STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315311	A. BUILDING _____ B. WING _____	07/22/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PHILLIPSBURG CENTER	843 WILBUR AVENUE PHILLIPSBURG, NJ 08865

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	**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: a.) ensure their written policy for extending the use of gowns was devised in accordance with nationally accepted guidelines for infection prevention and control to prevent the spread of COVID-19, b.) implement mitigation strategies to prevent the spread of COVID-19 for five days by not appropriately identifying four residents (Resident #1, #2, #3, and #4) exposed to COVID-19 as persons under investigation for [MEDICAL CONDITION] and c.) ensure gowns were not continuously worn from resident to resident while providing care in accordance with the U.S. Centers for Disease Control and Prevention. This deficient practice was identified on 1 of 2 cohort units (non-COVID unit) during a tour conducted on [DATE]. Upon observation and interview, it was identified that the facility practice included that all residents in the facility were placed on transmission-based precautions which allowed for the extended use of personal protective equipment (PPE) to be shared from resident to resident that had tested baseline negative for COVID-19. The facility became aware on [DATE] that two residents had tested positive for COVID-19, and the facility failed to identify their roommates as exposed to COVID-19 as persons under investigation (PUI) in an effort to mitigate the spread of [MEDICAL CONDITION]. During the survey conducted on [DATE], the surveyors observed facility staff wearing the same single-use long sleeve gowns entering and exiting the room of the exposed PUI residents and going into and out of other resident rooms that were not-ill without discarding their gowns after use. In accordance with facility provided documents as of [DATE], the surveyor noted that the facility had a COVID-19 outbreak that began on [DATE]. Two residents tested positive for COVID-19 and one had expired. The facility had a second COVID-19 outbreak that began on [DATE] when two staff members tested positive, and additonally on [DATE] when two residents tested positive for COVID-19. The facility's failure to appropriately implement extended use of PPE guidelines for COVID-19 in accordance with the U.S. Centers for Disease Control and Prevention (CDC), and their failure to identify four residents as exposed to COVID-19 and implement strategies to prevent the spread of COVID-19, 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 8:15 PM when the facility was notified of the two confirmed positive COVID-19 cases, and continued until [DATE] when the facility alleged complete implementation of the elements of the removal plan. The facility administration was notified of the immediate jeopardy situation on [DATE] at 2:30 PM. The evidence was as follows: On [DATE] from 9:35 AM to 10:25 AM, two surveyors interviewed the Licensed Nursing Home Administrator (LNHA), the Director of Nursing (DON), and the Registered Nurse/Infection Preventionist (RN/IP) in a conference room. The RN/IP stated that she worked full time as an Infection Preventionist, but her days were split between this facility and other sister-facilities. She stated that she only worked approximately two days a week in this facility. The RN/IP explained to the surveyors that the facility recently had a second COVID-19 outbreak that began on [DATE], in which two staff members tested positive for COVID-19, and it continued on [DATE] when two residents were swabbed and subsequently tested positive for COVID-19. She stated that the two residents recently diagnosed with [REDACTED]. The RN/IP further stated that in addition to the two residents that tested positive for COVID-19, the facility had two residents identified as Persons Under Investigation (PUI) for COVID-19, one of which went to the [MEDICAL TREATMENT] center and another resident had a community physician visit and would be on the AQU unit for 14 days. The RN/IP stated that the entire facility has been on full PPE since March and added that everybody in the building was on droplet precautions and .even if all residents test negative, they are still on droplet precautions. The surveyor asked the RN/IP if the facility was extending the use of any PPE, including gowns, face shields, masks. The RN/IP stated that gowns were reused in non-COVID areas and the same gowns are used when going from room-to-room between residents that have all tested negative for COVID-19. The RN/IP and DON stated that the facility utilized two sets of signs outside the resident rooms. She stated that a resident who tested negative for COVID-19 and was not a PUI, would have a white sign posted on their door with a stop sign that would read, Extended Contact Plus Droplet Precautions. The RN/IP stated that this white sign meant that the staff must wear a gown, gloves, face mask, and eye protection upon entering the room. She added that eye protection and a face mask was universally mandated on the units as part of the facility policy and staff just had to wear a gown and gloves when entering the room. The RN/IP elaborated that the white sign for Extended droplet precautions meant that staff could go room-to-room wearing the same gown to extend the use of the gowns, but that they could only re-use the gowns between residents that had the