STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315519	A. BUILDING _____ B. WING _____	06/26/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ATRIUM POST ACUTE CARE OF HAMILTON	3 HAMILTON HEALTH PLACE HAMILTON, NJ 08690

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(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	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** PART A: Based on observation, interview, a review of records and other pertinent facility documents, it was determined that the facility failed to ensure: a.) the implementation of their outbreak response plan by implementing and maintaining an infection prevention and control surveillance system and a cohort tracking system for residents that were under investigation for COVID-19; b.) staff assignments were cohorted appropriately to prevent the spread of COVID-19; c.) used gowns were not continuously worn during a staff assignment between caring for residents that were confirmed positive for COVID-19 and a resident who had no known history of COVID-19; and, d.) gowns were not worn between caring for residents in the same PUI cohort group. This deficient practice was identified during the tour of 2 of 2 nursing units (Unit 1 and Unit 2) conducted on [DATE]. On [DATE], the surveyor reviewed the facility's COVID-19 outbreak response plan, the resident and staff line list, infection data reporting sheets, and other pertinent documents the facility provided as they related to COVID-19. The documents revealed that there was no system in place to appropriately track the cohort group of residents who were under investigation for COVID-19, and there was no method of an effective infection surveillance system. Upon observation and interview, it was identified that facility staff was provided with a reusable face mask and gloves and a weekly allotment of two disposable gowns, one N-95 mask, three pairs of shoe coverings, and hairnets. During the tour, it was identified that the nursing, therapy, and social work staff continuously wore their gowns when caring for residents who were under investigation for COVID-19 when additional gowns and personal protective equipment (PPE) were available in storage bins on 2 of 2 units. During tour of the COVID-19 wing located on Unit 1, it was identified that a Licensed Practical Nurse (LPN #4) shared a Certified Nursing Aide (CNA) assignment covering the entire unit which consisted of residents who were in four different cohort groups (including residents who were confirmed positive for COVID-19, recovered from COVID-19, potentially exposed and under investigation for COVID-19, and residents who had tested negative for COVID-19). The LPN was observed wearing an improperly donned gown coming out of the room of two residents who were identified as confirmed positive for COVID-19, then entered a room and closed the door of a resident who was a person under investigation (PUI) for COVID-19 without removing the contaminated PPE. The interviews revealed that LPN #4 had been continuously wearing the same single-use gown provided between the two resident cohort groups. In accordance with facility provided documents as of [DATE], the surveyor learned that 15 of 51 COVID-19 positive residents had expired between [DATE] to [DATE], with the outbreak ongoing as late as [DATE]. The facility's failure to appropriately track the residents under investigation for COVID-19 cohort group, implement an effective surveillance program, appropriately follow the US Centers for Disease Control and Prevention (CDC) guidelines for extending the use of PPE, and failure to cohort staff to the designated cohort groups to the extent possible, posed a serious and immediate threat to the safety and wellbeing of all non-ill residents. This resulted in an Immediate Jeopardy (IJ) situation that began on [DATE] at 5:45 PM. The immediacy was removed on [DATE] at 5:15 PM based on an acceptable Removal Plan implemented by the facility and verified by the surveyor during an onsite visit conducted on [DATE]. The evidence was as follows: On [DATE] from 9:58 AM to 11:05 AM, the surveyor interviewed with the Director of Nursing/Infection Preventionist (DON/IP) and the newly hired Corporate Registered Nurse (CRN). The DON/IP stated that the Licensed Nursing Home Administrator (LNHA) would not be at the facility today. The DON/IP noted that the facility utilized the U.S. Centers for Disease Control and Prevention (CDC) as the facility's nationally accepted guidelines for infection prevention and control for COVID-19. She further stated that the facility had implemented a method to extend PPE use, specifically the use of a face shield, and N-95 respirator masks. The DON/IP stated that