STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315248	A. BUILDING _____ B. WING _____	04/21/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ANDOVER SUBACUTE AND REHAB II	**99 MULFORD ROAD ANDOVER, NJ 07821**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0580 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, facility policy review, record reviews and staff interviews, it was determined the facility failed to notify a resident representative (R15) and a resident's physician (R8) of a significant change of condition 2 of 25 sampled residents. The findings include: Review of facility policy titled, Change of Condition, last revised 08/01/17, read in part The Facility will promptly inform the resident, consult with the resident's Attending Physician, and notify the resident legal representative when the resident endures a significant change in their condition . R15 was admitted to the facility on [DATE] with a past medical history that included dementia. Per copy of court documents found in R15's chart, R15's sibling was appointed their legal guardian on 10/08/19. On 03/30/20, it was documented on the Interdisciplinary Progress Notes sheet, MD was made aware that residents Roommate in hospital and tested positive for COVID. The progress note further mentioned to order for COVID and move to S2 (South 2). R15 was swabbed for COVID-19 and moved to South 2 that same day. Further review of R15's medical record revealed that the test results for COVID-19 came back positive on 04/04/20. Per nursing progress note on 04/04/20 at 11:00 AM, Positive for COVID-19, NP . made aware . On 04/10/20 at 09:40 AM, it was documented on the Interdisciplinary Progress Notes sheet, Rc'd (received) telephone call from POA (power of attorney) .updated on Residents DX (diagnosis) COVID-19. Resident is afebrile at this time no SOB (shortness of breath) noted MD verified/assessed on 04/09/20. POA wants to be updated on (change) in health status. Requesting to speak with DON (director of nursing). DON notified. On 04/10/20 at 9:50 AM, it was documented on the Interdisciplinary Progress Notes sheet, Spoke (POA) about (+) COVID- apologized for not informing (+) COVID . On 04/12/20 at 1:00 PM, it was documented on the Interdisciplinary Progress Notes sheet by nursing, Resident has serious problems! Intake is just composed of fluids small quantity. Not able to eat or take medication. Continue to Monitor. There was no evidence found in the record that R15's POA was notified of this change in condition. On 04/13/20 at 4:00 AM, it was documented on the Interdisciplinary Progress Notes sheet, Responded to nurse call on the floor .no breathing, unresponsive to both verbal and tactile stimuli. Pupils fixed and dilated. R15 was pronounced dead at 5:00 AM per nurse's progress note. On 4/17/20 at 7:02 PM in an interview with the DON, she confirmed that the notification in change of condition was delayed regarding notifying the resident's POA of the positive COVID-19 results. She stated she spoke with the resident's POA and wrote the note on 04/10/20 at 9:50 AM. On 04/16/20 at 2:53 PM, the surveyor observed R8 lying supine on a stretcher in the hallway on the third-floor unit. The surveyor observed R8 wearing an oxygen mask and heard R8 making a vibrating noise during breathing. During that observation, R8 was being wheeled to the elevator by emergency personnel in Personal Protective Equipment that included face masks, gowns and gloves. On 04/16/20 at 2:56 PM Employee (E) 3, standing at the third-floor nurse's station, stated R8 was being taken to the emergency room for respiratory distress and stated she did not know how long R8 had been like that. During an interview with the surveyor on 04/16/20 at 2:58 PM, the third-floor unit supervisor stated R8 started with shortness of breath that morning and spiked a temperature in the afternoon. Review of the Admission Record revealed R8 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Annual Minimum Data Set (MDS - an assessment tool), dated 03/12/20, revealed R8 had a Brief Interview for Mental Status (BIMS) score of 09 which indicated a moderate cognitive impairment. Review of the Quarterly MDS, dated [DATE], revealed R8 had a BIMS