The surveyor interviewed the staff member

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transporting Resident #3, who identified himself as the Housekeeping Director (HKD). The surveyor asked the HKD why he was transferring the resident, and the HKD stated that he didn't know why he was told to bring the resident to the [redacted] floor. The HKD was observed wearing a yellow washable gown, N95 mask, and gloves. No surgical mask or face shield was observed on the HKD.

The surveyor then interviewed the dementia unit 7-3 LPN#1, who stated that Resident #3 had a fever of 103.4 degrees Fahrenheit (F) and was suspected of being C19+, so they were transferring the resident to the [redacted] floor where the other C19+ residents resided.

At 11:57 AM, the surveyor interviewed the dementia unit 7:00 AM -3:00 PM Certified Nursing Aide (CNA) #1, who was observed wearing a yellow washable gown, N95 mask, and face shield. The 7-3 CNA #1 stated that the census on the unit was 33 residents, and today they had one nurse and two CNA's working. The 7-3 CNA #1 stated that signs and symptoms of COVID-19 were fever, cough, shortness of breath, and diarrhea. The 7-3 CNA #1 further stated that when the facility found out a resident who resided on the floor tested positive for COVID-19, the resident would be transferred to the second floor. Then the roommate of the resident who was identified as positive would be placed on transmission-based precautions because the resident was exposed.

The surveyor asked the 7-3 CNA #1 what PPE she was expected to wear while providing care for the residents on the unit. The 7-3 CNA #1 stated that as soon as she entered the facility,

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her temperature would be taken and was given an N95 mask, a face shield, and a washable yellow gown. The 7-3 CNA #1 stated that she was given the N95 mask and washable yellow gowns about seven days ago when another facility affected by COVID-19 residents was on the news. The 7-3 CNA #1 stated prior to that she was provided with a blue surgical mask. The 7-3 CNA #1 told the surveyor that prior to the implementation of the washable gowns and N95 masks, the staff were entering the resident's rooms on the first-floor dementia unit who had sign and symptom of COVID-19. The 7-3 CNA #1 stated that she didn't find out the residents were positive until they were moved to another unit upstairs, but the staff had been taking care of the residents while they were symptomatic without the appropriate PPE. The 7-3 CNA #1 stated, "We had a lot of people coughing in our faces, and we didn't have the masks." The 7-3 CNA #1 stated that she was given one washable yellow gown upon entering the facility, which was worn all day and then handed in at the end of the shift. The 7-3 CNA #1 stated that just today, she had gone into a resident's room who was suspected of being C19+ because of a high fever and that resident (Resident #3) was just moved to the [redacted] floor. The 7-3 CNA #1 stated that after she went into that resident's room, she had then entered other resident rooms that were Asymptomatic of the virus and still had on the same gown.

At 12:12 PM, the surveyor observed the dementia unit 7-3 LPN #1 standing outside of a resident's room at her medication cart, not wearing an N95 mask or surgical mask. The surveyor interviewed the dementia unit 7-3 LPN #1, who stated that she was so hot, and she

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couldn't breathe, so she had to take the mask off. The surveyor then observed the 7-3 LPN #1 apply the N95 mask. The surveyor asked the dementia unit 7-3 LPN #1 when she had first received the N95 mask and gown. The 7-3 LPN #1 replied that it was about "a week or a week and a half ago" when another facility affected by COVID-19 residents was on the news. The 7-3 LPN #1 stated that before that, the nurses working on the unit were given surgical masks to wear and had no gowns. This statement corroborated with the statement made by the dementia unit 7-3 CNA #1. The 7-3 LPN #1 stated that the facility would give each nurse an N95 mask to be worn for seven days. The 7-3 LPN #1 explained that at the end of her shift, she would return the N95 face mask, and it would be stored in a brown paper bag along with the face shields. The 7-3 LPN #1 further stated that she would return her washable yellow gown at the end of the day as well and then pick up her designated N95 mask, face shield, and a new gown at the start of her next shift. The 7-3 LPN #1 stated that she was not removing the gowns while caring for residents on the [redacted]-floor dementia unit and going room to room with the same gown on. The 7-3 LPN #1 stated, "None of us are, but I can only speak for myself."

