STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315044	A. Building B. Wing	11/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mohawk Meadows	1 O'Brien Lane Lafayette, NJ 07848

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38079 Based on interview, record review, and review of facility documentation, it was determined that the facility failed to clarify a physician's order for Paxlovid (an antiviral medication used to treat COVID-19, a deadly virus) for a vaccinated resident (Resident #4), for it to be administered within 24 hours for one of 14 residents reviewed for COVID-19 care. The original order was for Paxlovid to be administered for five days was faxed to the pharmacy on [DATE] but failed to include a dosage amount. This caused the pharmacy to contact the facility three additional times for clarification of the Paxlovid order. Resident #4 was provided a different antiviral medication on [DATE] (3 days later) and expired at the facility on [DATE]. COVID-19 is known to be a highly infectious communicable disease which can lead to hospitalization and death. The facility had a positive confirmation of COVID-19 on [DATE], was currently still in an outbreak, and had been unable to mitigate the spread of the infection. The facility's failure to ensure Resident #4, who was at risk for severe outcomes from COVID-19, received the necessary treatment to avoid a worsening of their COVID-19 condition in a timely manner, including death, resulted in an Immediate Jeopardy (IJ) situation. The facility was notified of the IJ situation on [DATE]. The IJ continued from [DATE] until [DATE], once the survey team received an acceptable Removal Plan (RP), which was verified by the survey team on [DATE], removing the immediacy. The non-compliance remained on [DATE] for F684, with no actual harm with the potential for more than minimum harm that is not immediate jeopardy. The evidence was as follows: A review of the hybrid medical record revealed that Resident #4 had been readmitted on [DATE], with diagnoses which included but were not limited to; pneumonia, systemic inflammatory response syndrome (an inflammatory response to the whole body to harmful stressors), and hypertensive heart disease. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the most recent quarterly Minimum Data Set (MDS) an assessment tool used to facilitate treatment, dated [DATE], included but was not limited to; a Brief Interview for Mental Status (BIMS) of 04 out of 15 indicating Resident #4 was cognitively impaired. Resident #4 continuously had an altered level of consciousness. Resident #4 required staff assistance for Activities of Daily Living (ADL). A review of the resident centered Care Plan (CP) included but was not limited to; a focus area date initiated [DATE] and revised [DATE], + (positive) COVID and may result to s/s (signs and symptoms) of respiratory distress. Interventions included Paxlovid as ordered dated [DATE]. A review of the Progress Notes (PN) from [DATE] through [DATE], included the following: a note dated [DATE] at 21:52 (9:52 PM), Resident #4 had tested positive for COVID-19. A note dated [DATE] at 22:59 (10:59 PM), nonproductive cough and will continue to monitor and that Resident #4 was to start Paxlovid. A note dated [DATE] at 7:05 AM, nonproductive cough, resident is to start Paxlovid when available. A note dated [DATE] at 16:41 (4:41 PM), moist cough noted nonproductive. To start on Paxlovid. A note dated [DATE] at 16:03 (4:03 PM), lethargic, increased secretions, on supplemental oxygen for comfort. Will continue to monitor. A note dated [DATE] at 21:12 (9:12 PM), lethargic, Mulnupiravir (an antiviral medication used to treat COVID-19) D (day) ,d+[DATE] [1 of 5]. Pain medication administered for signs and symptoms of pain and discomfort. Nonproductive cough. Will continue to monitor. A note dated [DATE] at 13:54 (1:54 PM), lethargic noted with worsening of condition. Pain medication for generalized discomfort. Medication for increased secretions. A note dated [DATE] at 4:47 AM, labored breathing, pain medication administered for body discomfort, medication for increased respiratory secretions. A note dated [DATE] at 2:55 AM, unresponsive, absent respiration, no pulse, pronounced at 1:10 AM (deceased). The PNs failed to document any rationale for the resident not receiving the Paxlovid, that the physician was notified and his response, or communication with the pharmacy. A review of the Physician's Orders Sheet (POS) revealed the following: a physician's order dated [DATE] for hospice evaluation related to dysphagia (difficulty in swallowing food or liquid). A telephone order dated [DATE] and not timed, for Paxlovid PO (by mouth) BID (twice a day) x (times) 5 days for COVID-19. Hold Eliquis (medication to keep the blood thin) x 5 days while on Paxlovid. TORB (telephone order read back) Dr [name redacted] / [name redacted Registered Nurse (RN) who signed the order] faxed and noted. An entry dated [DATE] and not timed, clarification of above order Paxlovid 150 mg (milligrams) TT (2 tablets) with 100 mg T (one tablet) BID x 5 days. TORB Dr [name redacted] to and was signed by the Director of Nursing (DON) RN. There was no indication that the clarified order had been faxed to the pharmacy or noted. A telephone order entry dated [DATE] and not timed, to D/C (discontinue) Paxlovid 150 mg 2 tabs with 100 mg 1 tab PO BID x 5 days and to begin Molnupiravir 200 mg 4 caps (capsules) po BID x 5 days Hold Eliquis [an anticoagulant] 2 days post completion of Molnupiravir. TORB Dr [name redacted], signed by the nurse and faxed and noted. A review of the Medication Administration Record (MAR) dated ,d+[DATE], included a handwritten order for Paxlovid PO BID x 5 days DX (diagnosis) COVID-19. The MAR revealed the times 9 AM and 5 PM and indicated X on the dates of [DATE] and [DATE]. There was no documentation on the back of the MAR regarding why the medication was not administered. On [DATE] at 1:39 PM, the DON was questioned about the above orders. The DON stated that there was no problem getting the Paxlovid. The DON further stated she was not aware of the situation with Resident #4 and that it was a delayed treatment. On [DATE] at 2:13 PM, the surveyor attempted to call the doctor three times with no success. (continued on next page)

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 3:00 PM, the DON was in the conference room in the presence of the survey team. The DON stated, there was a breakdown and that the nurse realized Paxlovid could not be crushed. She stated that the pharmacy made deliveries twice a day at 3:00 PM and midnight. The DON further stated that the Paxlovid was ordered [DATE], and that I don't know what happened. The DON stated that Resident #4 was administered a different medication on [DATE], she was not sure where the breakdown occurred, and she was just made aware of the situation when the surveyors informed her. On [DATE] at 3:12 PM, during a telephone interview, a pharmacist with the facility's contracted pharmacy, stated that Resident #4's Paxlovid order was received [DATE] and delivered to the facility on [DATE] at 2:52 PM. On [DATE] at 3:30 PM, during an interview with the surveyors, a Licensed Practical Nurse (LPN) #1 stated the process for medication orders would be to take the order, document it on the POS, fax the order to the pharmacy, and document it on the Medication Administration Record (MAR). LPN #1 stated there was never a delay obtaining medications. She further stated that if the medication was noted as not available, she would call the pharmacy to ensure the order was received, check if the medication was in the back up supply, and call the physician. She stated the information would be documented in the electronic medical record and endorsed to the next shift nurse. LPN #1 stated that if the information was not documented, it was not done, and that documentation was important for communication with all disciplines. LPN #1 further stated the if a medication was not available, the area on the MAR would be circled and a note would be made on the back of the MAR. Any blanks on the MAR would indicate that the medication was not administered. On [DATE] at 10:15 AM, the DON provided an email dated [DATE] at 4:52 PM, from the pharmacy representative (PR) which revealed the facility's inaction caused a delay in Resident #4 receiving the Paxlovid. The email included but was not limited to; ,d+[DATE] (2023) POS received for the Paxlovid on , d+[DATE] at 8:31 PM. ,d+[DATE] (2023) the order was entered at 7:56 AM, set to profile at 11:34 AM, because clarification was needed whether it was for renal or regular dosing. Called the facility spoke with RN (DON) and was told will clarify and update. ,d+[DATE] (2023) Nurse [name redacted] (LPN #2) clarified the order at 2:53 PM that the order was for renally impairing dosing. The order was then un-profiled at 11:21 PM and moved to the batch for ,d+[DATE], order still needed clarification to DDI (drug dosing interaction per DON) with other meds (medications) the patient was on (Eliquis and Tamsulosin). ,d+[DATE] (2023) the order was moved to the batch for ,d+[DATE] (2023) at 12:45 AM. The pharmacy spoke with RN and clarified the other meds were being held for two days while the patient was on Paxlovid. The order was moved to the delivery batch and the label was also printed. The med was toted at 1:16 AM and was delivered to the facility at 5:15 AM. The DON stated that the nurses do not note the time an order was faxed. She stated she clarified the physician's order on [DATE], and noted it on the POS. She further stated she was not sure when she spoke to the doctor because it was not documented and that she was unsure what happened between the unclarified times. The DON stated that all the POS orders should have included times with the dates, but she did not realize they did not. On [DATE] at 10:44 AM, LPN #2 stated he recalled Resident #4 who was moved to the COVID-19 positive unit on [DATE] and was ordered Paxlovid. LPN #2 added that when faxing an order for Paxlovid, there were blood test results that needed to be relayed to identify if the resident needed a renal dose. LPN #2 stated he was not working [DATE], but when he returned to work on [DATE], he saw the order still needed clarification, so he contacted the pharmacy. LPN #2 stated that the medication had not been delivered until [DATE]. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 12:22 PM, LPN #2 was interviewed again. LPN #2 stated that if a medication was not available, he must notify the physician and document to cover us and sometimes we need an alternative medication. He stated documentation should be done to make sure no side effects are happening to the resident. LPN #2 stated there was always delays with receiving medications from the pharmacy and that the DON knows. On [DATE] at 12:44 PM, the DON stated that she was not aware receiving medications from the pharmacy was a problem until the surveyors informed her. She stated when there was a problem, the staff could call the PR directly and that the LNHA was aware and had to call the PR at times. The DON stated that delays in receiving medications could cause a decline in a resident's medical condition. On [DATE] at 1:47 PM, the PR was at the facility and interviewed in the presence of the survey team. The PR stated that she was not a pharmacist but the representative and a nurse. The PR stated all events and communications would be documented in the pharmacy computer. She stated that included when a clarification of orders was done and when the pharmacy would be contacted by the facility to be asked about delays in receiving medications. The PR stated she reviewed the situation regarding Resident #4 not receiving the Paxlovid. The PR stated the first order on [DATE], was written incorrectly. A call was made on [DATE] to clarify but the facility did not clarify until [DATE]. She stated that could cause problems with delays in medications. The PR further stated that the Internet at the facility was not good causing technical issues that impede communication and that the DON and LNHA were aware. On [DATE] at 9:55 AM, the PR provided email documentation of the events from the pharmacy computer. The communication revealed that the pharmacy contacted the facility on [DATE] at 11:34 AM, to clarify if the medication was for renal or regular dosing. The pharmacy again contacted the facility on [DATE] at 11:53 AM, spoke to the RN (DON) and again requested clarification. It was noted in that communication that the RN (DON) was to clarify and contact the pharmacy. There were no other communications from the facility until the pharmacy called again on [DATE] at 14:53 PM (2:53 PM), 27 hours later, and received clarification from LPN #2 that Resident #4 required renal dosing. A communication from the pharmacy on [DATE] at 00:19 AM (12:19 AM), was sent to clarify the drug interactions. The pharmacy spoke to an RN on [DATE] at 00:57 AM (12:57 AM) to clarify any drug interactions and at that time, the Paxlovid was ready to be sent to the facility. When the Paxlovid was delivered on [DATE], the nurse realized the medication could not be crushed due to Resident #4's diagnosis of dysphagia. On [DATE] at 10:30 AM, the DON reviewed the POS with the surveyor. The DON's telephone order transcription with the clarification of only the dosage amount which was not included in the original [DATE] order was documented. The DON's clarification on [DATE] did not clarify if Resident #4 was to receive renal or regular dosing. The order did not document if it was faxed to the pharmacy. The DON stated that the only way to verify if the telephone order she transcribed was received by the pharmacy was to check the pharmacy records. The DON acknowledged her transcribed order did not document that it was faxed to the pharmacy. When made aware that the pharmacy communication had no record of the telephone order she had transcribed, the DON had no additional information to provide. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 12:06 PM, Resident #4's physician (MD) was interviewed in the presence of the survey team. The MD stated that there were a lot of residents on Paxlovid at first (when COVID-19 began). He stated resident's being prescribed Paxlovid required blood tests to determine if a renal or regular dose was required. The MD stated his expectation was that if he ordered a medication, the resident would be administered that medication in less than 24 hours. The MD further stated that with Paxlovid you have to get it into the patient's mouth soon or it's no good. He stated that if not given within 24 hours, one of my patients died . The MD stated it was [name redacted Resident #4]. The MD next stated that if a resident does not receive their medication, it could cause worsening, even death and that Resident #4 wasn't that bad but had respiratory symptoms. A review of the facility provided, Abstract of Death Certificate Information date received [DATE], included but was not limited to; date pronounced dead [DATE]. Cause of death: a. Respiratory failure and b. COVID infection. A review of the facility provided, 1.0 Medication Shortages/Unavailable Medications revised [DATE], included but was not limited to; Policy: when medications are not received . for the customers, the licensed nurse will urgently initiate action in cooperation with the attending physician and the pharmacy provider. Procedure: F. When a missed dose is unavoidable: 