of 09 which indicated a moderate cognitive impairment. Review of the physician's orders [REDACTED]. Review of the Medication Administration Record [REDACTED]. Review of R8's Interdisciplinary Progress Notes (IDPN), completed by nursing revealed: 04/14/20 at 2:35 PM, a temperature (T) of 100.7 F, pulse (P) 95, blood pressure (BP) 139/75, oxygen level (SPO2) of 98% on room air (RA), R8 was alert and two Tylenol were administered as needed (PRN). There was no documentation that a follow up temperature was obtained to determine the effectiveness of the Tylenol. There was no other documented clinical assessment or follow-up documentation. 04/15/20 at 2:15 AM, T 102 F, BP 130/80, pulse (P) 60 beats per minute (bpm), respirations (R) 22 and SPO2 98 % RA. Tylenol was administered. The T was rechecked at 3 AM and noted to be 99 F. There was no other documented clinical assessment or follow-up documentation. 04/15/20 at 8:00 AM, slept fairly the whole night. There was no other documented clinical assessment or follow-up documentation. 04/15/20 at 3:00 PM, the latest T was 99 F post Tylenol that was administered for a T of 100.6 during the shift. There was no other documented clinical assessment or follow-up documentation. 04/15/20 at 6:00 PM, T of 100.6 F, Tylenol administered and will monitor. There was no other documented clinical assessment or follow-up documentation. 04/15/20 at 9:45 PM, T 99 F, BP 136/84, P 92, R 20 and SPO2 94% on RA. 04/16/20 at 2:30 PM, Resident noted to be resp (respiratory) distress, O2 Sat (arrow down symbol) 60's . call to physician to send to hospital emergency room for evaluation and treatment. There were no previous documented calls to the physician regarding R8's temperature readings, vital signs, or changes in condition over the two days from 04/14/20 to 04/16/20. 04/16/20 (no time written), SPO2 of 70% on RA, T 102.9 F, change in status, increased and labored breathing use of accessory muscles (utilized by people with respiratory distress to help the flow of air in and out of the lungs). 04/16/20 at 7:00 PM, report from hospital emergency room that Resident #8 was admitted with [MEDICAL CONDITION] and possible COVID-19. Review of the facility provided, Temperature Check (Coronavirus monitoring) logs for the third-floor units revealed the following: 04/14/20: 7am - 3pm shift: T 99.9, blank other symptoms, blank comments, and signed checked by wing-nurse signature 04/15/20: 11pm - 7 am shift: T 98.6, blank other symptoms, blank comments, blank checked by wing-nurse signature 3pm - 11pm shift: T 100.3, blank other symptoms, blank comments, and signed checked by wing-nurse signature 7am - 3pm shift: T 101.7, blank other symptoms, blank comments, and signed checked by wing-nurse signature 04/16/20: 7am - 3pm shift: T 102.9, blank other symptoms, blank comments, blank CNA signature and signed checked by wing-nurse signature. During an interview with the surveyor on 04/17/20 at 2:32 PM, E4 stated the staff does not always call the physician when a resident had a temperature and that the PRN Tylenol would be tried first and if that didn't work, the staff should call the physician. E4 stated that she would have to monitor the symptoms and that any changes should be documented in the notes. E4 stated they would not ask for a COVID-19 test right away and confirmed no test was ordered for R8. E4 stated the staff would communicate symptoms and the temperatures would be on the temperature logs for the staff to monitor but that she was unaware of anything until yesterday when R8 just wasn't himself. E4 also stated that as of today, R8 had to be intubated (a tube inserted into a person's airway to help a person breathe) at the hospital. On 04/17/20 at 4:08 PM, the surveyor requested the missing Temperature Check (Coronavirus monitoring) logs third-floor unit from 04/14/20 the 11pm - 7am and 3pm - 11pm shifts and 04/16/20 11pm - 7am shift from the DON. The surveyor also requested any policies or procedures on the Temperature Check Coronavirus monitoring logs, Monitoring Residents for COVID-19 or related topics. The facility was given opportunity and could not provide additional policies/procedure, information or documentation regarding any of the above.