At 12:21 PM, the surveyor observed the Housekeeper (HK) on the dementia unit enter Resident #5 and Resident #6's room without performing hand hygiene prior to entering the room. The surveyor further observed the HK exit the resident's room without performing hand hygiene and then enter the room of Resident #7. The surveyor observed that the HK was wearing a yellow washable gown and a blue N95 mask. The HK was not observed wearing a surgical

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mask or a face shield. The HK stated that her responsibility was to collect garbage, wipe down and disinfect areas such as bedrails, keypads, door handles, and the nurse's station three times a day. The HK stated that she never changed her gown throughout the day. The HK stated that she did not go to the second floor, where the C19+ residents were located. The HK could not speak to which residents on the unit were symptomatic or pending test results for the virus. The HK further stated that she was to use an alcohol-based hand rub before entering the resident's rooms and then wash her hands when she was done cleaning the resident's rooms.

On 4/22/20 at 12:35 PM, the surveyor entered the [redacted]-floor unit, which contained rooms [redacted]

At 12:40 PM, the surveyor interviewed the 7:00 AM - 3:00 PM CNA #2, who stated that she received a mask and face shield in the morning, which she would keep until it got soiled. The 7-3 CNA #2 stated that she also received a yellow washable gown every day upon entering the facility, which was tuned in at the end of the day and then laundered. The 7-3 CNA #2 stated that she was going room to room wearing the same PPE with residents that were infected, symptomatic, and Asymptomatic. The 7-3 CNA #2 stated, "We don't have enough." The surveyor asked who said that? How do you know you don't have enough PPE?" The 7-3 CNA #2 stated that the staff just assumed that because we weren't getting the PPE equipment. The 7-3 CNA #2 told the surveyor that for about "two weeks now," the staff had been provided with washable gowns and N95 masks, and she was unaware of any event that precipitated the administration of the

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gowns and N95 masks. The 7-3 CNA #2 stated that before the gowns and N95 masks, the staff were wearing surgical masks and gloves while providing care to the residents. The 7-3 CNA #2 further stated that the management gave the staff three different N95 masks to choose from, and she chose her mask, "based off of comfort and style." The 7-3 CNA #2 stated that she would perform hand hygiene before and after entering a resident's room.

At 12:50 PM, the surveyor interviewed the 7-3 LPN #2, who stated that she was a per diem nurse, and this was only her second day working at the facility the past month. The 7-3 LPN #2 stated that when she came to work, she got her temperature taken and was given the same N95 mask and face shield that she had worn yesterday. The 7-3 LPN #2 stated that the face shield must be worn when entering the resident's room, and the gown was washable and changed out daily. The 7-3 LPN #2 stated the other PPE like the N95 mask and face shield was changed out weekly. The 7-3 LPN #2 stated that to her knowledge, there were no C19+ residents who resided on the unit, and as soon as a resident tested positive, they were moved upstairs. The 7-3 LPN #2 did not speak of residents on the unit that were pending COVID testing results.

On 4/22/20 at 1:00 PM, the surveyor entered the [redacted] floor. The [redacted]-floor unit contained two hallways with a nurse's station in the center. One hallway the surveyor was told was where residents that were C19+ resided, and the other hallway was where COVID-19 negative (C19-) residents resided.

The surveyor observed C19+ Resident #8 and

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Resident #9 sitting upright in bed in their room. The surveyor observed a staff member sitting on Resident #9's bed and feeding the resident lunch. The staff member had her face shield up and was observed wearing an N95 mask, gloves, and a washable yellow gown. The surveyor did not observe that the staff member was wearing a surgical mask over her N95 mask. The surveyor further observed that there was no sign on the resident's door indicating that the resident was C19+, and no PPE was attached to the resident's door or located outside of the room in accessible bins.

A review of the line listing and the facility census by room number indicated that Resident #8 and Resident #9 were C19+.

At 1:01 PM, the surveyor observed C19+ residents, Resident #10 and Resident #11 C19+, in their bedroom. The surveyor observed a stop sign on the door of the resident's room and a PPE bin, which contained no assessable PPE hanging on the resident's door. The surveyor overheard the Resident #10 cough. Both residents observed were not wearing face-masks in the room.