staff used, gowns throughout the day on both units and that gowns were also continuously worn by staff on the COVID-19 wing cohorted (treating as a group) on Unit 1. The DON/IP continued that the facility was cohorting nursing and housekeeping staff by only keeping them assigned to residents that had tested positive for COVID-19, but that staff knew to use a well-to-ill rounding strategy, and that PPE could not be reused from a COVID-19 positive room to a COVID-19 negative or PUI room. The DON/IP added that the facility was also testing all residents for a baseline COVID-19 result on admission. If negative for COVID-19, they would be retested every week, and as needed. She continued that for those residents that tested positive for COVID-19, the facility would re-test them after their recovery period. The facility utilizes a test-based strategy to determine recovery by retesting the residents to ensure two lab-confirmed negative results within a few days apart. The DON/IP noted that the facility currently had residents in-house that had acquired the infection in the facility and tested positive for COVID-19, as late as [DATE]. The surveyor asked how many residents were confirmed positive for COVID-19, and the DON/IP stated that she thought there were eight (8) residents on the COVID-19 wing from resident rooms ,[DATE]. The surveyor asked for the facility's data tracking and surveillance related to their COVID-19 outbreak and any further documents or tools the facility was utilizing during the outbreak, including a PPE utilization/ burn rate (average calculation of daily consumption rate of each PPE used to estimate current PPE inventory with the burn rate to ensure adequate supplies are available). The DON/IP indicated that their primary tracking method was the resident outbreak line list, but that she also had a copy of her tracking of residents and staff who were tested for COVID-19. The DON/IP confirmed a Facility Outbreak Reporting Daily Survey was sent daily to the New Jersey Department of Health (NJDOH), which included cumulative numerical data. The surveyor also asked about the facility's PPE utilization/ burn rate, and the DON/IP stated she wasn't sure about that, but that she would check. The DON/IP acknowledged that she didn't maintain a current in-house data surveillance system, but that she could indicate the residents who were new admissions in the last 14 days and which residents had recovered from COVID-19 using the alphabetized resident census list. The DON/IP explained that Unit 1, rooms ,[DATE] were rooms designated for COVID-19 positive residents. The hallway running perpendicular to the COVID-19 unit was Unit 1 rooms ,[DATE], and was designated for new hospital admissions in the last 14 days and were under investigation for COVID-19. She added that Unit 2, rooms ,[DATE], were all negative for COVID-19. She said that the facility would put two Persons Under Investigation (PUI) for COVID-19 residents together in the same room if they were admitted the same day or one day apart, and quarantine them for 14 days with droplet precautions (a method of transmission-based precautions in which a gown, gloves, mask, and face shield are worn by staff when in close proximity or contact with the resident or the resident's environment to prevent the spread of infection). The surveyor asked the DON/IP how many COVID-19 positive residents the facility had on the census, and the DON/IP stated she believed there were either seven or eight residents. The surveyor then asked how many residents on the census were identified as PUI, and the DON/IP stated there was one, and it was an exposed roommate of a resident who had tested positive for COVID-19 (Resident #5). The surveyor asked the DON/IP how the facility identified residents who are PUI. The DON/IP stated that a PUI would be a resident who had symptoms of COVID-19 and has a test result pending and an exposed resident who had a roommate or staff that tested positive for COVID-19. She stated that none of the residents in the building currently had symptoms of COVID-19, so it was only one resident on the census that was a PUI (Resident #5). The surveyor asked if there were any other situations in which a resident would be considered a PUI, and the DON/IP stated that the facility tested all the residents for COVID-19, so she wasn't sure beyond that. The surveyor asked how the facility handled new admissions, and the

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