white sign posted on their door. The DON added that any resident that had a white sign outside the door meant they had tested negative for COVID-19. The RN/IP confirmed that all the residents on the non-COVID hallway had white signs for Extended droplet precautions on their door except one PUI resident on that side (Resident #7). The DON stated that gowns could be shared between the residents within the negative COVID-19 cohort group. The surveyor inquired if or how that process differed for identified PUI and COVID-19 residents, and the RN/IP confirmed that both the identified PUI residents and COVID-19 positive residents had a yellow sign on their door which indicated Patient-Specific Contact plus Airborne precautions. She stated this meant that staff must wear a respirator mask, gown, gloves and eye protection when entering the room. The RN/IP added that the difference was, when exiting a room of a COVID-19 positive or identified PUI room, that all PPE must be discarded at the exit of the room and could not be extended or shared between different residents. The DON and RN/IP confirmed there was no method to delineate the positive COVID-19 from the PUI residents, but stated that staff are informed upon report who had tested positive for COVID-19 and who was PUI. The surveyor asked the RN/IP and the DON when they would consider a resident a PUI. The RN/IP stated the facility would identify a resident as a PUI, if: 1.) a resident went to the [MEDICAL TREATMENT] center, 2.) if a resident went to another community appointment or special treatment appointment, 3.) a new admission to the facility, and 4.) if a resident had signs or symptoms of COVID-19. She stated if a resident met any of that criteria they would be placed in a private room to the extent possible, and have a yellow sign posted on their door to indicate, Patient-Specific airborne precautions. She stated that this sign would remain on their door for at least 14 days. She stated that the PPE, specifically the gown, would be discarded upon exiting the room. The surveyor asked if there were any other circumstances in which a resident would be considered PUI, and the RN/IP stated she could not think of any other scenarios. The DON and LNHA were unable to speak to any other PUI scenarios as well. The surveyor asked how the facility identifies and manages roommates of residents that test positive for COVID-19, and the RN/IP stated that we move the positive resident away from their roommates and put the positive residents on the AQU unit, and we test the roommates for COVID-19. She continued that the facility would also assess and monitor those roommates for signs or symptoms of COVID-19 and that all residents in the building were on transmission-based precautions already, so there was no need to do anything differently for the roommates of positive residents, except to monitor and test them. She added that in addition, all residents get tested for COVID-19 weekly. The RN/IP confirmed that the facility only had two residents who were confirmed positive for COVID-19 (Resident #5 and #6) and two residents who were identified as PUI residents (Resident #7 and Resident #8). The surveyor asked the DON if the residents who tested positive for COVID-19 had roommates, and the DON stated yes. The surveyor requested a list of the roommates of the two

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315311	A. BUILDING _____ B. WING _____	07/22/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PHILLIPSBURG CENTER	843 WILBUR AVENUE PHILLIPSBURG, NJ 08865

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 1) residents who were confirmed positive for COVID-19. The RN/IP stated that the facility follows the US CDC guidelines and corporate policies for infection control and prevention related to COVID-19. The DON and LNHA stated that they have adequate supply of PPE and reported no shortages throughout the outbreaks. The surveyor reviewed the COVID-19 outbreak line list dated [DATE] and compared it to the Daily Census report dated [DATE] which reflected a total in-house census of 49 residents. The reports indicated that three (3) residents resided in private rooms in the AQU/COVID-19 unit, including the two (2) residents that tested positive for COVID-19 (Resident #5 and Resident #6), and one (1) resident that had recently had a community physician visit and was a PUI (Resident #8). The other 46 residents were on the non-COVID hallway. The Daily Census report reflected that the other resident that the facility identified as a PUI (Resident #7) resided in a private room on the non-COVID hallway. At 11:10 AM, the surveyors entered the non-COVID section of the U-shaped hallway and began to make general observations throughout the unit. The surveyors observed that all but one of the resident rooms had a white sign posted on the door that read to Stop and Please see the Nurse before entering the Patient's room! It further specified, Extended Contact plus Droplet Precautions. The surveyor continued to observe the one PUI resident room (Resident #7) on the non-COVID unit that did not have a white sign, but instead had a yellow sign on the door that indicated to Stop and Please see the Nurse before entering the Patient's room. The yellow sign specified, Patient-Specific Contact plus Airborne Precautions. There were no other resident rooms with the yellow sign posted on the door on the non-COVID unit. The surveyors also observed, located at various accessible points