A review of the line listing and the facility census by room number indicated that Resident #10 and Resident #11 were C19+.

At 1:02 PM, the surveyor observed C19+ Resident #12 lying in bed in his/her room wearing a face mask. There was no stop sign outside of the door, indicating the resident in the room was C19+. The surveyor further observed that the PPE holder attached to the door of the resident's room contained a box of gloves.

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A review of the line listing and facility census indicated that the Resident #12 was C19+.

At 1:03 PM, the surveyor further observed a C19+ Resident #13 in his/her room watching television. The resident was not observed wearing a face- mask. The surveyor observed that there was a stop sign on the door and a PPE holder that contained gloves.

A review of the line listing and facility census indicated that Resident #13 was C19+.

At 1:05 PM, the surveyor observed a C19+ Resident #14 in his/her room. A stop sign was observed at the door, and the PPE bin hanging on the door contained gloves.

A review of the line listing and facility census indicated that Resident #14 was C19+.

At 1:10 PM, the surveyor observed the second floor 7:00 AM - 3:00 PM CNA #3 walk into C19+ Resident #15's room. The surveyor observed the 7-3 CNA #3 apply a pair of gloves and take the garbage outside of the room. The surveyor did not observe the 7-3 CNA #3 perform hand hygiene before entering or exiting Resident #15's room. The surveyor observed the 7-3 CNA #3 tie the garbage bag while walking outside of the resident's room wearing the same gloves she applied inside of the room. The surveyor then observed 7-3 CNA #3 walk down the hall and opened the door to the soiled utility room to throw away the garbage. The surveyor observed the 7-3 CNA #3 remove her soiled gloves upon entering a C19+ Resident #10 and Resident #11's room without performing hand hygiene and

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without donning a new pair of gloves. The 7-3 CNA #3 was observed moving around items on the overbed table of Resident #10. The CNA #3 exited the room without performing hand hygiene and entered C19+ Resident #16's room and washed her hands inside that room for 15 seconds.

At 1:14 PM, the surveyor interviewed with the [redacted] floor 7-3 CNA #3, who stated that the census on the [redacted] floor was 22. The 7-3 CNA #3 stated that one of the hallways was for the C19+ residents, and the other hallway was for the C19- residents. The surveyor asked the 7-3 CNA #3 how many residents resided in the unit who were positive for COVID-19. The 7-3 CNA #3 stated that she wasn't quite sure, maybe four to five, because the residents were being moved back and forth. The 7-3 CNA #3 stated, "So I'm always getting the fresh infected ones." The 7-3 CNA #3 stated that the signs and symptoms of the virus varied from resident to resident. The 7-3 CNA #3 stated that some residents would have nausea, vomiting, anorexia (not eating), and some had respiratory symptoms such as coughing. The 7-3 CNA #3 explained to the surveyor that in the morning, when she arrived at work, her temperature was taken and then received her mask, face shield, and gown. The 7-3 CNA #3 stated that she wore the same gown all day and then, at the end of the day, would remove the gown to be washed by the facility. The 7-3 CNA #3 further stated that she would wear the N95 mask until it was soiled and would get a new one every two to three days. The 7-3 CNA #3 stated that she received the N95 mask on Monday (4/20/2020). The 7-3 CNA #3 further stated that she was the only CNA working on the unit and was taking care of the C19+ and C19-

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residents on the floor. The 7-3 CNA #3 stated that she was to wash her hands for 15 seconds before entering and exiting the resident's rooms.