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 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 1) DON/IP indicated that the facility placed the residents on a 14 day quarantine period and on droplet precautions. The DON/IP stated that the facility would also consider this cohort group under the PUI cohort because they were placing the residents newly admitted on droplet precautions because of an unknown exposure to COVID-19 in the hospital or community. The surveyor asked about residents who went out to [MEDICAL TREATMENT] or other specialized appointments outside the facility, and if they would be placed on droplet precautions. The DON/IP replied that the facility currently had no residents that go to a [MEDICAL TREATMENT] center or other specialized treatment centers for appointments. Still, if the facility did, they too would be placed on droplet precautions for the 14 days from their last appointment date. The DON/IP confirmed this would meet the facility's PUI definition due to an unknown exposure. Further, the surveyor reviewed the undated My In-House Tracker for testing of residents in the presence of the DON/IP. The surveyor identified that there was one (1) resident who had tested negative for COVID-19 on [DATE], and had refused subsequent weekly COVID-19 tests and resided on Unit 1. The DON/IP acknowledged this resident was also on droplet precautions and a PUI. The surveyor then asked how many residents of the current census were PUI? The DON/IP put a checkmark next to all the residents that were new admissions in the last 14 days. There were 15 residents, but she also added that 4 of the newly admitted residents had either had COVID-19 or recovered from COVID-19, so, therefore, 11 residents were PUI. She confirmed that the resident who refused subsequent testing and the resident that had a roommate that tested positive would put the facility total at 13 PUI. The surveyor reviewed the list more closely and noticed that the DON/IP identified a resident who was a PUI for being a new admission in the same room as a resident not identified as a PUI on the census list. The DON/IP indicated that the roommate completed their 14-day quarantine today, and the other roommate completes their 14-day quarantine tomorrow. The DON/IP acknowledged she did not have numerical calculations for the data for the three cohort groups to track the progress of the outbreak. At that time, the surveyor reviewed the rooms of the residents that were PUI with the floor plan, which revealed that the PUI's were spread throughout 2 of 2 units on various sides of the hallway and not cohorted to a single area or ensure they were separated from the residents who were non-ill, non-exposed. The DON/IP also acknowledged that the PUI cohort group of residents were placed in rooms throughout the 2 of 2 units. She admitted that she didn't have a surveillance tracker to identify where each PUI, COVID-19 positive, COVID-19 recovered, and COVID-19 negative resided within the building. On [DATE] at 11:10 AM, the surveyor toured Unit 2 (PUI/negative and not exposed/negative) with the CRN and observed the following: 1. The surveyor toured the Unit 2 hallway and observed that the PUI residents were not in a designated cohort area of the unit, but spread throughout the unit in various rooms throughout, and with a single PPE storage bin located outside the room of Resident #5. The storage bin was stocked with several long-sleeve gowns and gloves, a disposable thermometer, and a disposable stethoscope. On top of the bin was a bottle of alcohol-based hand gel (ABHG). A review of the staff assignment sheet for [DATE] revealed that nursing assignments were not cohorted to the extent possible when LPN #1 had an assignment with five residents that were PUI and three residents non-exposed and negative for COVID-19. The other nursing assignment consisted of five residents that were PUI and seven residents that were non-exposed and negative for COVID-19. At 11:15 AM, the surveyor observed an Occupational Therapist (OT) wearing a long sleeve disposable gown, N-95 respirator mask, a face shield exit the room of a resident who was identified as non-ill and non-exposed. At that time, the surveyor interviewed the OT and asked about her use of PPE while in the resident's room. The OT confirmed that the resident was not on droplet precautions, but stated she wore full PPE because COVID-19 was highly contagious and it's everywhere, so we have to wear PPE. The OT continued that she removed her PPE only when exiting the unit, and before lunch. She further stated, we re-use it. She noted the only time it would not be reused, was if she had to go to a COVID-19 positive resident. She confirmed she would wear the same gown between residents of the various cohort groups, which was okay as long as the resident didn't have COVID-19. At 11:29 AM, the surveyor observed a Physical Therapist (PT) exit the resident's room identified to be a PUI