in the hallway, large plastic storage bins of PPE which included single-use long sleeve gowns, face masks, boxes of gloves in various sizes, and disinfecting wipes. At 11:24 AM, the surveyor observed an Activities Aide (AA) assisting with a music activity from outside of each resident room. The AA was wearing a face mask, eye protection and a gown in the hallway. The AA stated that since the COVID-19 outbreaks, they had stopped any activity that required shared items, such as magazines or picture books. She stated that all items brought into the resident rooms were left there for the residents to use indefinitely. The AA stated that she had been in-serviced on COVID-19 including donning and doffing of PPE and hand hygiene. She also stated that she utilized a well-to-ill activity schedule for 1:1 room visits in which she visited all the residents with white signs on their door first. The surveyor asked the AA about the use of PPE in the facility. The AA stated that PPE was worn when interacting with all the residents in the building. She further stated that all staff wore a face mask and eye protection throughout the building, and if the residents have a white sign on their door for Extended droplet precautions, it meant that PPE could be shared between those residents because they had all tested negative for COVID-19. The surveyor asked what the difference was between the yellow sign posted on the door of Resident #7 that read, Patient-Specific Contact plus Airborne precautions and the white sign posted on all the other resident rooms in the hallway that read Extended Contact plus Droplet precautions. The AA stated that Resident #7 went to the [MEDICAL TREATMENT] center, therefore due to the resident's possible unknown exposure to COVID-19, the resident needed to have the yellow sign for patient-specific PPE. The surveyor asked for clarification of what patient-specific PPE meant on the yellow sign posted on the door of Resident #7, and she stated that it meant, We don't share PPE in that room. We take it off before exiting the room and put on new PPE if going to another resident room. She stated that the white signs on doors mean PPE can be shared between residents that all have the same white signs, but if a resident had a yellow sign it meant that everything comes off and the PPE cannot be shared between residents after exiting that room. The AA confirmed there was only one resident on the non-COVID section that had a yellow sign posted on their door, and that was Resident #7. The surveyor continued to interview the AA, and the AA stated that there were two residents that had tested positive for COVID-19 last week, (Resident #5 and Resident #6.) She stated those residents were temporarily moved to the AQU/COVID-19 unit at the end of the U-shaped hallway behind the double doors. The surveyor asked if Resident #5 and Resident #6 had roommates at the time they tested positive for COVID-19, and the AA replied yes. She then brought the surveyor to the room of an unidentified PUI resident, Resident #1. She stated that Resident #1 shared a semi-private room with Resident #6, before Resident #6 tested positive for [MEDICAL CONDITION]. The AA showed the surveyor the room of Resident #1 which had a white sign posted on the door indicating Extended droplet precautions. She confirmed that because Resident #1 had a white sign on the door, it meant that PPE could be shared between all the other residents that also had a white sign on their doors. At that time, the AA took the surveyor to the former room of Resident #5 who had tested positive for COVID-19 last week. The AA stated that Resident #2, Resident #3, and Resident #4 had all shared a quad-room with Resident #5 at the time Resident #5 tested positive for COVID-19. The surveyor observed a white sign indicating Extended droplet precautions on the door of the three roommates. The surveyor asked the AA if the facility had informed her to do anything different for the roommates of the residents that had tested positive for COVID-19, and she stated she was not told to do anything different for them or follow any different procedures. She confirmed that because Resident #2, #3 and #4 had a white sign on their door, she and other staff could wear the same gown between the other 42 residents on the unit, because they all had the white signs indicating Extended droplet precautions. At 11:26 AM, a second surveyor observed the Registered Nurse/Unit Manager (RN/UM) in the hallway. The RN/UM was wearing a gown, face mask and eye protection. At that time the surveyor interviewed the RN/UM who stated that if a resident tested positive for COVID-19, all PPE must be discarded prior to exiting the room using a receptacle located inside the resident's room. The RN/UM elaborated that in the non-COVID unit, the staff must wear gown, gloves, eye protection and at a minimum a surgical mask. She stated that the staff on the unit may use the same gown to care for different residents as long as they tested negative for COVID-19. She confirmed that residents that tested negative for COVID-19 had white sings on their door that indicated Extended droplet precautions. At 11:41 AM, the surveyor observed the DON wearing a face mask and eye protection standing outside a resident room that had a white sign for Extended droplet precautions. The surveyor observed the DON open a PPE storage bin located in the hallway and don a long sleeve, single-use gown and a pair of gloves. The DON stated to