At 1:26 PM, the surveyor interviewed the [redacted] floor, 7:00 AM - 3:00 PM LPN #3, who stated that she was the full-time nurse working on the unit. The 7-3 LPN #3 stated that signs and symptoms of COVID-19 varied from high fever, coughing, shortness of breath, and gastrointestinal (stomach) symptoms. The 7-3 LPN #3 stated that she would send the resident who was C19+ to the hospital if the person was not eating and had difficulty breathing. The 7-3 LPN #3 stated that it was the third week that she was wearing PPE because, at first, the staff wasn't allowed to because the management stated that the residents weren't infected, and it wasn't necessary. The surveyor asked the 7-3 LPN #3 when she was issued the N95 mask. The 7-3 LPN #3 stated, "Last week, today was the fifth day, so today they gave everyone a new one. The 7-3 LPN #3 further stated that today two nurses were working on the unit and one CNA. The 7-3 LPN #3 stated that the staff was given one gown at the beginning of their shifts, which they would wear all day. The 7-3 LPN #3 stated that the 7:00 AM - 3:00 PM CNA #3 was wearing the same gown while taking care of the C19+ and C19- residents on the unit. The 7-3 LPN #3 stated, "I don't feel like I'm being safe. I have a family at home, and I don't feel safe."

At 1:40 PM, the surveyor observed the second floor 7-3 CNA #3 go into C19- rooms on the unit that were indicated as containing residents that were negative and Asymptomatic of the virus. The surveyor was unable to observe the exact rooms the 7-3 CNA #3 entered because the

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F 880	Continued From page 16 surveyor was standing at a distance. At 1:42 PM, the surveyor interviewed the second floor, 7:00 AM - 3:00 PM LPN #4, who stated that the one hallway is considered C19+, and the other side was considered C19-. The 7-3 LPN #4 stated that staffing varied, sometimes there would be two nurses working, but there was always only one nurse and one CNA working the 11:00 PM - 7:00 AM shift on the [redacted] floor. The 7-3 LPN #4 stated symptoms of COVID-19 varied from resident to resident. She would have some residents with a fever and a cough and some residents that didn't have symptoms. The 7-3 LPN #4 stated that she would be very concerned if a C19+ resident were in respiratory distress, and that would initiate her to send the person to the hospital. The 7-3 LPN #4 stated that from the first C19+ resident on, the staff was issued N95 masks. The 7-3 LPN #4 further stated that she was unsure of the specific time frames as to when the N95 masks were issued. The 7-3 LPN #4 stated that the staff was given an N95 mask and face shield for one week or until it became soiled. The 7-3 LPN #4 stated that she was given one washable gown at the beginning of her shift, which was handed in at the end of her shift. The 7-3 LPN #4 further stated that the staff was going in and out of resident rooms wearing the same gown and N95 mask without putting a surgical mask over the N95 mask. The 7-3 LPN #4 confirmed that the 7-3 CNA #3 working on the unit was the only CNA working on the [redacted] floor during the 7:00 AM - 3:00 PM shift, and was going in and out of all the resident's rooms on the unit. The 7-3 LPN #4 stated that staff were supposed to wash their hands for 20 seconds before and after going in and out of resident's rooms.	F 880		

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At 1:55 PM, the surveyor interviewed the Staffing Coordinator/Certified Nursing Aide (SC/CNA), who stated that she oversaw the staffing of the building, and it had been challenging since the outbreak of COVID-19. The SC/CNA stated that she was trying her best to keep the staff isolated to working on the same unit. The SC/CNA further stated that they had received gowns for the staff to wear three weeks ago. The staff received one gown at the beginning of the shift, one at the end of the shift, and that they were not changing their gowns throughout the day. The SC/CNA stated that if the staff was going from a C19+ room to a C19- room, the staff should be changing their gowns no matter what.

At 2:22 PM to 2:41 PM, the surveyor conducted an interview with the Director of Nursing (DON), who stated that the facility was treating all the residents as if they were infected. The DON stated that before the usage of the N95 masks, the staff was utilizing the surgical masks for droplet precautions. The DON stated that on 4/14/20, she went unit to unit to make sure all the nurses received N95 masks, face shields, and gowns. The surveyor asked the DON how frequently the staff received a new N95 mask. The DON stated that it depended on the mask and if the mask became soiled. The DON stated that it also depended on if the staff worked overtime. For example, depending on how frequently the staff worked, the masks would be changed every three, five, or seven days. The DON did not speak to the placement of a surgical mask over the N95 mask.