1. Document missed dose on the MAR . a. initial and circle to indicate any missed dose. Document the explanation for the missed dose on the back of the MAR and indicate see nurses notes explanation 2. Document explanation of missed dose in the nurse's notes: b. notification of pharmacy and response. c. actions taken. A review of the facility provided, Physician Orders revised [DATE], included but was not limited to; Purpose: ensure that all physician orders are complete and accurate. Policy: nursing will verify that physician orders are complete, accurate and clarified as necessary. Procedure: I. Telephone Orders. A. the licensed nurse will transcribe onto the POS the date, time and signature of the person receiving the order. c. the order will be faxed to the pharmacy. III. Medication orders will include the following: name of the medication; dosage; frequency; duration of the order; and the route and the condition/diagnosis for which the medication was ordered. VI. Order will include a description complete enough to ensure clarity of the physician's plan of care. A review of the facility provided, Telephone and Verbal Physicians Orders updated [DATE], included but was not limited to; Purpose: to ensure accurate physicians and verbal and telephone orders. Policy: all telephone and verbal physician's orders are to be read back to the doctor. A review of the facility provided, Nursing Documentation dated ,d+[DATE], included but was not limited to; Purpose: a key factor in our role and responsibility as patient care advocates. It provides a record of injury or potential injury and further observation, basis for implementation of measures to reduce risk of further occurrences and is critical to determine if the standard of care was rendered to a patient. Guidelines. When to chart: 1. Record nursing actions and individual responses as soon after they occur as possible. What to chart: 3. All injuries, illnesses, and unusual health situations until they are resolved. There should be entries on a regular basis until the problem is no longer present. 4. All contacts with the primary care prescriber: a. what information was relayed. c. if the contact is made by phone, document what was discussed and the results. d. document the plan for follow-up. 9. Any action you take in response to an individual's problem. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of the facility's provided, Job Description Licensed Practical Nurse revised ,d+[DATE], included but was not limited to; 2. Implements physician's orders timely and accurately. Document accurately and completely. 3. Reports physicians' orders that need clarification to RN (Registered Nurse) to obtain clarification. A review of the facility provided, Job Description Registered Nurse dated [DATE], included but was not limited to; 3. Maintains acceptable standards of nursing practice and carries out physician orders. 10. Implements physician orders timely and accurately. Documents accurately and completely. A review of the facility provided, Job Description Registered Nurse dated [DATE], included but was not limited to; 3. Maintains acceptable standards of nursing practice and carries out physician orders. 10. Implements physician orders timely and accurately. Documents accurately and completely. A review of the facility provided, Job Description Director of Nursing dated [DATE], included but was not limited to; 1. Implements the objectives, policies, and standards of nursing practice. 3. Make frequent rounds on units to monitor the quality of care provided. 9. Establishes and maintains and effective system of medical records and ensure these are completed in a timely manner. 13. Confers with the nursing department staff. Provides guidance as needed. 20. Monitors nursing department for compliance with regulatory guidelines. 21. Ensures Matrix, MARS, TARS (Treatment Administration Record), falls and Incident reports and investigations are complete. NJAC 8:,d+[DATE].1; 29.2(d)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40823 PART A. Refer to F684 Based on observations, interviews, review of medical records and review of facility documents on [DATE], [DATE], [DATE], and [DATE], it was determined that the Administrator failed to ensure that the facility policies on Medication Shortages/Unavailable Medications and Outbreak Response Plan was initiated and implemented to ensure all residents received the care and service needed to maintain their quality of life. The facility's LNHA and administrative staff were notified of the IJ for 835 s/s L on [DATE] at 5:02 p.m. The facility provided and acceptable removal plan on [DATE]. The survey team accepted the removal plan and verified the removal plan onsite on [DATE] during the survey. The non-compliance remained on [DATE] for F835, with no actual harm with the potential for more than minimum harm that is not immediate jeopardy. The evidence was as follows: The facility failed to clarify a physician's order for Paxlovid (an antiviral medication used to treat COVID-19, a highly contagious virus) for a vaccinated resident (Resident #4). The original order for Paxlovid was faxed to the pharmacy on [DATE] but failed