located near the end of the hallway on Unit 2. There was a stop sign to see the nurse before entering and a sign that indicated droplet precautions were required. The surveyor observed the PT exit the room while wearing a long-sleeve single-use gown, a face mask, face shield, and a hair net. She continued to walk down the hallway to a room behind the nurses' station wearing the contaminated PPE. The PT doffed her gown in the staging room and discarded it. The surveyor interviewed the PT, who stated that she only sees residents on Unit 2. She just completed an initial evaluation on that resident because he/she was just admitted from the hospital and was on droplet precautions for 14 days. The surveyor asked about the extended use of PPE, and the OT confirmed that gowns were reused between residents but only when going from droplet to droplet room. She added that she could not go from a resident room that was on droplet precautions while wearing the full PPE then go to a resident room that was not on droplet precautions, adding that the reason was that this could potentially cause cross-contamination. At 11:41 AM, the surveyor observed LPN #3 in the hallway wearing a long-sleeve isolation gown and a mask. LPN #3 stated that she was not functioning as a nurse but instead had a Certified Nursing Aide (CNA) assignment today, which included residents that were PUI and residents that were non-ill, non-exposed to COVID-19 and had tested negative for [MEDICAL CONDITION]. LPN #3 further stated that she wears the gown everywhere because the gown is a general gown to be worn for general care. She also said that if it got dirty, she would get a new one. She stated that while there were no COVID-19 residents on the unit, she would need to change her gowns if she had to go between two isolation rooms because of how COVID-19 spreads. LPN #3 stated that Unit 2 only had exposed residents because they were new admissions from the hospital or residents who had tested negative for COVID-19 and had completed the 14-day quarantine. LPN #3 added that the Receptionist puts PPE bags together, and each staff member would get one bag per week with ,[DATE] gowns, one N-95 respirator mask, a couple of shoe covers, and hair coverings. She stated that even though she received an individually packaged weekly allotment of PPE, there were gowns kept on the unit if more were needed. At 11:59 AM, the surveyor observed the Medical Records Coordinator (MRC) wearing a gown and face mask exiting the PPE staging room behind the nurses' station. The MRC stated that she was responsible for going to both units and delivering beneficiary notices to residents. The MRC said that she donned and doffed the PPE in the staging room behind the nurses' station and that she could wear the same gown between residents that were non-ill, non-exposed/negative for COVID-19, and that a new gown could be shared between PUI residents on droplet precautions. She stated that a new gown would be needed if going from a PUI to a not exposed resident and not ill. She continued that she would store her gowns in the staging area and put it in the clear plastic bag. 2. On the same day, [DATE] at 12:05 PM, the surveyor observed the meal truck delivered to the floor and noted the following during the lunch delivery service on Unit 2: At 12:08 PM, the surveyor observed the SW wearing the same blue short sleeve disposable gown deliver a regular non-disposable tray to a resident that was non-ill, not exposed, and had tested negative for COVID-19. The surveyor observed the SW enter the resident's room, place the tray on the bedside table, and adjusted the table and moved it closer to him/her with her bare hands. The SW then exited the resident's room and did not offer to assist the resident with a hand hygiene wipe or encourage them to use the hand hygiene wipe on the tray before the lunch service. She then exited the room and did not perform hand hygiene, and she immediately returned to the tray truck to pick up another tray. She took a tray for a resident that was identified as a PUI and on droplet precautions. She was not wearing a face shield or gloves and delivered the tray to the resident's room, touching the bedside table and adjusting the tray closer to the resident. The SW then exited the room, used ABHG, and walked down the hallway to the PPE staging area. At that time, the SW told the LPN/Charge Nurse that she needed a new gown because she went into a resident room on droplet precautions. The surveyor observed the LPN/Charge Nurse tell the SW that she could continue wearing the same gown that she had on, but that she would just have to only serve the rest of the lunch trays to PUI residents and on droplet precautions. The