STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315514	A. BUILDING _____ B. WING _____	**06/15/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
EGG HARBOR CARE CENTER	**6818 DELILAH ROAD EGG HARBOR TOWNSHIP, NJ 08234**

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 -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and review of pertinent facility documents, it was determined that the facility failed to always prevent the potential spread of infection by assuring that the infection control practices were followed in accordance with Centers for Disease Control Guidance and facility policy to refrain from group dining during an outbreak of COVID-19 to prevent the potential spread of infection. This deficient practice was identified on 1 of 2 nursing units (Ocean Breeze), and was evidenced by the following: On 06/15/2020 at 11:48 AM, during the initial tour of the facility the surveyor observed eight residents seated in the dining room during lunch. Certified Nursing Assistant (CNA) #1 pushed a wheelchair bound resident into the dining room and seated the resident alone at a table for lunch. There were two residents seated at one table. CNA #1 approached the residents and informed them that only one resident could be seated at each table. She then proceeded to assist one of the residents to move to another nearby table. The surveyor interviewed CNA #1, who stated that the dining room opened for lunch today and residents were served dinner in their rooms. She further stated that the facility tried to make the residents comfortable and get used to socializing again. At 12:05 PM, the surveyor entered the activity room and observed CNA #2 who wore a mask and was seated at a table with a resident as the resident ate lunch. CNA #2 stated that residents came to the dining room and activity room for lunch to be around people. She stated that the dining areas opened more than two weeks ago when everyone started clearing after being tested for COVID-19. She further stated that only one person was permitted to be seated at a table at a time. At 12:15 PM, the surveyor interviewed CNA #3 who confirmed that there were nine residents eating lunch in the dining room. He stated that normally there was no more than four or five residents in the dining room at lunch time. He further stated that the dining room opened last week, and residents were required to be spaced apart and wear masks after their meal. At 12:20 PM, the surveyor interviewed Licensed Practical Nurse (LPN)#1 who stated that she last worked on the unit three or four weeks ago and observed a small number of residents eating lunch in the dining room at that time. She stated that only one resident was permitted to be seated at a table at a time. LPN #1 confirmed that there were eight residents eating lunch in the dining room. She further stated that the residents who were present in the dining room were not interviewable due to dementia and could only answer basic questions. At 12:40 PM, the surveyor interviewed the Unit Manager (UM) who stated that communal dining at lunch time resumed on her unit a couple of days ago and she would take full responsibility for that decision. She stated that she was unsure if the Director of Nursing (DON) or the Quality Assurance Nurse (QA) who were both responsible for infection control at the facility were aware that the dining room reopened for communal dining with social distancing. The UM stated that she was told that residents could eat in the dining room if they were seated six feet apart but was unsure who informed her that was permitted. She further stated that residents who were placed on quarantine in isolation to rule out a [DIAGNOSES REDACTED]. At 12:59 PM, the surveyor interviewed the DON who stated that she just learned that residents were eating in the dining room on the Ocean Breeze Unit. She stated that the residents just got in there. She further stated that she would not expect to see staff transporting residents or serving them meals in the dining room as it was closed on 03/12/2020. The QA Nurse (Infection Control Nurse) was present during the interview and stated that she was not aware that the dining room was opened and utilized for communal dining. In a later interview at 1:16 PM, the DON stated that there was no signage on the dining room or activity room to indicate that they were closed. She further stated that the unit would cease and assist communal dining immediately as it was not in line with their facility policy. The surveyor reviewed the facility policy, Outbreak Prevention Plan (Effective March 6, 2020 and Revised May 12, 2020) and the which revealed the following: Suspend communal dining. NJAC 8:39 19.4 and 27.1(a)

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