STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315513	A. BUILDING ______ B. WING ______	C 10/25/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA SKILLED NURSING & REHAB VOORHEES EAST	113 SOUTH ROUTE 73 VOORHEES, NJ 08043

(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 #: NJ149259 Census: 81 Sample Size: 8 The facility is 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 has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Survey date: 10/25/2021 Census: 81	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	F 880		12/20/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 11/17/2021

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	F 880		

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 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.

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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, facility document reviews, facility policy review, Occupational Safety and Health Administration (OSHA) guidelines, and Centers for Disease Control and Prevention (CDC) guidelines, it was determined that the facility failed to implement an infection prevention and control program (IPCP) designed to provide a safe and sanitary environment to help prevent the possible development and transmission of Coronavirus (COVID-19) as well as other communicable diseases and infections. Specifically, the facility failed to ensure multi-use vital sign equipment was disinfected between residents' use in two of two hallways on the second and third floors, ensure unvaccinated staff wore the appropriate personal protective equipment (PPE) required when the facility was in outbreak status, and ensure nursing staff did not exit a room that had a resident on transmission-based precautions still wearing a gown. The deficient practices occurred when the facility was in outbreak status related to the COVID-19	F 880	POC 10-25-21 Infection Prevention and Control CFR(s): 483.80(a)(1)(2)(4)¿(f) F880 SS=E Directed Plan of Correction The facility has implemented the following actions to assist with implementing appropriate corrective actions: A root cause analysis was conducted with the assistance from the Infection Preventionist, Quality Assurance and Performance Improvement (QAPI) committee and Governing Body.	

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F 880	Continued From page 3 pandemic and had the potential to affect all residents. Findings included: Reference: A publication by Occupational Safety and Health Administration (OSHA): Title 29 Part 1910.1030. Bloodborne pathogens, accessed on 10/26/2021 from: http://www.ecfr.gov/cgi-bin/textidx?SID=4e5245f66094d270bc2bd93105f6a92d&mc=true&node=se29.6.1910_11030&rgn=div8, included the following: "Standard Precautions: equipment or items in the patient environment likely to have been contaminated with infectious body fluids must be handled in a manner to prevent transmission of infectious agents (e.g., wear gloves for direct contact, properly clean and disinfect or sterilize reusable equipment before use on another patient)." 1. On 10/25/2021, between 10:17 AM and 10:47 AM, Licensed Practical Nurse (LPN) #2 was observed as she pushed a medication cart and mounted vital sign equipment towards Room #Executive Order 26, 4.b.. The resident in Room #Executive was on transmission-based precautions from being a new admission. After she had entered the room, the LPN positioned the vital sign equipment directly in front of the resident who lived in the room. LPN #2 wrapped and fastened the Executive Order 26, 4.b. (a Executive Order 26, 4.b. Executive Order 26, 4.b. around the resident's Executive Order 26 and then clipped a Executive Order 26, 4.b. Executive Order 26, 4.b. Executive Order 26, 4.b. to a Executive Or r on the resident's Executive Order 26, 4. After recording the readings from the devices, LPN #2 unwrapped the Executive Order 2 and then unclipped the	F 880	The facility employs a qualified Infection Preventionist who completed the CDC training. Education for topline staff has been initiated for the following in-service training, with staff competency validated by the Director of Nursing, Medical Director or Infection Preventionist: Module 1 Infection Prevention and Control Program. https://www.train.org/main/course/1081350/ Topline staff and infection preventionist Education has been initiated for CDC COVID-19 Prevention Messages for Front Line Long Term Care Staff: Keep COVID-19 Out! https://youtube/7srwrF9MGdw Frontline Staff Education for all staff has been initiated for Module 6A Principles of Standard Precautions https://www.train.org/main/course/1081804/	

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F 880	Continued From page 4 Executive Order 26, 4.b. . LPN #2 Executive Order 26, 4.b. and the pulse oximeter back on the mount. Afterwards, the LPN pulled the vital sign machine behind her into the hallway. LPN #2 failed to disinfect the vital sign equipment after she exited Room Executive O. LPN #2 then entered Rooms Executive O, Executive O, and Executive O where she repeated the exact sequence described above while in the rooms. The residents in the rooms were not on transmission-based precautions. LPN #2 failed to disinfect the vital sign equipment after she exited Room Executive O and before she entered Room Executive Ord. After LPN #2 was done passing medication to the resident in Room Executive O, the LPN pushed the vital sign equipment back into the hallway. LPN #2 failed to disinfect the vital sign equipment after potentially exposing the equipment to contaminants within the residents' rooms. During an interview on 10/25/2021 at 10:52 AM, LPN #2 stated that she received training on cleaning of the equipment. Per LPN #2, she was to disinfect the equipment before and after use with each resident. She acknowledged she did not have a disinfectant on her; therefore, she did not disinfect the identified equipment between residents' care. LPN #2 stated there was the potential to transmit infection when she failed to disinfect the identified equipment between residents' care. An observation on 10/25/2021 between 11:04 AM through 11:27 AM, revealed LPN #3 passed medication in Rooms Executive O and Executive O on the Executive C floor. The rooms had residents who were on transmission-based precaution from being new admissions. LPN #3 went into the identified	F 880	All staff Education has been initiated for Module 6B Principles of Transmission Based Precautions https://www.train.org/main/course/1081805/ All staff Education has been initiated for Module 11A Reprocessing Reusable Resident Care Equipment https://www.train.org/main/course/1081814/ Topline staff and infection preventionist Ongoing education will continue for new staff, as well as nurse agency staff, upon hire and contract. Traditional POC 1). All patients have the potential to be affected by this deficient practice. The infection preventionist immediately re-educated LPN s # 2 and 3. The vital sign equipment used by LPN s #2 and #3 was cleaned and disinfected. All vital sign	