F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Provide and implement an infection prevention and control program.**

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

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 1) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, record reviews, and review of facility documents, the facility failed to ensure: 1) appropriate transmission based precautions were ordered and implemented (immediate isolation from asymptomatic roommates) for suspected COVID-19 residents (R1, R2, R3, R13 and R14), 2) a system of surveillance to prevent the spread of infection (screening, tracking, monitoring and/or reporting of fever and other signs/symptoms of COVID-19) for six residents (R1, R2 ,R3, R8, R12, R16), 3) staff properly used personal protective equipment (PPE) when caring for COVID-19 19 positive or COVID-19 suspected residents, 4) staff were properly trained to use the infrared forehead thermometer on staff, visitors and residents, 5) implementation of hand washing practices consistent with CDC (Centers for Disease Control and Prevention) guidelines to reduce the spread of infections and prevent cross-contamination during the COVID-19 pandemic, and 6) posting of contact/droplet precaution signage throughout the facility. These failures in proper infection control practices had the potential to affect all residents in the facility through the development and transmission of COVID-19 and other communicable diseases. It was determined the provider's non-compliance 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), Medical Director and the Administrative Assistant were made aware the IJ existed for the 405 residents in the facility on [DATE] at 12:25 PM. The sample size was 25 residents (R). An acceptable action plan was received on [DATE] at 8:45 PM. The Immediate Jeopardy was removed on [DATE] at 4:30 PM, after onsite verification on [DATE]. The findings include: Review of the facility's [DATE] policy and procedure CARING FOR RESIDENTS WITH A SUSPECTED OR A CONFIRMED CASE OF COVID-19, revealed the following procedures: Patients testing positive for COVID-19 or suspected of COVID-19 will be evaluated by PMD to determine the need for hospitalization . If hospitalization is not medically necessary, the resident is to remain in the facility. Patients with known or suspected COVID-19 will be transferred to the designated unit and when feasible provided with a private room. On admission, a resident with known or suspected COVID-19 will be provided with a private room when available. Residents that have a confirmed case of COVID-19 can cohort with other residents who have a confirmed COVID-19. Residents with suspected or confirmed COVID-19 will have the door in their room kept closed at all times. All efforts will be made to have consistent caregivers assigned to residents with suspected or confirmed COVID-19. These staff members will not float to other units. The IDT will limit the number of caregivers that enter the room over the course of the shift to limit exposure. The following measures will be implemented for residents with known or suspected COVID-19: A facemask will be placed on the resident and worn as tolerated Transmission based precautions will be instituted to include placement of isolation cart at entrance of room and signage on the door Caregivers will don appropriate personal protective equipment (PPE) - gown, mask, face/eye shield, gloves Dedicated equipment to included BP machine, stethoscope, thermometer, and when needed glucose finger stick monitoring supplies will be provided and stored inside the room Vital signs will be taken twice per shift and this will be aligned with medication administration and AOL care When respirator face masks are available, they will be utilized by caregivers . When residents with known or suspected COVID-19 require transfer to an acute care hospital setting ., The IDT will take all necessary measures to identify resident preferences and goals for care while at the same time adhere to the CDC guidelines to prevent transmission of the disease. Residents and representatives will be provided with education on Advanced Directives and MOLST. Education will focus on current information with regards to recovery and mortality. The Resident's representative will receive a daily update on the resident's condition via phone at a prearranged time . IDT stands for Interdisciplinary Team. 1) Appropriate Transmission Based Precautions Review of the facility's COVID-19 binder on [DATE], revealed a document from the CDC, titled, Flowchart to Identify and Assess 2019 Novel Coronavirus. The following recommendations were under the section Upon Arrival (to the facility): Take steps to ensure all persons with symptoms of suspected COVID-19 or other respiratory infection {e.g., fever, cough) adhere to respiratory hygiene and cough etiquette, hand hygiene, and triage procedures. Post visual alerts (e.g., signs, posters) at the facility entrance and in strategic places (e.g., waiting areas, elevators} to provide Residents and HCP with instructions (in appropriate languages) about hand hygiene, respiratory hygiene, and cough etiquette. Instructions should include how to use