the resident in the room that she was coming into the room to assist them with toileting needs. The DON then closed the resident's door behind her upon entering the resident room. At approximately 11:45 AM, a second surveyor observed a Certified Nursing Aide (CNA #3) wearing a single-use long sleeve gown, face mask and eye protection exit the room of the exposed PUI Residents #2, #3, and #4 without discarding the gown. The surveyor observed CNA #3 obtain a mechanical lift (a two-person surface-to-surface transferring device) from the hallway and proceed to another resident room. At 11:46 AM, the surveyor observed a Licensed Practical Nurse (LPN) wearing a single-use long sleeve gown, gloves, eye protection and a face mask exit a room where three residents resided. Posted on the outside of that door was a white sign for Extended droplet precautions. The LPN walked to a medication cart at the end of the hallway wearing the same PPE. She removed her gloves and discarded them into the medication cart trash can. While wearing the same gown, she then took a cup of apple sauce and went into another resident room that had a white sign for Extended droplet precautions posted on the door and donned gloves inside the resident room. At approximately 11:48 AM, the two surveyors observed CNA #3 and the LPN still wearing the same single-use long sleeve gown, face mask and eye protection enter the room of a resident that was negative for COVID-19 with the mechanical lift. The CNA #3 then closed the door behind her. After they finished in the room, the surveyors observed both the LPN and CNA #3 exit the room without doffing the PPE. After storing the mechanical lift, CNA #3 then proceeded to enter the room of Residents #2, #3 and #4 wearing the same gown. The CNA #3 informed the surveyor that she and the LPN were transferring a resident who had tested negative for COVID-19. The second surveyor then observed the CNA #3 exit the room of Resident #2, #3, and #4 wearing the same gown and then entered another resident room across the hallway that had a white sign for Extended droplet precautions. At 11:52 AM, the surveyor observed the DON exit the room of the resident she was earlier assisting to use the bathroom. While wearing the the gown, face mask and eye protection, the DON walked down the hallway to the medication cart and poured a glass of water from the water pitcher on the cart. She re-entered the same resident room that had the white Extended droplet precaution sign. At 11:57 AM the surveyor observed the DON exit the room wearing the same single-use long sleeve gown. The DON continued to walk down the hallway wearing the gown that she had worn while in the resident room. At 12:00 PM, the DON confirmed that Resident #1 was the roommate of Resident #6 who had tested positive for COVID-19, and Resident #2, #3, and #4 were the roommates of Resident #5 that tested positive for COVID-19. This corresponded with the interview with the AA at 11:24 AM. The DON confirmed the room numbers of the residents, and acknowledged all the residents had white Extended droplet precaution signs on their doors except for the Resident #7 because he/she went to the [MEDICAL TREATMENT] center. She informed the surveyor that We can wear the same PPE in the rooms of each resident that had a white sign, and there was nothing different done regarding how PPE was used for the Residents #1, #2, #3 and #4. At 12:17 PM, the surveyor observed CNA #1 deliver lunch trays into the room of Residents #2, #3, and #4 which had the white Extended droplet precaution sign outside the door. The CNA #1 was wearing a single-use long-sleeve gown, face mask, gloves and eye protection. The CNA #1 placed the tray next to Resident #3, exited the room and wearing the same gown returned to the meal truck to continue passing trays. The surveyor

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315311	A. BUILDING _____ B. WING _____	07/22/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PHILLIPSBURG CENTER	843 WILBUR AVENUE PHILLIPSBURG, NJ 08865

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 2) stopped and interviewed the CNA #1 at that time. She stated she had just passed out the tray to Resident #3 and was going room-to-room to pass out all the lunch trays. She added that after the trays were all passed she would return to the rooms assigned to her to assist the residents with their meals. The surveyor asked for information about Residents #2, #3, and #4. The CNA #1 confirmed that they were all roommates of Resident #5 who tested positive for COVID-19 last week. The surveyor asked if she was informed to do anything different upon entering or exiting the room of Residents #2, #3, and #4 and the CNA #1 stated that they do nothing different. The CNA #1 added that the facility tested all the residents in the facility every week for COVID-19, and if a resident developed signs or symptoms of COVID-19 they would be moved to a private room and given a yellow sign for Patient-specific airborne precautions. She confirmed that the yellow sign meant that PPE would have to be discarded upon exiting a room of a resident that was under suspicion for COVID-19, because it could not be shared. She confirmed PPE would be discarded even if she didn't touch anything in the room. The surveyor asked why it should not be shared, and the CNA #1 stated because it could spread [MEDICAL CONDITION]. The CNA #1 stated that Resident #2, #3, and #4 had no known signs or symptoms of COVID-19 