SW left the same gown on and continued to pass out lunch trays to residents on droplet precautions. The SW did not wear a face shield or gloves when handling the lunch trays and touching the resident's bedside tables. At 12:18 PM, the surveyor observed the LPN/Charge Nurse doff her PPE gown in the room behind the nurses' station; she then clipped it, allowing the gown to hang freely in the staging area room. At 12:28 PM, the surveyor interviewed the SW, who confirmed she was in-serviced on hand hygiene and how/when to don and doff PPE. The SW stated that she could wear the same gown when going from PUI to PUI, but she could not enter a resident room that was not a PUI afterward and would have to change her gown. The SW stated that she washes her hands with ABHG between contact with the resident or their environment. She said, I don't use the face shield much as the face shield is used more for the COVID unit. The SW stated that the face shield was to protect her from droplets from a cough or a sneeze and acknowledged it was difficult to predict if and when someone else coughs or sneezes. At 12:38 PM, the surveyor interviewed a CNA assigned to Unit 2. The CNA was not wearing a gown in the hallway but holding a new one. The CNA stated that COVID-19 was spread through droplets, and therefore, he would have to wear a gown, gloves, N-95 respirator mask, face shield, and shoe coverings when entering a PUI room. The CNA stated that a face shield was only needed to provide direct care to the resident; otherwise, it wasn't required to drop off a tray or just check on the resident. The CNA stated that if a resident

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This would prevent cross-contamination while wearing the same gowns between the same resident cohort groups. 3. On [DATE] at 12:56 PM, the surveyor toured Unit 1 with the CRN, which included a hallway consisting of the following cohort groups: residents that were PUI for COVID-19, residents that were non-ill/negative for COVID-19, a resident that had recovered from COVID-19 and a resident who was a PUI because he/she refused to be retested for COVID-19. (This cohort did not correspond with what the DON/IP told the surveyor during an interview at 9:58 AM, in which the hallway was for new admissions and still within their 14-day PUI quarantine period.) Perpendicular to the Unit 1 hallway was the COVID-19 wing, which included residents that were either confirmed positive for COVID-19 or were in recovery from COVID-19. At 12:59 PM, the surveyor observed a Registered Nurse (RN) in the hallway of the COVID-19 wing of Unit 1. The RN was wearing an N-95 respirator mask, a face shield, and a long-sleeve disposable gown. At that time, the surveyor interviewed the RN who stated that her assignment consisted of rooms ,[DATE], and included residents that had tested positive for COVID-19, residents that were under investigation for COVID-19, and a resident who had tested negative for COVID-19 but was a PUI because he/she refused subsequent testing. The RN stated that she wasn't only assigned to COVID-19 residents, as she had other cohort groups in her assignment. She said, however, that she utilized a well-to-ill rounding strategy not to cross-contaminate. The RN stated that she had three residents that were confirmed (+) for COVID-19 (Resident #1, Resident #2, and Resident #3); This did not correspond with the number of confirmed positive cases, the line listing or what the DON/IP had told the surveyor during the interview at 9:58 AM. The RN stated that she would wear her same PPE for all COVID-19 positive residents, but if she had to see her PUI residents, she would have to remove her PPE and don new PPE. The RN confirmed that the same PPE could be worn between the same PUI to PUI resident room cohorts as well. At 1:00 PM, the surveyor observed LPN #4 wearing an N-95 respirator mask, a face shield, and a long-sleeve disposable gown in the hallway. The surveyor observed that the gown was not tied at the waist, and the ties were hanging loosely on her sides, nearly touching the floor. LPN #4 entered the private room of Resident #1, who was on the COVID-19 wing and closed the door behind her. At 1:04 PM, the surveyor observed LPN #4 exit the room of Resident #1, and immediately enter the room of Resident #2 and Resident #3, who were roommates on the COVID-19 wing and confirmed positive for COVID-19. LPN #4 was wearing the same PPE, and the single-use gown was still untied at the waist, causing the lower half of the gown to freely move as the LPN walked. LPN #4 then closed the door behind her. At 1:07 PM, the surveyor observed the same LPN #4 exit the room of Resident #2 and Resident #3 who were confirmed