to include a dosage amount. This caused the pharmacy to contact the facility three additional times for clarification of the Paxlovid order. The facility's failure to ensure Resident #4, who was at risk for severe outcomes from COVID-19, received the necessary treatment to avoid a worsening of their COVID-19 condition in a timely manner. Resident #4 was provided a different antiviral medication on [DATE] and expired at the facility on [DATE]. On [DATE], Resident #4 was evaluated for hospice evaluation related to dysphagia (difficulty in swallowing food or liquid). On [DATE], (time missing), a telephone order (TO) was received, the TO indicated Paxlovid PO (by mouth) BID (twice a day) x (times) 5 days for COVID-19. Hold Eliquis (medication to keep the blood thin) x 5 days while on Paxlovid. TORB (telephone order read back) Dr [name redacted] / [name redacted Registered Nurse (RN) who signed the order] faxed and noted. An entry dated [DATE] and not timed, clarification of above order Paxlovid 150 mg (milligrams) TT (2 tablets) with 100 mg T (one tablet) BID x 5 days. TORB Dr [name redacted] to and was signed by the Director of Nursing (DON) RN. There was no indication that the clarified order had been faxed to the pharmacy or noted. The TO further indicated on [DATE] (time missing), to D/C (discontinue) Paxlovid 150 mg 2 tabs with 100 mg 1 tab PO BID x 5 days and to begin Molnupiravir 200 mg 4 caps (capsules) po BID x 5 days Hold Eliquis 2 days post completion of Molnupiravir. TORB Dr [name redacted], signed by the nurse and faxed and noted. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	A review of the Medication Administration Record (MAR) for ,d+[DATE], revealed the aforementioned TO for Paxlovid. The MAR revealed the Paxlovid was not administered on [DATE] and [DATE] at 9:00 a.m. and 5:00 p.m. There was no documentation on the Resident's MR regarding why the medication was not administered. On [DATE] at 1:39 PM, the DON was questioned about the above orders. The DON stated that there was no problem getting the Paxlovid. The DON further stated she was not aware of the situation with Resident #4 and that it was a delayed treatment. On a follow up interview with the DON on [DATE] at 3:00 p.m., the DON stated, there was a breakdown and that the nurse realized Paxlovid could not be crushed. She stated that the pharmacy made deliveries twice a day at 3:00 PM and midnight. The DON further stated that the Paxlovid was ordered [DATE], and that I don't know what happened. The DON stated that Resident #4 was administered a different medication on [DATE], she was not sure where the breakdown occurred, and she was just made aware of the situation when the surveyors informed her. On [DATE] at 12:44 PM, the DON stated that she was not aware receiving medications from the pharmacy was a problem until the surveyors informed her. She stated when there was a problem, the staff could call the pharmacy representative (PR) directly and that the LNHA was aware and had to call the PR at times. The DON stated that delays in receiving medications could cause a decline in a resident's medical condition. On [DATE] at 1:47 PM, the PR was at the facility and interviewed in the presence of the survey team. The PR stated the first order on [DATE], was written incorrectly. A call was made on [DATE] to clarify but the facility did not clarify until [DATE]. She stated that could cause problems with delays in medications. The PR further stated that the Internet at the facility was not good causing technical issues that impede communication and that the DON and LNHA were aware. On [DATE] at 12:06 PM, Resident #4's physician (MD) was interviewed in the presence of the survey team. The MD stated resident's being prescribed Paxlovid required blood tests to determine if a renal or regular dose was required. The MD stated his expectation was that if he ordered a medication, the resident would be administered that medication in less than 24 hours. The MD further stated that with Paxlovid you have to get it into the patient's mouth soon or it's no good. He stated that if not given within 24 hours, one of my patients died . The MD stated it was [name redacted Resident #4]. The MD next stated that if a resident does not receive their medication, it could cause worsening, even death and that Resident #4 wasn't that bad but had respiratory symptoms. PART B. Refer to F880 The facility Administrator failed to ensure that contact tracing was immediately initiated upon the identification of a COVID-19 positive staff member, Certified Nursing Assistant (CNA#1), who was symptomatic and provided care to 7 residents on [DATE] and tested positive for COVID-19 on [DATE]. CNA #2, who was symptomatic and provided care to 2 residents on [DATE] and [DATE] who tested positive for COVID-19 on [DATE]. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The facility failure initiates a COVID-19 surveillance and monitoring process to identify signs and symptoms ((s/s)) of COVID-19 for the residents who were exposed on [DATE], [DATE], [DATE], and [DATE] to prevent the transmission of the highly contagious virus. The facility failure to follow the relevant Centers for Disease Control and Prevention (CDC), Federal, and State guidance for infection control, and to implement the facility's policies on COVID-19 Outbreak Response Plan, Resident Surveillance r/t Covid-19, Covid-19 Positive Resident, Covid-19 Positive Staff Member, COVID-19 Contact Tracing Policy and Procedure, and Covid 19 Testing of Staff prevent exposure and mitigate the spread of COVID-19, a highly transmissible infectious disease. The facility's system-wide failure to immediately conduct contact tracing upon the identification of COVID-19-positive staff and residents to prevent the spread of COVID-19, a contagious infectious and highly contagious virus, posed a serious and immediate risk to the health and well-being of all staff and residents for contracting COVID-19. A serious adverse outcome was likely to occur as the identified non-compliance resulted in an Immediate Jeopardy (IJ) situation that was identified on [DATE] at 7:21 p.m. The removal plan was accepted and verified as implemented by the survey team during an onsite visit on [DATE] at 2:45 pm. The IJ situation began on [DATE], when CNA #1 reported to work on [DATE] who had a fever, congestion, and body aches. CNA #1 reported to work on [DATE] and provided care to 7 residents and tested positive for COVID-19 on [DATE]. The facility was unable to provide a documentation that the residents, who were exposed on [DATE] were being monitored for signs and symptoms of COVID-19 and tested for COVID-19 to prevent the transmission of highly contagious virus. During an interview with the surveyors on [DATE] at 11:16 a.m., the Infection Preventionist (IP) stated that the LNHA was aware of the first COVID-19 positive on [DATE] and the outbreak started on [DATE] until today, [DATE]. The team including but limited to the DON, LNHA, and IP had been working together and in contact with the Local Department of Health (LHD). The IP further stated that she reported to the LNHA who oversees her. The IP explained that LNHA did not provide instructions or directions because the IP was communicating and depending on the LHD guidance. During the interview with the surveyors on [DATE] at 11:28 a.m., the LNHA stated that she was responsible of the building operations such as implementing the policies. The LNHA confirmed she was aware of the outbreak since [DATE]. The LNHA further stated that the outbreak plan was not reviewed and implemented until [DATE] because the facility was in contact and depending on the LHD. The LNHA explained she witnessed the IP with her papers and forms during the meetings, however, she did not verify the documentation of the contact tracing of staff who were exposed to the residents who tested positive for COVID-19. Furthermore, the LNHA explained that she also did not review or ensure that the documentation for testing was in place. In addition, the LNHA stated that the residents monitoring for signs and symptoms of COVID-19 was not in placed until [DATE] when the police system was initiated. The LNHA explained that the CNAs were checking the body temperature, and the nurses were checking for the signs of symptoms of COVID-19. The LNHA was unable to provide documented evidence that the aforementioned process/system was as implemented. A review of the Job Description titled Employee Health/Infection Control Nurse under .II. Infection Control A. General Responsibilities 1. Plan and organize all aspects of the Infection Control Department. Develop, review, and updated Infection Control Policies and Procedures . (continued on next page)

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	315044	A. Building B. Wing	11/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mohawk Meadows	1 O'Brien Lane Lafayette, NJ 07848

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On [DATE] the surveyor reviewed the Facility Administrator Job Description updated [DATE] which indicated the following: Directs Administration of long-term care nursing home within authority of New Jersey Department of Health regulations by performing the following duties personally or through subordinate supervisors. Review of the Essential Duties and Responsibilities include the following: 1. Plans for and administers the managerial, operational, fiscal, and reporting components of the facility; 2. Plans, develops, organizes, implements, evaluates, and directs the facility's programs and activities in accordance with guidelines issued by the governing body; 3. Directs and coordinates activities of medical, nursing, and administrative staff members and services; 4. Ensures the development of all policies and procedures, including resident rights as well as long-term care activities; 5. Ensures that the residents' rights to fair and equitable treatment, self determination, individually, privacy, property, and civil rights, including the right to wage complaints are well established and maintained at all times; 6. Ensures that hospitalized residents' health needs are addressed via Interdisciplinary Team meetings and weekly meetings with hospital liaison; 7. Assists department directions in the development, use, and implementation of departmental policies and procedures