face masks or tissues to cover nose and mouth when coughing or sneezing, to dispose of tissues and contaminated items in waste receptacles, and how and when to perform hand hygiene. Ensure that Residents with symptoms of suspected COVID-19 or other respiratory infection (e.g., fever, cough) are not allowed to be among other Residents. Identify a separate, well-ventilated space that allows residents to be separated by 6 or more feet, with easy access to respiratory hygiene supplies. Ensure rapid triage and isolation of Residents with symptoms of suspected COVID-19 or other respiratory infection (e.g., fever, cough): Implement triage procedures to detect persons under investigation (PUI) for 2019-nCoV (Novel Coronavirus) during or before Resident admission and ensure that all Residents are asked about the presence of symptoms of a respiratory infection and history of travel to areas experiencing transmission of COVID-19 or contact with possible COVID-19 Residents. Implement respiratory hygiene and cough etiquette (i.e., placing a facemask over the Resident's nose and mouth if that has not already been done) and isolate the PUI for 2019-nCoV in an Airborne Infection Isolation Room (AIIR), if available. On [DATE] at 9:25 AM, an observation of the East Unit (second floor) room assignments for room [ROOM NUMBER] revealed that R13 (awaiting COVID-19 test results since the resident was symptomatic) was placed in the same room with R14, who was not suspected of having COVID-19. A review of the medical record for R13 revealed the resident was admitted on [DATE] with a [DIAGNOSES REDACTED]. A review of the medical record for R14 revealed the resident was admitted on [DATE] with a [DIAGNOSES REDACTED]. Interview with E14 on [DATE] at 9:30 AM, revealed confirmation that R13 did show symptom which included fever of 100, and this was reason for resident being tested for COVID-19. When asked about R14's status. E14 did reveal that R14 did not have any symptoms of COVID-19 and was not suspected of having COVID-19. She explained that they did not move R13 because they are awaiting for the COVID-19 test result to come back. Review of ACULABS (a lab report) dated [DATE] revealed that R13 was POSITIVE for [DIAGNOSES REDACTED] CoV-2 (Coronavirus). R1 was admitted to the facility on [DATE] with a past medical history that included [MEDICAL CONDITION]. Per the IDT Progress Notes review, R1 was noted to have a high temperature (T) on [DATE]. R1 was seen by her provider that same day and an order for [REDACTED]. The results for the test came back positive on [DATE]. R1 was transferred to South 2, the designated COVID-19 isolation unit, that same day. R2 was admitted to the facility on [DATE] with a past medical history that included Type 2 Diabetes. On [DATE], R2 was moved to the East 1 unit. R3 was admitted to the facility on [DATE] with a past medical history that included [MEDICAL CONDITION]. R3 was R1's and R2's roommate before R1 was moved to South 2. During an observation on the East 1 Unit on [DATE] at approximately 2:45 PM, it was revealed a sign outside of room for R2 and R3, which indicated there was a COVID-19 positive resident in the room. Per record review, R1 was noted to have a high temperature on [DATE]. R1 was seen by her provider and an order for [REDACTED]. The results for the test came back positive on [DATE]. During an interview with E8 on [DATE] at approximately 2:50 PM, when asked if there was a COVID-19 positive person in room with the COVID-19 signage in East 1 unit, E8 stated that R1 had been moved to the COVID-19 isolation wing on South 2. E8 then took down the sign. On [DATE] at approximately 2:55 PM, the HR (human resource) director also confirmed R1 was moved to South 2 unit on [DATE]. R2 and R3 roomed with R1 for 5 days from [DATE] to [DATE] when R1 was a person under investigation for COVID-19, until subsequently moved to the COVID-19 isolation wing. 2) System of surveillance Record review during the 5 days R1 was suspected COVID-19 and cohorting with R2 and R3 revealed no indication of an assessment or additional monitoring for COVID-19 symptoms that include in part: cough, shortness of breath or difficulty breathing, and chills aside from temperature checks. Review of the facility documentation, Temperature Check (Coronavirus monitoring) logs for East 1 unit from [DATE] to [DATE] revealed several monitoring sheets missing. Of the 16 days reviewed, there were 18 out of 48 shifts missing temperature logs. The dates were: ,[DATE], ,[DATE], ,[DATE] to ,[DATE], and ,[DATE] to ,[DATE]. On the provided temperature check logs, there were also columns for Other Symptoms and Comment. Review of the temperature logs on East 1 for R1, R2 and R3, did not reveal any documentation in those columns. Review of R1's Interdisciplinary Progress Notes also did not reveal any additional monitoring of signs and symptoms of COVID-19 while on East 1 from [DATE] to [DATE]. Review of R2's Interdisciplinary Progress Notes also did not reveal any additional monitoring of signs and symptoms of COVID-19 while on East 1 from [DATE] to [DATE]. Review of R3's Interdisciplinary Progress Notes did not reveal any additional monitoring of signs and symptoms of COVID-19 while on East 1 from [DATE] to [DATE]. A review of the medical record for R16's revealed the resident was admitted on [DATE] with a [DIAGNOSES REDACTED]. Record review of the Progress Notes dated [DATE] at 7:00 PM revealed R16 had a high T of 104.9. The next T of 99.1 was documented at 11:22 PM on that same day. A physician order, dated [DATE], ordered COVID-19 test and labs to be drawn. Orders were carried out, and results were pending. Further review of the Medication Administration Record [REDACTED]. Review of the Temperature log dated [DATE] revealed that R16 temperature was not documented at all. This was the day after he had a temperature of 104.9. Review of