positive for COVID-19, wearing the same PPE, including the untied gown. LPN #4 then left the COVID-19 wing and proceeded to walk down the hallway where there were residents who were PUI and negative for COVID-19. The surveyor observed that as the LPN #4 walked down the non-COVID hall, as the LPN's untied, unsecured gown moved freely. The surveyor also identified that LPN #4 did not disinfect the face shield. The surveyor then observed LPN #4 enter a room down the non-COVID hallway. The surveyor followed and noted that the LPN #4 entered Resident #4's room, who had a sign on the door to stop and see the nurse before entering and a sign that read, Droplet Precautions. There was a PPE storage bin outside the resident's room stocked with new gowns and gloves. A review of the Census Report Dated [DATE], Resident #4 was a new admission on [DATE] and identified by the DON/IP as a new admission PUI. At approximately 1:12 PM, the surveyor observed LPN #4 exit the room of Resident #4 (PUI/baseline negative) wearing the same PPE, including the untied, unsecured gown and the face shield as she was wearing while in the COVID-19 positive room. As the LPN #4 exited Resident #4's room, and before the surveyor could stop or interview LPN #4, the Corporate RN pulled LPN #4 aside and told her to remove her PPE and get new PPE before proceeding any further. At approximately 1:16 PM, the surveyor observed the LPN #4 doff her PPE and perform hand hygiene at the pantry sink located across the hallway from Resident #4. The surveyor interviewed the LPN #4 at that time. LPN #4 stated that she was working as a CNA that day. LPN #4 noted that another CNA worked that day, and together they were assigned to the entire floor. LPN #4 confirmed that meant she was assigned to care for the COVID-19 residents, including Resident #2 and Resident #3, and residents that were PUI and had tested negative for COVID-19. She stated that Everyone here is on droplet precautions, and even though rooms (room numbers redacted) are non-COVID, we treat them like they have it. She further clarified that she wears a gown in all the rooms because the PUI residents might get COVID-19. LPN #4 also stated that Resident #4 was a PUI and had tested negative for COVID-19, but she still had to wear PPE when entering the room because the resident was on droplet precautions. LPN #4 stated that she went into Resident #4's room because his/her call light was on, and she wanted to check to see what the resident needed. She acknowledged she entered the room, closed the door, and then saw that LPN #5 was already in the room, so she opened the door and left. The surveyor asked LPN #4 when she dons and doffs her PPE, and she replied that she dons the PPE first thing in the morning and that she can wear the same PPE from PUI to PUI room. She stated that she could wear the same PPE between residents that were confirmed positive for COVID-19 but that she wasn't supposed to go from COVID-19 positive to PUI wearing the same PPE. The surveyor asked if she knew the status of Resident #2 and Resident #3, and the LPN #4 confirmed that those residents had recently tested positive for COVID-19 but were asymptomatic. She acknowledged she had just exited the room of Resident #2 and #3 (COVID-19 positive) before entering the room of Resident #4 (PUI/baseline negative) wearing the same PPE. The LPN #4's explanation of why she did that was because Resident #4's call light was on. LPN #4 added that the gowns should be tied and secured at the waist. At approximately 1:20 PM, the Corporate RN acknowledged that she saw LPN #4 exit the COVID-19 positive area while wearing the same PPE in which she had entered/exited a room for a PUI/baseline negative room. The CRN stated this was why she told the LPN #4 to change her PPE because she could not go from COVID-19 positive to a PUI room due to cross-contamination risks. At 1:22 PM, the surveyor interviewed the Corporate RN a second time. The surveyor asked the RN when she dons and doffs her PPE when she has an assignment that includes COVID-19 positive and PUI/baseline negative residents. The RN stated that if she had to go from COVID-19 positive to a PUI room, she would have to doff her PPE and apply new PPE, and she would take it from a fully stocked PPE bin in the hallway. The surveyor asked why that was important, and the RN stated, You just can't do that, even if I don't touch anything .it's because of cross-contamination. The RN further added that not changing the PPE from COVID to non-COVID could potentially expose the PUI resident to COVID-19. At 1:35 PM, the surveyor interviewed a Housekeeper who stated that she cleaned all the PUI resident rooms first, and she said that she would change her