The DON stated that the staff was provided with the washable yellow gowns on 4/14/20. The

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process for the gowns was that the staff would wear them throughout their shift, and then the gowns would be returned at the end of their shift and washed. The surveyor asked the DON if the CNA working on the second floor today was going room to room wearing the same gown. The DON stated, "probably as long as they are not soiled." The DON further stated that the C19+ residents should be wearing a mask in their rooms, and staff should wash their hands for 20 to 30 seconds before entering and exiting a resident's room.

At 3:00 PM, the surveyor interviewed the HKD, who stated that the housekeeping staff was to wear gowns, gloves, and a mask while cleaning the resident's rooms. Face shields were not required because the housekeeping staff did not have direct contact with the residents in the room. The HKD stated that he told his staff to clean high touch areas three times a day, such as the elevator buttons, doorknobs, and keypads. The HKD further stated that the housekeeper on the second floor was not cleaning the C19+ rooms and that the nursing staff was responsible for cleaning those resident rooms.

A review of the line listing provided by the facility indicated that two of the fourteen staff members that were tested for the virus worked in the housekeeping department. One of them tested C19+, and the other was pending testing results as of 4/20/20.

At 3:13 PM, the surveyor interviewed the 3:00 PM - 11:00 PM Registered Nurse/Supervisor (RN/S) who stated that she was helping the staff by taking a medication cart and passing medication during her shift while supervising the

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F 880	Continued From page 19 building. The RN/S stated that she had never taken a medication cart on the [redacted] floor to pass medications because they had a full time 3:00 PM - 11:00 PM nurse on the [redacted] floor, who was very good and would take a medication cart for the C19+ residents and another nurse would take a medication cart for the C19- residents. The RN/S stated that on the 11:00 PM - 7:00 AM shift, there was always one nurse and one CNA working on the [redacted] floor. The RN/S stated that she received her N95 mask about two weeks ago but could not specify the date. The RN/S further stated, "at the beginning of the shift, you get a gown, and then when you leave, you take it off." The RN/S stated that if the gowns were soiled, the staff needed to put on a new gown. The surveyor asked the RN/S what it would take for a gown to be soiled. The RN/S stated that if a resident were to cough or spit on a staff member, the gown would be considered soiled and should be changed. The RN/S further stated that the CNA's were told to change their gowns after they leave a C19+ room, but she was unaware if they followed that protocol. On 4/22/20 At 4:44 PM, the surveyor re-entered the [redacted]-floor unit, which contained rooms [redacted] The surveyor observed Resident #17 and Resident #18 seated on their wheelchairs with their overbed tray tables in front of them. The surveyor observed the 3:00 PM - 11:00 PM CNA #4 enter the room wearing a gown, an N95 mask, a face shield, no gloves, and no surgical mask hand out dinner trays to both residents in the room. The surveyor observed 3-11 CNA #4 move around items on the residents over bed tables and set up both resident's dinner trays for them. The surveyor then observed the 3-11 CNA #4 perform hand	F 880		

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hygiene for 20 seconds before exiting the room.

A review of the line listing and facility census indicated that Resident #17 and Resident #18 were pending COVID testing results as of 4/21/20.

A review of Resident #17's Interdisciplinary Notes (IN) dated 4/21/20 indicated that the resident's physician ordered the nasal swab for COVID-19, and the resident was currently on droplet precautions pending the results.

A review of Resident #18's Interdisciplinary Notes (IN) dated 4/21/20 indicated that the resident's physician ordered the nasal swab for COVID-19 because the resident was observed to be lethargic and the resident was currently on droplet precautions pending the results.

At 4:47 PM, the surveyor observed the 3-11 CNA #4 enter the room across the hallway and speak to Resident #19 briefly and then exit the room. The 3-11 CNA #4 was not observed performing hand hygiene before or after exiting the resident's room. The surveyor then observed the 3-11 CNA #4 enter Resident #20's room, move around items on the resident's overbed table, and set up the resident's dinner tray. CNA #4 was observed performing hand hygiene for 20 seconds after exiting the resident's room. CNA #4 was never observed changing her gown after exiting the resident's rooms.

A review of the line listing and facility census indicated that Resident #19 was Asymptomatic of the virus and not including on the line listing.