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 2) the Progress Notes dated [DATE] at 5:30 AM, stated resident was unresponsive and was pronounced dead at 6:09 AM. No documentation of coronavirus monitoring was found regarding the respiratory symptoms which included coughing or shortness of breath assessment of R16 from [DATE] to [DATE]. In an interview with the Administrative Assistant (AA) on [DATE] at 6:00 PM, she was asked about the lack of documentation regarding assessment notes and medications or nursing interventions given for the fever. The AA attempted to find documentation, but no further documentation could be provided. Review of ACULABS (a lab report) dated [DATE] revealed that R16's [DIAGNOSES REDACTED] CoV-2 (Coronavirus) was Detected. On [DATE] at 2:53 PM, the surveyor observed R8 lying supine on a stretcher in the hallway on the third-floor unit. The surveyor observed R8 wearing an oxygen mask and heard R8 making a vibrating noise during breathing. During that observation, R8 was being wheeled to the elevator by emergency personnel in PPE that included face masks, gowns and gloves. During an interview with the surveyor on [DATE] at that time, E3 at the third-floor nurse's station stated R8 was being taken to the emergency room for respiratory distress and stated she did not know how long R8 had been like that. During an interview with the surveyor on [DATE] at 2:58 PM, E4, stated R8 started with shortness of breath that morning and spiked a temperature in the afternoon. Review of the Admission Record revealed R8 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Annual Minimum Data Set (MDS - an assessment tool), dated [DATE], revealed R8 had a Brief Interview for Mental Status (BIMS) score of 09 which indicated a moderate cognitive impairment. Review of the Quarterly MDS, dated [DATE], revealed R8 had a BIMS of 09 which indicated a moderate cognitive impairment. Review of R8's physician's orders [REDACTED]. Review of the Medication Administration Record [REDACTED]. Review of R8's Interdisciplinary Progress Notes, completed by nursing revealed: [DATE] at 2:35 PM, a temperature (T) of 100.7 F, pulse (P) 95, blood pressure (BP) ,[DATE], oxygen level (SPO2) of 98% on room air (RA), R8 was alert and two Tylenol were administered as needed (PRN). There was no documentation that a follow up temperature was obtained to determine the effectiveness of the Tylenol. There was no other documented clinical assessment or follow-up documentation. [DATE] at 2:15 AM, T 102 F, BP ,[DATE], pulse (P) 60 beats per minute (bpm), respirations (R) 22 and SPO2 98 % RA. Tylenol was administered. The T was rechecked at 3 AM and noted to be 99 F. There was no other documented clinical assessment or follow-up documentation. [DATE] at 8:00 AM, slept fairly the whole night. There was no other documented clinical assessment or follow-up documentation. [DATE] at 3:00 PM, the latest T was 99 F post Tylenol that was administered for a T of 100.6 during the shift. There was no other documented clinical assessment or follow-up documentation. [DATE] at 6:00 PM, T of 100.6 F, Tylenol administered and will monitor. There was no other documented clinical assessment or follow-up documentation. [DATE] at 9:45 PM, T 99 F, BP ,[DATE], P 92, R 20 and SPO2 94% on RA. [DATE] at 2:30 PM, Resident noted to be in resp (respiratory) distress, O2 Sat (arrow down symbol) 60's . call to physician to send to hospital emergency room for evaluation and treatment. There were no previous documented calls to the physician regarding R8's temperature readings, vital signs, or changes in condition over the two days from [DATE] to [DATE]. [DATE] (no time written), SPO2 of 70% on RA, T 102.9 F, change in status, increased and labored breathing use of accessory muscles (utilized by people with respiratory distress to help the flow of air in and out of the lungs). [DATE] at 7:00 PM, report from hospital emergency room that Resident #8 was admitted with [MEDICAL CONDITION] and possible COVID-19. Review of the facility provided, Temperature Check (Coronavirus monitoring) logs for the third-floor units revealed the following: [DATE]: 7am-3pm shift: T 99.9, blank other symptoms, blank comments, and signed checked by wing-nurse signature [DATE]: 11pm -7am shift: T 98.6, blank other symptoms, blank comments, blank checked by wing-nurse signature 3pm -11pm shift: T 100.3, blank other symptoms, blank comments, and signed checked by wing-nurse signature 7am -3pm shift: T 101.7, blank other symptoms, blank comments, and signed checked by wing-nurse