PPE between each PUI room, but when she gets to the COVID-19 wing, she would wear the same PPE throughout, except the gloves. The Housekeeper confirmed there was no short supply of PPE and always was accessible in the bins if she needed it. At 2:02 PM, the surveyor interviewed the LPN/Charge Nurse #2. The LPN/Charge Nurse #2 stated that staff could not go from COVID-19 positive rooms to a PUI resident room because that's dirty to clean and can cause spread of COVID-19. LPN/Charge Nurse #2 stated that even if the staff is not touching anything in the room, they shouldn't be over there at all while wearing the same PPE from a COVID-19 room. At 2:15 PM, the DON/IP showed the surveyor the PPE inventory and stated, we have a lot of gowns. The DON/IP noted that she was still looking for the PPE burn rate calculations that the surveyor had asked for that morning. She stated that she believed that the facility had ,[DATE] weeks of PPE in inventory. The Corporate RN said that the Corporate office had even more if needed. The DON/IP and Corporate RN confirmed that staff should not be going from COVID-19 positive to a PUI/baseline negative resident room, potentially exposing a resident to COVID-19. The DON/IP confirmed that the PPE process hasn't changed since she started working at the facility in [DATE], and that staff can wear the same PPE when caring for residents within the same cohort group. The surveyor asked for the US CDC guidelines that support this practice. No response was given. At 2:50 PM, the surveyor interviewed the LPN #5 in the room of Resident #4 (PUI/baseline negative) when LPN #4 entered the room. LPN #5 stated that she was assisting Resident #4 to the bathroom. LPN #5 said the resident was a PUI and had a negative baseline test, and he/she wasn't having any symptoms of COVID-19. LPN #5 stated that she was allowed to wear the same PPE when caring for residents in the same cohort group, but that the same PPE could not be worn from COVID-19 positive to a PUI room. LPN #5 also stated that if staff went from Resident #2 and #3 (COVID-19 positive) to Resident #4 (PUI/baseline negative) wearing the same PPE, it could potentially spread [MEDICAL CONDITION] to Resident #4. LPN #5 further stated that gowns should not be worn behind the nurses' station. The LPN added that LPN #4 entered Resident #4's room because the call light was on, and she closed the door behind her but didn't touch anything but the doors/doorknobs in the resident's environment. At 3:57 PM, the surveyor observed LPN #6 walking down the hallway wearing a long sleeve single-use gown. The gown was not tied at the neck or waist. The surveyor interviewed LPN #6,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315519	A. BUILDING _____ B. WING _____	06/26/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ATRIUM POST ACUTE CARE OF HAMILTON	3 HAMILTON HEALTH PLACE HAMILTON, NJ 08690

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) who stated that she worked the ,[DATE] PM evening shift. She just finished getting a report for all the residents on her assignment, which included rooms (room numbers redacted) (which included COVID-19 positive, PUI, and negative for COVID-19 cohort groups). She stated she was about to check on her residents. The surveyor asked about the unsecured ties on her gown, and LPN #6 began tying them in front of the surveyor and acknowledged that they should be tied securely. The surveyor reviewed the facility's policies and CDC guidelines for COVID-19. A review of the facility's Prevention and Control of [MEDICAL CONDITION] policy signed as reviewed on [DATE] included to Identify dedicated employees to care for resident under investigation of COVID-19 and or who have confirmed COVID-19 patients and provide infection control training. It further included providing the right supplies to ensure the easy and correct use of PPE .Make PPE, including facemasks, eye protection, gowns, and gloves available immediately outside of the resident room; position a trash can near the exit inside any resident room to discard PPE. (The policy did not address a PPE staging area or wearing PPE outside the resident roo