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F 880	Continued From page 5 rooms with a multi-use vital sign machine such as the one described in the observation with LPN #2. LPN #3 did not disinfect the vital sign equipment between uses with the residents. Without disinfecting the equipment, LPN #3 proceeded to Room [Executive Ord] which had a resident who was not on any type of transmission-based precautions. LPN #3's practice failed to ensure she was not cross-contaminating the residents with contaminants that were picked up on the residents and within their rooms. During an interview on 10/25/2021 at 11:35 AM, LPN #3 verified that she did not disinfect the multi-use vital sign equipment between residents' use. Per LPN #3, the facility educated on the need to properly disinfect vital sign equipment between residents' use on a weekly basis. LPN #3 stated that she completely forgot to disinfect the equipment. On 10/25/2021 at 4:31 PM, the Infection Control Preventionist (ICP) was interviewed, with the Director of Nursing (DON) and the Nursing Home Administrator (NHA) present. The ICP provided her ICP certification which indicated she was certified as an ICP through the Centers for Disease Control and Prevention (CDC) Nursing Home Infection Preventionist Training Course. The ICP stated that she was part of the quality assessment (QA) committee and conducted training with staff on infection control and prevention practices. The ICP stated she in-serviced with staff on a weekly and as-needed (PRN) bases. The ICP enumerated the training she had provided to staff, which included cleaning of multi-use equipment. The ICP stated shared equipment should be cleaned between each use	F 880	equipment within the facility was cleaned and disinfected. Resident # s [Executive], [Executive] and [Executive] have all been tested with no result of infection or negative outcome. DON/Infection Preventionist will re-educate nursing staff on the facility policy, Cleaning vs. Sanitizing vs. Disinfection, including the cleaning of vital sign equipment (shared equipment) before and after each use with each patient. DON/designee will conduct audits daily x 5 q shift, weekly x 3 q shift, monthly x 2 (4 x per month q shift, and then continued weekly to ensure compliance with proper cleaning of shared equipment before and after each use with each patient. All audits will be reviewed, trended, and analyzed by DON/infection preventionist and submitted to the QAPI committee for any further action needed x 3 months. 2.) All patients have the potential to be affected by this deficient practice. CNA #3 s mask was properly adjusted. CNA #3 was immediately re-educated on proper mask usage. Resident #[Executive] has been tested and with no result of infection or negative outcome. DON/Infection Preventionist will re-educate all staff on proper use of face mask using the facility policy, Personal	

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F 880	Continued From page 6 to prevent the spread of infection. Specifically, the ICP stated that when the cuff on the blood pressure machine was fastened on a resident, there was the potential that the cuff picked up a contaminant on the resident. The ICP stated that without disinfecting the equipment after its use, whatever contaminant that was picked up on the resident was transferred to another resident. The DON stated that she would provide education to staff on the identified concerns. The facility's policy titled, "Cleaning vs. Sanitizing vs. Disinfection," updated 10/2021 indicated, "The proper handling, cleaning, sanitizing, disinfection, transportation, and storage of patient care items and equipment are critical to prevent the transmission of infectious organisms." Reference: A review of the CDC Updated Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, updated 09/10/2021 and retrieved 10/25/2021, indicated, "Source control and physical distancing (when physical distancing is feasible and will not interfere with provision of care) are recommended for everyone in a healthcare setting. This is particularly important for individuals, regardless of their vaccination status, who live or work in counties with substantial to high community transmission or who have: Not been fully vaccinated ..." 2. An observation on 10/25/2021 at 10:26 AM revealed Certified Nurse Aide (CNA) #3 was in Room [REDACTED] talking with a resident. The observation revealed CNA #3 wore her N95 mask below the jaw and stood approximately two feet from the unidentified resident in the room.	F 880	Protective Equipment Usage Guide. DON/designee will conduct audits daily x 5 q shift, weekly x 3 q shift, monthly x 2 (4 x per month q shift, and then continued weekly to ensure compliance with proper usage of face mask. All audits will be reviewed, trended, and analyzed by DON/infection preventionist and submitted to the QAPI committee for any further action needed x 3 months. 3) All patients have the potential to be affected by this deficient practice. LPN #3 s gown was properly discarded. LPN was immediately re-educated by infection preventionist. Resident # s [REDACTED], [REDACTED] and [REDACTED] have all been tested with no result of infection or negative outcome. DON/Infection Preventionist will re-educate all staff on proper disposal of PPE using the facility policy, Personal Protective Equipment Usage Guide. DON/designee will conduct audits daily x 5 q shift, weekly x 3 q shift, monthly x 2 (4 x per month q shift, and then continued weekly to ensure compliance with proper disposal of PPE. All audits will be reviewed, trended, and analyzed by DON/infection preventionist and submitted to the QAPI committee for any further action needed x 3 months.	