and professional standard of practice; 8. Consults with department directors concerning the operations of their respective departments to assist in eliminating/correcting problem areas and/or improvement of services; 9. Establishes and maintains liaison relationship and communication with facility staff and services and with residents and their family; 10. Assists in recruitment and selection of competent department directors, supervisors, facility non-licensed staff, consultants, etc.; 11. Ensures that all personnel are assigned duties based on their ability and competency to perform the job and in accordance with job description; 12. Reviews and checks competence of workforce and makes necessary adjustments/ corrections as required or that may become necessary; 13. Ensures the provision of staff orientation and staff education; 14. Counsels/disciplines personnel as requested or as may become necessary; (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	15. Ensures that all facility personnel, residents, and visitors follow established safety regulations to include fire protection/prevention, smoking regulations, infection control, 16. Ensures that physicians are in compliance with facility policies governing the admission, medical treatment, visit requirements, plan of care, orders, etc. Reports problem areas to the Medical Director; 17. Reviews accident/incident reports (e.g., falls, injuries, or an unknown source, abuse, etc.). Monitors to determine the effectiveness of the facility's Quality Assurance and Performance Improvement (QAPI) program; 18. Conducts daily meetings with appropriate staff during facility inspections to discuss survey findings and formulation of plans of action/correction; 19. Assists in developing plans of correction for cited deficiencies. Ensures such plans incorporate timetables and methods of monitoring to ensure that such deficiencies do not recur; 20. Represents establishment at community meetings. Review of the LNHA Supervisory Responsibilities include: 1. Manages thirteen department directors who supervise their respective employees in the Admissions Department, Business Office, Dietary Department, Housekeeping and Laundry Department, Human Resources Department, Maintenance Department, Nursing Department, Recreation Department, Rehab Department, Social Services Department, Special Projects (In-Service), Quality Assurance and Performance Improvement Office, and Security Department; 2. Is responsible for the overall direction, coordination, and evaluation of these departments; 3. Carries out supervisory responsibilities in accordance with the organization's policies and applicable laws; 4. Interviews and hires employees who are to be trained by In-Service; Plans, assigns, and directs work; appraises performance; rewards and disciplines employees; addresses complaints and resolves problems. A review of the facility provided, 1.0 Medication Shortages/Unavailable Medications revised [DATE], included but was not limited to; Policy: when medications are not received .for the customers, the licensed nurse will urgently initiate action in cooperation with the attending physician and the pharmacy provider. Procedure: F. When a missed dose is unavoidable: 1. Document missed dose on the MAR .a. initial and circle to indicate any missed dose. Document the explanation for the missed dose .on the back of the MAR and indicate see nurses notes explanation 2. Document explanation of missed dose in the nurse's notes: b. notification of pharmacy and response. c. actions taken. (continued on next page)

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F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	A review of the facility provided, Physician Orders revised [DATE], included but was not limited to; Purpose: ensure that all physician orders are complete and accurate. Policy: nursing will verify that physician orders are complete, accurate and clarified as necessary. Procedure: I. Telephone Orders. A. the licensed nurse will transcribe onto the POS the date, time and signature of the person receiving the order. c. the order will be faxed to the pharmacy. III. Medication orders will include the following: name of the medication; dosage; frequency; duration of the order; and the route and the condition/diagnosis for which the medication was ordered. VI. Order will include a description complete enough to ensure clarity of the physician's plan of care. A review of the facility provided, Telephone and Verbal Physicians Orders updated [DATE], included but was not limited to; Purpose: to ensure accurate physicians and verbal and telephone orders. Policy: all telephone and verbal physician's orders are to be read back to the doctor. NJAC 8:,d+[DATE].1(a) NJAC 8:,d+[DATE].2(a) NJAC 8:,d+[DATE].3(a) NJAC 8:,d+[DATE].4(a) NJAC 8:,d+[DATE].1(a)(b) NJAC 8:,d+[DATE].2(d)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Provide and implement an infection prevention and control program. 