F 0885 **Level of harm -** Potential for minimal harm **Residents Affected -** Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and review of pertinent facility documents, it was determined that the facility failed to provide documented evidence reflecting that residents and their representatives were informed of newly confirmed COVID-19 [DIAGNOSES REDACTED]. This deficient practice was identified for 6 of 6 dates (5/19, 5/26, 6/2, 6/11, 6/18, and 6/20/20) in which a resident or staff tested positive for COVID-19. The evidence was as follows: On 6/22/2020 at 11:00 AM, the Director of Nursing (DON) provided the surveyor the facility's policy for family notification. The undated Family Notification policy indicated, At the time of admission, (an) email address is obtained from family members. A (digital media) link is emailed to them. At 3 PM every Friday, the LNHA (name redacted) gives them a facility update. Nursing staff does individual family notification on an ongoing basis. The policy did not address the method and timeframe in which families were notified when there was new confirmed positive COVID-19 case amongst a resident or staff member. A review of the undated Notification Policy did not address how residents were to be notified of newly confirmed COVID-19 outbreak status' or weekly updates, thereafter. The surveyor reviewed the letters sent to the resident representatives regarding the COVID-19 status of the facility. The notifications included an initial letter dated 3/3/2020 prior to the facility's outbreak. On 6/22/20 at approximately 4:00 PM, the DON stated that the initial letter was mailed out to the resident representatives by the previous Licensed Nursing Home Administrator (LNHA), and that she didn't have any other documentation then the initial letter dated 3/3/20. She stated that there were digital media conference calls conducted weekly, but that the new LNHA had that information and she wasn't at the facility to provide it. The DON stated that she couldn't speak to the notification process beyond that, as the new LNHA was responsible for the updates. On 6/24/20 the LNHA provided documentation via email at 5:15 PM of subsequent notifications sent to family representatives which included a letter dated 4/10/20, and meeting minutes for digital media conference calls conducted on 4/24/20 and 5/15/20. The minutes neither included who attended nor reflected evidence of informing the family of newly confirmed COVID-19 cases in the facility. There was no documented evidence provided of further communication with residents and their representatives after 5/15/20. A review of the facility's COVID-19 outbreak line list indicated the facility continued to have new confirmed positive cases of COVID-19 amongst residents and staff after 5/15/20. The following dates were opportunities in which notification of residents and their representatives were to be informed of the new COVID-19 status by 5 PM the next calendar day. The line list reflected the following: 1.) On 5/19/20, one staff member tested positive for COVID-19. 2.) On 5/26/20, two residents and one staff member tested positive for COVID-19. 3.) On 6/2/20, one staff member tested positive for COVID-19. 4.) On 6/11/20, one resident tested positive for COVID-19. 5.) On 6/18/20, one resident tested positive for COVID-19. 6.) On 6/20/20, one resident tested positive for COVID-19. The LNHA provided the surveyor a copy of a written letter addressed to families dated after surveyor inquiry on 6/23/20 in the same email. On 6/26/2020 at 11:30 AM, the surveyor interviewed the Licensed Practical Nurse (LPN). The surveyor asked the LPN how residents are notified of new COVID-19 cases within the facility, and the LPN stated that residents were informed only if they ask, and that there was no written letter or formal system to inform residents of newly confirmed positive cases of COVID-19. On 6/26/2020 at approximately 1:00 PM, the surveyor interviewed the LNHA. The LNHA acknowledged that she was the one responsible for updating families of the COVID-19 status within the facility. The LNHA stated that the facility had implemented weekly digital medial conference calls in which she presented information for five minutes, and the call was intended for presenting information and not for questions. The surveyor asked if she kept a record who attended the conference call meetings, and the LNHA stated there was no method to identify or log who attended those digital media conference calls. The surveyor asked how the families of new admissions received information of the media conferences, she stated that the facility tried to obtain email addresses of the representatives, and they would send out the invitation to attend the conference on Friday's. She confirmed the digital media conferences were only held on Friday's. The surveyor asked about informing the residents and families the next calendar day by 5 PM of a new confirmed positive case, and the LNHA acknowledged she was not aware the facility had to notify the families and residents within the 24 hours. On 6/26/2020 by 1:15 PM, there was no further documented evidence provided to the surveyor regarding informing the residents and representatives of newly confirmed positive COVID-19 cases. NJAC 8:39-5.1 (a)