A further review of the line listing and facility

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census indicated that Resident #20 was pending COVID testing results as of 4/20/20.

A review lab results dated 4/22/20 indicated that resident #20 was negative for COVID-19.

At 5:08 PM, the surveyor interviewed the 3-11 CNA #4, who stated that signs and symptoms of COVID-19 were cough, confusion, weight loss, loss of appetite, diarrhea, and vomiting. The 3-11 CNA #4 stated that she had observed this with some of the residents who tested positive for the virus, and then the residents were moved upstairs. The 3-11 CNA #4 further stated that she noticed if one resident in the room tested positive, the roommate was likely to test positive as well. The 3-11 CNA #4 stated that every day when she came into work, she would get her temperature taken and get a mask and face shield, which were stored in paper bags with her name on it. The 3-11 CNA #4 stated that the face shields were sprayed with disinfectant. The 3-11 CNA #4 stated, "They are telling us that we get one mask and one face shield once a week unless it gets soiled." The 3-11 CNA #4 told the surveyor that she returned her gown at the end of her shift and never had to change her gown during her shift unless it got soiled with feces. The 3-11 CNA #4 stated that she was unaware of residents on the floor or unit that were pending testing results for COVID. The 3-11 CNA #4 stated, "[I] don't know who they test day to day. Certain residents are alert and able to tell me if they were swabbed."

At 5:16 PM, the surveyor conducted a follow-up interview with the RN/S who stated that Resident #17 and Resident #18 were pending COVID testing because both residents were running a

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high fever, had a poor appetite, and were lethargic. The RN/S stated that if she were to go into the room to take care of the resident's she would perform hand hygiene, put on gloves, and then perform hand hygiene again for 20 seconds. The RN/S further stated that the resident's pending COVID results were automatically placed on droplet precautions, so it would not be necessary to change the gown you were wearing after leaving the room. The RN/S stated that the nurse leaving was supposed to give the CNA's report on who was pending test results for the virus.

On 4/22/20 at 5:30 PM, the surveyor entered the [redacted]-floor unit and observed the 3:00 PM - 11:00 PM CNA #5 enter C19+ Resident #21's room, remove the resident's dinner tray, throw it into a garbage bag and then entered another C19+ Resident #14's room to remove the resident's dinner tray. The 3-11 CNA #5 was observed wearing goggles, an N95 mask, a washable yellow gown, and gloves. The 3-11 CNA #5 was not wearing a surgical mask and was not observed performing hand hygiene before entering and exiting the resident's room.

A review of the line listing and facility census indicated that Resident #21 and Resident #14 were C19+.

At 5:32 PM, the surveyor was standing at the [redacted]-floor nurse's station and observed the 3-11 CNA #5 walk further down the C19+ hallway, go into a resident's room, remove the tray from the room, and throw it into the garbage. The surveyor was unable to observe the exact room that the 3-11 CNA #5 entered because of the distance from the nurse's station. The

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(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
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surveyor then observed the 3-11 CNA #5 put on a pair of bright orange gloves in the hallway.

At 5:36 PM, the surveyor observed the 3-11 CNA #5 wearing the same goggles, N95 mask, washable yellow gown, and bright orange gloves enter C19- Resident #22's room and remove the resident's dinner tray from the room. The surveyor then observed the CNA #5 enter C19- Resident #23 and Resident #24's room and removed the dinner trays from that room.

A review of the line listing and facility census indicated that Resident #22, Resident #23, and Resident #24 were C19-.

At 5:38 PM, the surveyor interviewed 3-11 CNA #5, who told the surveyor that she worked the 3:00 PM - 11:00 PM and the 11:00 PM - 7:00 AM shifts at the facility. The 3-11 CNA #5 stated that sometimes on the 3:00 PM - 11:00 PM shift, they would have two CNA's, but today she was the only CNA working. The 3-11 CNA #5 stated that the unit consisted of C19+ and C19- residents, and she treated all the residents on the unit like they were positive. The 3-11 CNA #5 stated that she wore a gown, gloves, N95 mask, and goggles throughout her shift when she cared for all the residents. The surveyor asked the 3-11 CNA #5, "Do you remove your gown at all during your shift when going from C19+ to C19- resident rooms?" The 3-11 CNA #5 replied, "No. To be honest, we don't. I keep the same gown on." The 3-11 CNA #5 further stated that she always wore the N95 mask when caring for all the residents on the unit. The 3-11 CNA #5 did not speak of changing or placing a new surgical mask over the N95 masks when going from C19+ to C19- resident rooms.