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F 880	Continued From page 7 On 10/25/2021 at 11:26 AM, CNA #3 was observed at the nurses' station wearing her mask below her jaw. During an interview on 10/25/2021 at 11:27 AM, CNA #3 stated that she had been educated to always ensure she wore her mask over her nose. Per CNA #3, her mask slipped down her nose when she talked. CNA #3 stated, "It's just hard to keep it up." On 10/25/2021 at 4:31 PM, the Infection Control Preventionist (ICP) was interviewed with the Director of Nursing (DON) and the Nursing Home Administrator (NHA) present. The DON stated that the facility was in outbreak status related to Executive Order 26, 4.b. when a resident Executive Order 26, 4.b. for the Executive Or on Executive Order 26, 4.b. . Per the DON, the facility had Execu residents who were Executive Order 26, 4.b. at the time of survey. The DON clarified that of the Executi residents, Executive Or of the residents Executive Order 26, 4.b. Executive Order 26, 4.b. and Executive Orde were Executive Order 26, 4.b. . The DON provided a list of all vaccinated staff. A review of the list indicated that CNA #3 Executive Order 26, 4.b. . The ICP stated that any staff member who was not vaccinated, regardless of whether the individual provided direct care or not, was required to use an N95 mask. Per the ICP, staff should ensure they wore their masks to cover their nose when they went in residents' rooms. The ICP stated that residents were to be encouraged to use their masks when direct care or other staff members went in their rooms. The ICP stated that proper use of source control (wearing masks over the nose) was important because it helped ensure residents did not get cross-contaminated by staff and staff were not cross-contaminated by	F 880		

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F 880	Continued From page 8 residents. The ICP added that it was also important to avoid resident-to-resident cross-contamination and staff-to-staff cross-contamination. Addressing the finding that CNA #3 was observed within a close proximity of a resident without wearing her mask over the nose and after having declined to be vaccinated, the ICP stated that although the facility's weekly test last conducted on Executive Order 26, 4.b. did not indicate that CNA #3 Executive Order 26, 4.b. she clarified that if the CNA was a carrier of the virus, there was the potential they had cross-contaminated the unidentified resident who occupied the room where CNA #3 was observed. The ICP concluded that the facility would keep the residents on closer monitoring. 3. An observation on 10/25/2021 between 11:04 AM through 11:27 AM, revealed Licensed Practical Nurse (LPN) #3 passed medication in Rooms Executive Ord and #Executive. The rooms had residents who were on transmission-based precaution from being new admissions. LPN #3 went into the identified rooms after donning full PPE, which included an N95 mask, face-shield, gloves, and gown. The LPN failed to strap her gown when she went in to provide care to the residents in the identified rooms and she exited the rooms while still wearing the gown. During an interview on 10/25/2021 at 11:35 AM, LPN #3 stated that she knew to doff her gown before she exited the rooms. Per LPN #3, there was no hazard-collecting container in the identified rooms. The Infection Control Preventionist (ICP) was present and had observed when the staff member exited Room #Executive while still wearing the	F 880	Executive Order 26	

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F 880	Continued From page 9	F 880		

gown and provided on-the-spot education to the LPN as well as verified that there were no hazard-collecting containers in the identified rooms.

On 10/25/2021 at 4:31 PM, the ICP was interviewed with the Director of Nursing (DON) and the Nursing Home Administrator (NHA) present. The DON stated that the facility had just received orders for necessary items such as additional isolation carts and hazard-collecting containers which were being distributed across the facility during the survey. Per the DON, the facility was on outbreak and with multiple residents who needed to be quarantined, the facility needed extra supplies. They had ordered the supplies the week before the survey but only received the delivery on the morning of the survey. The ICP stated that it was important for nursing staff to not exit rooms with gowns on after they provided care to residents on transmission-based precautions because there was the potential that they carried contaminants from the room to the areas of the facility that was not contaminated, thereby cross-contaminating the facility. The DON stated she would educate staff on the identified concerns.

The facility's policy titled, "Infection Control Policy," dated 07/2021, indicated under the standard precaution portion of the policy, "Remove soiled gown promptly before leaving the patient's room and wash hands after removal to prevent transfer of microorganisms."

New Jersey Administrative Code §
8:39-19.4(a)1-6

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
315513 (Y1)	A. Building B. Wing (Y2)	12/22/2021 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
PROMEDICA SKILLED NURSING & REHAB VOORHEES EAST	113 SOUTH ROUTE 73 VOORHEES, NJ 08043

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 12/20/2021	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
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	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

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
10/25/2021

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**