and therefore a white Extended droplet precaution sign was in place for those residents. The surveyor asked if the facility considered the resident's exposed to [MEDICAL CONDITION] if they had a roommate that tested positive for COVID-19, the CNA #1 acknowledged that the residents should be considered exposed because they were in the same room. The CNA #1 re-iterated to the surveyor that even if the residents are considered exposed, we don't do anything different because PPE is worn for all the resident's in the building. She confirmed that the gowns were shared between residents that had white Extended droplet precaution signs on their door, but not shared between residents that would have a yellow Patient-Specific airborne precaution sign on their door. While still wearing the same gown, she then proceeded to take another tray from the meal truck and deliver it to another resident room across the hallway that had a white Extended droplet precaution sign on their door. At approximately 12:22 PM, the surveyor observed the AA wearing a single-use long sleeve gown, face mask and eye protection exit the room of Resident #3. The surveyor stopped the AA in the hallway and she confirmed she had just exited the room of Resident #3 because she had to drop off an item. The AA did not discard the gown upon exiting the resident room and proceeded down the hallway. From 12:22 PM to 12:40 PM, the surveyors observed CNA #1, CNA #2 and the DON entering and exiting different resident rooms wearing their same gowns, delivering and setting up lunch trays to the residents on the non-COVID unit all with white Extended droplet precaution signs on the room doors. The surveyor reviewed the records for the two residents that had tested positive for COVID-19 (Resident #5 and #6). A review of the lab reports for Resident #5 and Resident #6 indicated that nasal swab specimens were collected on [DATE] and the result read, abnormal Positive (Detected) for [DIAGNOSES REDACTED]-CoV-2 (COVID-19) on [DATE]. The lab results indicated that the two positive COVID-19 case results were reported to the facility on [DATE] at 8:15 PM. A review of the Primary Payer report dated [DATE] for Residents #5 and #6 reflected that the resident's rooms were changed to private rooms on the AQU/COVID unit on [DATE]. At 1:14 PM, the surveyor interviewed the RN/IP and the Regional Clinical Coordinator (RCC). The RN/IP provided the surveyor a copy of the U.S. CDC guidelines, Preparing for COVID-19 in Nursing Homes updated [DATE], marked in red to highlight the section where the U.S. CDC guidelines addressed the extended use of PPE in nursing homes. The U.S. CDC guidelines document included, If extended use of gowns is implemented as part of crisis strategies, the same gown should not be worn when caring for different residents unless it is for the care of residents with confirmed COVID-19 who are cohorted in the same area of the facility and these residents are not known to have any co-infections (e.g. (multi-drug resistant organisms)). The RN/IP stated that this was what the facility had been implementing. The surveyor asked if the facility was using the same gown when caring for different residents, and the RN/IP acknowledged yes the facility was sharing the same gown for different residents that had the white Extended droplet precautions sign on the door. The RN/IP acknowledged those residents with the white sign on the door had tested negative for COVID-19. The RN/IP confirmed that in accordance with CDC guidelines, they should not be sharing the same gown between residents that had tested negative for COVID-19. She acknowledged that the guidelines addressed an exception for sharing gowns between different residents and that was if the residents had a confirmed COVID-19 [DIAGNOSES REDACTED]. The RN/IP confirmed that the facility was not sharing gowns between residents that had tested positive for COVID-19 because they had the yellow sign that indicated Patient-Specific airborne precautions, whereby PPE would get discarded upon exit of the room. The RN/IP and RCC stated based on the review of the U.S. CDC guidelines, they would stop Extended droplet precautions with the sharing of the gowns between residents that tested negative for COVID-19. According to the U.S. CDC guidelines, Responding to Coronavirus (COVID-19) in Nursing Homes updated [DATE], included, Roommates of residents with COVID-19 should be considered exposed and potentially infected and, if at all possible, should not share rooms with other residents unless they remain asymptomatic and/or have tested negative for (COVID-19) 14 days after their last exposure (e.g., date their roommate was moved to the COVID-19 care unit). Exposed residents may be permitted to room share with other exposed residents if space is not available for them to remain in a single room. A review of the facility's Infection Control Policies and Procedures for COVID-19 revised on [DATE] included, In addition to Standard precautions, Contact and Airborne precautions will be implemented for patient's suspected or confirmed to have COVID-19 based on the Centers for Disease Prevention & Control (CDC) guidance. It further included, implement universal use of facemasks/respirator and eye protection while in the Center. The policy provided did not address identifying roommates of residents that test positive for COVID-19 as exposed and PUI. A review of the Personal Protective Equipment (PPE): Use, Reuse and Extended Use of