signature [DATE]: 7am-3pm shift: T 102.9, blank other symptoms, blank comments, blank CNA signature and signed checked by wing-nurse signature. During an interview with the surveyor on [DATE] at 2:32 PM, E4 stated the staff does not always call the physician when a resident had a temperature and that the PRN Tylenol would be tried first and if that didn't work, the staff should call the physician. E4 stated that she would have to monitor the symptoms and that any changes should be documented in the notes. E4 stated they would not ask for a COVID-19 test right away and confirmed no test was ordered for R8. E4 stated the staff would communicate symptoms and the temperatures would be on the temperature logs for the staff to monitor but that she was unaware of anything until yesterday when R8 just wasn't themselves. E4 also stated that as of today, R8 had to be intubated (a tube inserted into a person's airway to help a person breathe) at the hospital. On [DATE] at 4:08 PM, the surveyor requested the missing Temperature Check (Coronavirus monitoring) logs third-floor unit from [DATE] the 11pm - 7am and 3pm - 11pm shifts and [DATE] 11pm - 7am shift from the DON. The surveyor also requested any policies or procedures on the Temperature Check Coronavirus monitoring logs, Monitoring Residents for COVID-19 or related topics. The facility was given opportunity and could not provide additional policies/procedure, information or documentation regarding any of the above. R12 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the facility's New Jersey Universal Transfer Form revealed on [DATE] R12 was transferred to the hospital emergency room (ER) for a T of 104.2 degrees Fahrenheit (F) and being very weak. The ER After Visit Summary, dated [DATE] , revealed discharge instructions for [MEDICAL CONDITION] Syndrome. These included: call 911 for a [MEDICAL CONDITION], if resident cannot be woken, chest pain or trouble breathing, stiff neck, bad headache, sensitivity to light, feeling weak, dizzy, or confused, stop urinating or urinate is less than normal, coughing up of blood or thick, yellow or green mucus, severe abdominal pain or abdomen is larger than usual. R12's End of Visit Vitals were blood pressure(BP) -,[DATE], T- 99.3 F, pulse (P)-101, respirations (R)-26 and oxygen saturation (SaO2) 95 percent (%). The discharge instructions also included to follow-up with the attending physician in three days ([DATE]) and to call the physician for a T of 100.4 F or higher. Review of the IDT on [DATE] at 7:30 AM, documented R12 had returned to the facility with a discharge [DIAGNOSES REDACTED]. At 8:00 AM the nursing note documented the following vitals: BP-,[DATE], 97.8 (T) P-76 and SaO,[DATE] %, Continue to monitor. The next documented IDT nursing note was on [DATE] at 9:00 PM. It revealed Resident in bed fighting the disease, no fever or pain noted on this shift. Resident cooperates well regarding care . On [DATE] at 6:40 PM, a late entry nursing note revealed on [DATE] R12 was found on the floor by his bed, had fell on the wet floor and obtained a small abrasion on the left side of his head. The resident's vitals were taken, range of motion assessed and pupils (eyes) were found to be equal, round and reactive to light and accommodation (PERRLA). The next IDT note was on [DATE] at 7:15 AM. It read Entered room, Resident (with symbol) eyes open, ashen, no verbal response, no painful response, no respiration, no pulse. R12's physician and registered nurse pronounced the resident deceased at 7:35 AM. Review of the facility's Internal Medicine Monthly Visit/Acute visit/Readmission form dated [DATE], revealed the following hand written notes from R12's physician: Found dead this am, Rigor Mortis present, CPR (Cardiopulmonary Resuscitation) not performed Physical-COVID-19 test was done? . High fever for the last few days-that was not brought to my attention. Flu like illness, likely COVID-19. On [DATE] at 3:15 PM, the COVID-19 surveillance monitoring and tracking was discussed with the DON. The DON stated all working staff temperatures were checked at the beginning of each shift upon entering the facility. If any staff person's temperature was equal or greater than 100.0, they are sent home. In regards to the residents' temperatures, the DON stated they were checked by the CNA's at the beginning of each shift every eight (8) hours. The CNA's recorded the temperatures on a Temperature List form. This form could be found at the Nurses' Station on each floor. If there were other COVID-19 symptoms such as shortness of breath, coughing, weakness, etc. this information would be documented by the nurse and found in the progress (IDT) notes. On [DATE] at 7:30 PM, the DON was asked for the facility's practice on assessment and monitoring after an unwitnessed fall. The DON stated the nurses perform Neuro (neurological) checks every four (4) hours for 72 hours. It was also stated the neuro checks should have been performed after R12's fall . This surveyor was unable to locate the Neuro checks or the resident's Advanced Directive/ MOLST (Provider Orders for Life Sustaining Treatment) information on the clinical chart. Later the DON confirmed R 12 was a full code, the Advanced Directive/ MOLST information were never provided. The facility's Temperature Check (Coronavirus monitoring) form was composed of eight columns, titled, Resident Name, Rm No.