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	315304	A. BUILDING _____ B. WING _____	04/24/2020

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F 880	Continued From page 24 At 5:48 PM, the surveyor interviewed the [redacted] floor 3:00 PM - 11:00 PM LPN #5, who stated that she was the only nurse working on the [redacted] floor during the shift and was responsible for taking care of the C19+ and C19- residents. The 3-11 LPN #5 told the surveyor that she would first administer medications to the C19- residents and then administer medications to the C19+ residents. Then around 7:00 PM or 8:00 PM, she would go back to the C19- resident rooms to pass the residents drinks and snacks if they wanted them. The 3-11 LPN #5 stated that she would wear her gown the entire shift and only change it if it became soiled. The 3-11 LPN #5 did not speak to having additional gowns on the unit. The surveyor observed that the 3-11 LPN #5 was wearing a washable yellow gown, N95 mask, and face shield. On 4/22/20 at 6:02 PM, the surveyor, the DON, and the Administrator were walking up the stairs in the facility to observe the PPE storage room. The surveyor asked the DON if the staff were expected to wear a surgical mask over their N95 masks. The DON stated, "No." The Administrator then stated that the staff would be too uncomfortable if they were to wear both those heavy masks. At 6:03 PM, the surveyor observed the locked PPE storage room in the presence of the DON and Administrator. The surveyor observed boxes upon boxes of disposable gowns, washable gowns, N95 masks, and surgical masks. The DON told the surveyor that the facility had a total of 365 N95 masks, 245 small N95 masks, 120 regular size N95 masks, and the rest were large-sized that she was going to give to another	F 880		

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facility. The DON further stated that the facility had 370 disposable gowns, 450 reusable, washable gowns, 300 looped ear masks (surgical masks). The Administrator stated that the OEM (personal protective equipment manufacturer) sent the facility 160 masks as well. At that time, the surveyor asked the DON in the presence of the Administrator why she was not changing out the washable gowns during the shift to be laundered if she had the PPE available. The DON stated that she was conserving and protecting the equipment because she did the math and determined that she would be out of PPE in three to four weeks if the PPE were used and discarded. The DON did not speak to the question of laundering the gowns throughout the shift.

At 7:24 PM, The DON stated that the 3:00 PM to 11:00 PM CNA working on the [redacted] floor should have been given report by one of the nurses, which residents on the unit were pending COVID-19 testing results.

A review of the facility's staffing assignments for [redacted], long and short hallways (rooms [redacted]) reflected that there was one nurse and one CNA working the 11:00 PM to 7:00 AM shift on 4/18/20 that identified one nurse and one CNA was responsible for caring for the residents on the C19+ and C19- hallways.

A review of the facility's staffing assignments for [redacted], long and short hallways (rooms [redacted]) indicated that there were two nurses and one CNA working the 7:00 AM to 3:00 PM shift on 4/18/20. This indicated that the one CNA was responsible for caring for the residents on the C19+ and C19- hallways.

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F 880	Continued From page 26 A review of the facility's staffing assignments for [redacted], long and short hallways (rooms [redacted]) indicated that there were two nurses and one CNA working the 3:00 PM to 11:00 PM shift on 4/18/20. This indicated that the one CNA was responsible for caring for the residents on the C19+ and C19- hallways. A review of the facility's staffing assignments for [redacted], long and short hallways (rooms [redacted]) indicated that there was one nurse and one CNA working the 11:00 PM to 7:00 AM shift on 4/19/20. This indicated that one nurse and one CNA were responsible for caring for the residents on the C19+ and C19- hallways. A review of the facility's staffing assignments for [redacted], long and short hallways (rooms [redacted]) indicated that there was one nurse and one CNA working the 7:00 AM to 3:00 PM shift on 4/19/20. This indicated that the one nurse and one CNA were responsible for caring for the residents on the C19+ and C19- hallways. A review of the facility's staffing assignments for [redacted], long and short hallways (rooms [redacted]) indicated that there was one nurse and one CNA working the 3:00 PM to 11:00 PM shift on 4/19/20. This indicated that the one nurse and one CNA were responsible for caring for the residents on the C19+ and C19- hallways. A review of the facility's staffing assignments for [redacted], long and short hallways (rooms [redacted])) indicated that there was one nurse and one CNA working the 11:00 PM to 7:00 AM shift on 4/20/20. This indicated that one nurse and one CNA were responsible for caring for the	F 880		