PPE for All Staff policy dated [DATE] included in a section titled, Buildings Where COVID-19 is Confirmed, Staff who are directly providing care to a patient who is suspected, presumed or confirmed for COVID-19 should use an N95 or approved KN95 respirator. It further included that, Staff must use gowns in caring for all patients and must follow extended use guidance. Staff on patient units who will not be entering patient rooms should NOT wear a gown. During a COVID-19 outbreak, gowns must be worn by all employees in patient care areas who are entering patient rooms. The facility defined Extended Use in their policy as, The same gown is worn by the same healthcare worker when interacting with more than one patient known to be infected with the same infectious disease when these patients housed in the same location (i.e. COVID-19 patients residing together in dedicated wings/units). Reuse of gowns can be considered only if there are no additional co-infectious [DIAGNOSES REDACTED].Diff) (infectious diarrhea)) among patients. Staff must remove and discard the gown if it becomes visibly soiled. The policy further included, When caring for patients with NO infectious process: Patients/residents who have tested negative for COVID-19 and are asymptomatic are considered non-infectious. Staff member may wear the same gown to go in and out of those patients rooms and into the hallway. Do not touch the front or sleeves of the gown. (This practice does not correspond with the U.S. CDC guidelines for extending the use of gowns). When caring for people with the same infectious process (e.g. COVID-19 .) Staff member may wear the same gown between patients. Gown must be removed in the room and discarded after leaving the room unless going directly to the room of another patient with the same infectious process. Staff member must change gowns when caring for patients with different infectious processes: Staff member may wear gown upon entering the room of a patient with an infectious process IF coming from room of patient(s) with no infectious process. Change gown between patients who have different infectious processes. In order to extend the use of a gown, cluster patient care around common infectious processes to decrease the number of times the gown has to be changed. At 1:21 PM , a second surveyor toured the central supply room with the LNHA who stated this was where they stored their PPE. The LNHA stated that the nursing supervisors for each shift have the key to the central supply room in the event they need to get more PPE for the units. He confirmed they had adequate PPE and showed the surveyor a form by the door titled, Central Supply Sign Out Log which served as an accountability system and a burn list used to identify what PPE and how much was removed from the central supply room during restocking of the units. The surveyor observed a large quantity of respirator masks, surgical masks, goggles, boxes of gloves of various sizes, multiple hand sanitizers, and multiple boxes of gowns. At that time, a central supply (CS) staff member informed the surveyor that there were even more gowns stored inside another locked cabinet but that all units and the front central supply area was well stocked. At 1:50 PM, the RCC informed the surveyors that all the residents were tested for COVID-19 on Monday [DATE] as part of their weekly testing program including Resident #5 and #6. The RCC stated the facility was notified of the confirmed positive results for Resident #5 and #6 on Thursday [DATE], and their rooms were changed that day to the AQU/COVID-19 unit. The RCC acknowledged the roommates of the confirmed positive residents did not have yellow signs on their doors to reflect Patient-Specific airborne precautions. The facility was notified of the IJ situation on [DATE] at 2:30 PM. The facility's LNHA, DON, RN/IP, and RCC were informed that the facility failed to identify the roommates of the confirmed positive residents as exposed and potentially infected with COVID-19, and failed to avoid the re-use of single-use gowns between the unidentified exposed PUI residents and the residents that tested negative for COVID-19. This failure placed the non-ill residents in an Immediate Jeopardy situation that began on [DATE] at 8:15 PM. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315311	A. BUILDING _____ B. WING _____	**07/22/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PHILLIPSBURG CENTER	**843 WILBUR AVENUE PHILLIPSBURG, NJ 08865**

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) Removal plan was accepted on [DATE] at 12:48 PM and the immediacy was removed on [DATE] based on the accepted implemented elements of that Removal Plan. The Removal Plan was verified by the surveyors during an onsite visit on [DATE]. The plan included the following: All residents that are not COVID positive are being treated as PUI's and have been placed on patient specific contact and airborne precautions. The affected residents will be retested weekly x 2 weeks for COVID and will be ruled out as Person's Under Suspicion if they remain asymptomatic for 14 days ([DATE]) after the positive test and then test negative for COVID. Extended use of gowns has been discontinued for patients that are not COVID positive, all other patients' that are not COVID positive are on patient specific gowns. Staff have been re-educated on patient specific use of gowns for residents designated as PUI's. A plan has been implemented as of [DATE] whereby sta