(room number) ,Date, Time, Temp.(temperature), Other Symptoms, Comment and CNA (Certified Nursing Assistant) Signature. On [DATE] at approximately 10:40 AM, the Temperature Check form was reviewed with the DON . A request for temperature checks and COVID-19 monitoring was requested for R12. The facility presented the South Two List for Temperature Check, dated [DATE], ,[DATE] (11:00 PM- 7:00 AM) Shift. R12 'S name was on the list in room [ROOM NUMBER] with a Temp reading of 99.1. All other columns were blank. The facility was unable to provide the requested temperature checks for five (5) days in April (,[DATE], ,[DATE], ,[DATE], ,[DATE], ,[DATE] and [DATE] (,[DATE] and ,[DATE] shift)). On [DATE] the facility emailed R12's Neurological Flow Sheet, which revealed neurological assessments were only assessed for 56 hours, with the last documented time of 3:15 PM on [DATE]. 3) PPE Usage On the North 2 (non COVID-19) unit, an observation with the HR Director on [DATE] at approximately 3:30 PM, E7 was seen not wearing a gown upon entering resident room [ROOM NUMBER]. E7 was then observed walking out of resident room [ROOM NUMBER] and exited the unit through the closed double doors. On [DATE] at 5:51 PM in an

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	315248	A. BUILDING _____ B. WING _____	04/21/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ANDOVER SUBACUTE AND REHAB II	99 MULFORD ROAD ANDOVER, NJ 07821

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 3) interview with the DON, when asked what personal protective equipment (PPE) staff were currently required to wear on non COVID-19 units, the DON stated they were to wear a face mask (currently N95) and a gown. The CDC recommendation from https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html. .In addition to the actions described above, these are things facilities should do when there are COVID-19 cases in their facility or sustained transmission in the community Healthcare Personnel Monitoring and Restrictions: Because of the higher risk of unrecognized infection among residents, universal use of all recommended PPE for the care of all residents on the affected unit (or facility-wide depending on the situation) is recommended when even a single case among residents or HCP is identified in the facility; this should also be considered when there is sustained transmission in the community. The health department can assist with decisions about testing of asymptomatic residents. On [DATE] at 2:56 PM, the surveyor observed the third-floor unit nurse's station. The surveyor observed a staff member standing on the outside perimeter of the round, nurse's desk with their face mask positioned below their nose. The staff member was talking to and in close proximity to five other staff members behind and around the nurse's station. The staff member was identified as E1. The surveyor observed one of the other staff members had been within arm's length from E1. On [DATE] at approximately 3:00 PM, E1 stated she had lowered her face mask because it was change of shift. E1 stated she had no excuse for the improper use of the face mask and that she had been in-serviced the beginning of [DATE] on the proper use of PPE. E1 stated she should have positioned the face mask the right way over her nose to protect everyone. On [DATE] at 3:24 PM, the surveyor observed, on the main floor between the nurse's station and the south hall, a staff member with her face mask positioned below both her nose and mouth, down below her chin. The staff member was in close proximity to eight other staff members and was loudly projecting her voice and was calling out assignments and instructions. The staff member was identified as E2. The surveyor observed three other staff members had been within arm's length from E2. On [DATE] at approximately 3:30 PM, E2 stated her mask was positioned below her nose and mouth because sometimes it was hard to breathe with the mask fully on the face. E2 stated she knew that was not the correct way to don the face mask and that the purpose of the face mask was important to prevent the spread of [MEDICAL CONDITION]. During an interview with the surveyor on [DATE] at 2:58 PM, E4 stated the staff had been in-serviced on the use of PPE by the facility educator who was now out sick. E4 stated it was everyone's responsibility to check that their own PPE and each other's PPE was on correctly. During an interview with the surveyor on [DATE] at 3:50 PM, the DON stated that all staff had been trained on how to use and wear their PPE. The DON stated face masks should always be worn correctly and cover the nose and mouth. The DON identified E2 as a staff member who worked in the Quality Assurance position at the facility. Review of E1's, Personal Protective Equipment (PPE) Competency Validation, dated [DATE], revealed a competent, Return verbal demonstration to prevent cross contamination between staff. The PPE Competency Validation also revealed, 4. Don Mask/Respirator - secure ties/elastic bands at middle of head and neck; 