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F 880	Continued From page 27 residents on the C19+ and C19- hallways. A review of the facility's staffing assignments for [redacted], long and short hallways (rooms [redacted]) noted that there was one nurse and two CNA's working the 7:00 AM to 3:00 PM shift on 4/20/20. This indicated that one nurse was responsible for caring for the residents on the C19+ and C19- hallways. A review of the facility's staffing assignments for [redacted], long and short hallways (rooms [redacted]) indicated that there was one nurse and two CNA's working the 3:00 PM to 11:00 PM shift on 4/20/20. This indicated that one nurse was responsible for caring for the residents on the C19+ and C19- hallways. A review of the facility's staffing assignments for [redacted], long and short hallways (rooms [redacted]) indicated that there was one nurse and one CNA working the 11:00 PM to 7:00 AM shift on 4/21/20. This indicated that one nurse and one CNA were responsible for caring for the residents on the C19+ and C19- hallways. A review of the facility's staffing assignments for [redacted], long and short hallways (rooms [redacted]) indicated that there two nurses and two CNA's working the 7:00 AM to 3:00 PM shift on 4/21/20. This indicated that designated staff were assigned to the C19+ and C19- rooms. A review of the facility's staffing assignments for [redacted], long and short hallways (rooms [redacted]) indicated that there two nurses and one CNA working the 3:00 PM to 11:00 PM shift on 4/21/20. This indicated that one CNA was caring for the residents on the C19+ and C19- rooms.	F 880		

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A review of the facility's staffing assignments for [redacted], long and short hallways (rooms [redacted]) indicated that there two nurses and one CNA working the 7:00 AM to 3:00 PM shift on 4/22/20. This indicated that one CNA was responsible for caring for the residents on the C19+ and C19- hallways.

A review of the facility's staffing assignments for [redacted], long and short hallways (rooms [redacted]) indicated that there was one nurse and one CNA working the 3:00 PM to 11:00 PM shift on 4/22/20. This indicated that the one nurse and one CNA were responsible for caring for the residents on the C19+ and C19- hallways.

A review of the "NEW CDC Guidance on Use of Masks, Gowns, and Eye Protection to Conserve Supplies," dated 3/18/20, acknowledged that the country did not have enough PPE supplies to meet the needs of health care providers during the COVID-19 Pandemic. The guidance provided offered health care providers ways in which PPE could be re-used when caring for residents. The guidance suggested for gowns, "Extended use of isolation gowns (disposable or cloth), such that the same gown is work by the same HCP [Health Care Provider] when interacting with more than one patient known to be infected with the same infectious disease when these patients housed in the same location (i.e., COVID-19 patients residing in an isolation cohort)."

A review of the facility's, Use of Personal Protective Equipment (PPE) During a Public Health Emergency dated 3/18/2020 indicated, "Extended use of isolation gowns (disposable or cloth), such that the same gown is worn by the

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F 880	Continued From page 29 same HCP when interacting with more than one patient known to be infected with the same infectious disease when these patients housed in the same location (i.e., COVID-19 patients residing in an isolation cohort). This can be considered only if there are no additional co-infectious diagnoses transmitted by contact." The facility's Use of Personal Protective Equipment (PPE) During a Public Health Emergency Policy and Procedure did not indicate the appropriate usage of the PPE between non-infected, symptomatic, resident's pending testing results, or COVID-19 positive residents' usage between residents. NJAC 8:39-27.1(c)	F 880		