5. fit flexible band to nose bridge and 6. fit snug to face and below chin. The competency also included to correctly identify the appropriate PPE to be worn based on anticipated level of exposure. Review of the facility handout addressed to the employees, dated [DATE], revealed that with the COVID-19 outbreak in the facility, staff may have been exposed. Staff may continue to work provided the included but not limited to 1. Healthcare Personnel (HCP) should report temperature and absence of symptoms each day prior to starting work for the 14-day period after their exposure and 2. HCP wears a facemask while at work for the same 14-day period. Review of the facility, PPE Strategies for LTCFs during Cluster of COVID-19 Infections:, not dated, revealed when there are cases in the facility universal masking of HCP while in the facility. During an interview with the surveyor on [DATE] at 2:40 PM, the DON stated there was no record of an in-service regarding PPE for E2. The DON stated E2 never showed up for it (the in-service) because E2 mostly worked the 3pm - 11pm shift. The DON acknowledged that all staff should have been in-serviced. 4) Infrared Thermometers On [DATE] at 2:30 PM surveyor entered the front door of the facility into the reception area. Upon observation, surveyor's temperatures were checked immediately on the forehead area. One reading obtained on a surveyor read 91 Fahrenheit (F) and another temperature reading was taken again but it was lower than normal finding, again at 91 F. No further test was done and the surveyor was directed to go inside the facility. Review of the Medical Infrared forehead thermometer manufacturer's information provided by the facility, revealed an illustration that indicated the area to obtain the temperature was in the middle of the forehead. The instructions also revealed after entering the room from a low or high temperature outside, to wait for 20 minutes until the temperature of the subject is adjusted to the temperature environment; before measurement, please be sure there is no hair, sweat, makeup or hat covering and that the ambient (relating to the immediate surroundings) temperature should be stable and not tested in places with large airflow. On [DATE] at 8:50 AM entered the front door of the facility into the reception area. Upon observation, surveyor's temperatures were checked on the neck, and not the appropriate area of the forehead. One reading obtained on a surveyor read 94.7 Fahrenheit (F). During an interview with the surveyors on [DATE] at 4:10 PM, the Central Supply manager stated he handled the ordering of the digital thermometers and that they were starting to break down. The Central Supply manager also stated that the facility had three digital thermometers on order. He also stated, I don't know how or if the thermometers are calibrated because we never had to do that before. The facility was unable to present information regarding the calibration requirements for the thermometers being used during the survey. During an interview with the surveyors on [DATE] at 4:12 PM, the Medical Director stated the Certified Nursing Assistants (CNA) were taking the temperatures and were trained just as part of their CNA training and not specifically in-serviced by the facility. 5) Hand Washing Practices An observation on the 2-South unit at 2:50 PM on [DATE], E11 was observed handling soiled linen at the doorway in room [ROOM NUMBER]. She discarded it in the soiled linen cart and did not change her gloves. She then went to another room without performing any hand hygiene. At 3:05 PM E11 was observed at the doorway of the COVID-19 unit removing and discarding her gloves first. She then removed her contaminated PPE gown with ungloved hands and discarded the gown. She did not perform hand hygiene before leaving the unit. At 3:10 PM E12, was observed removing her soiled PPE at the doorway of the COVID-19 unit. She did not perform hand hygiene before leaving the unit. There was only one large trash bin at the main entrance of the unit. A used PPE gown was not thrown in the proper receptacle but instead was thrown into a smaller size trash bin which was overflowing. It was noted that the door could only be opened with a turn handle knob. There was no place designated at the entry in which staff could perform hand hygiene measures. Upon opening the door, there was a hallway with still no place to perform hand hygiene. The hand sanitizer was not close by, and it was found on top of the nursing medication cart two rooms away. It was not easily accessible to the staff who needed to perform hand hygiene. At 3:15 PM, E13 was observed at the doorway of the COVID-19 unit, wiping her face shield with ungloved hands. She was using the Sani wipes to clean and disinfect the face shield. After cleaning, she did not do hand hygiene. An interview with E10 on [DATE] at 3:15 PM revealed E11 and E12 should have performed hand hygiene before leaving the unit. On [DATE] at 9:55 AM, two physical therapy staff members (E15 and E16) were observed walking in the hallway. They were still wearing gloves as they opened the door to exit the West unit (second floor). They removed their gloves after exiting and did not perform han