40823 Based on observation, interview, record review and review of pertinent documentation on 11/16/23, 11/17/23, 11/20/23, and 11/21/23, it was determined that the facility failed to ensure that Centers for Disease Control and Prevention (CDC) and Centers for Medicare and Medicaid Services (CMS) guidance was implemented to limit the spread of infectious disease. The facility failed to initiate contact tracing for the following: a.) A Certified Nursing Assistant (CNA #1), who provided care to 7 residents on 9/11/23 and 9/12/2023 and then tested positive on 9/13/2023; CNA #2, who came to work and was symptomatic and provided care to 2 residents on 9/20/23 and tested positive for COVID-19 on the same day. The facility failed initiate a COVID-19 surveillance and monitoring process to identify signs and symptoms (s/s) of COVID-19 for the residents who were in the care of staff who tested positive on 9/12/13, 9/19/13, and 9/20/23. The facility failed to mitigate the transmission of the highly contagious virus by not initiating infection control guidance protocols and not implementing the facility's policies and procedures for COVID-19 Outbreak Response Plan, Resident Surveillance r/t [related to] COVID-19, COVID-19 Positive Resident, COVID-19 Positive Staff Member, COVID-19 Contact Tracing Policy and Procedure, and COVID 19 Testing of Staff. The facility's system-wide failure to immediately conduct contact tracing upon the identification of COVID-19-positive staff and residents to prevent the spread of COVID-19, a contagious infectious and potentially deadly virus, posed a serious and immediate risk to the health and well-being of all staff and residents for contracting COVID-19. A serious adverse outcome was likely to occur as the identified non-compliance resulted in an Immediate Jeopardy (IJ) situation that was identified on 11/16/23 at 7:21 p.m. The removal plan was accepted and verified as implemented by the survey team during an onsite visit on 11/20/23 at 2:45 p.m. The non-compliance remained on 11/21/23 for F880, with no actual harm with the potential for more than minimum harm that is not immediate jeopardy. The IJ situation began on 9/13/23, when CNA #1 reported to work on 9/11/23 and 9/12/23, with symptoms of fever, congestion, and body aches. CNA #1 reported to work on 9/12/23 and provided care to 7 residents. The facility was unable to provide a documentation that the residents, who were exposed on 9/12/13 were being monitored for signs and symptoms of COVID-19 and were tested for COVID-19 to prevent the transmission of deadly virus. Subsequently, on 9/20/23, CNA #2 reported to work having the signs and symptoms of COVID-19, according to CNA #2 before coming to work, she wasn't feeling well, was coughing, had sore throat, and took Tylenol at 10:00 a.m. to help with the cold. After work, CNA #2 went to emergency room (ER) and tested positive for COVID-19 9/20/23. CNA #2 provided direct care to 2 residents on 9/20/23. The facility was unable to provide a documentation that the residents, who were exposed on 9/20/23 were being monitored for signs and symptoms of COVID-19 and were tested for COVID-19 to prevent the transmission of a deadly virus. On 9/24/23, Resident #14, who was exposed to CNA #2 on 9/20/23, and tested positive for COVID-19 on 9/24/2023. The facility failed to monitor for signs and symptom of COVID-19 and to initiate staff contact tracing who provided care from 9/22/23 to 9/24/23 (48 hours prior to being tested positive). (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 11/16/23 at 8:16 a.m., during the entrance conference with the Administrator, Director of Nursing (DON), and the Administrator Assistant (AA), the Administrator and the DON stated that as of today 11/16/23 the facility had 6 residents confirmed with COVID-19. The surveyors were provided a line listing (LL) of residents and employees who tested positive for COVID-19 indicating a total of 36 residents, 24 employees, and 7 deaths. The LL further indicated that CNA #1 was the first identified COVID-19 positive on 9/13/23 who worked on A2 unit, CNA #2 was the second identified COVID-19 positive on 9/20/23 who worked on B1 unit and Resident #14 was the first resident tested positive on 9/24/23 on B1 unit who was exposed to CNA #2. A review of the Outbreak LL for COVID-19 from 9/12/23 through 11/14/23 indicated the following: On 09/13/23, 1 facility staff who was vaccinated tested positive for COVID-19 On 09/20/23, 1 facility staff who was vaccinated tested positive for COVID-19. On 10/02/23, 4 facility staff who were vaccinated tested positive for COVID-19. On 10/05/23, 1 facility staff who was vaccinated tested positive for COVID-19. On 10/08/23, 1 facility staff who was vaccinated tested positive for COVID-19. On 10/16/23, 1 facility staff who was vaccinated tested positive for COVID-19. On 10/19/23, 1 facility staff who was vaccinated tested positive for COVID-19. On 10/20/23, 1 facility staff who was vaccinated tested positive for COVID-19. On 10/21/23, 2 facility staff who were vaccinated tested positive for COVID-19. On 10/22/23, 3 facility staff who were vaccinated tested positive for COVID-19. On 10/23/23, 3 facility staff who were vaccinated tested positive for COVID-19. On 10/24/23, 1 facility staff who was vaccinated tested positive for COVID-19. On 10/25/23, 1 facility staff who was vaccinated tested positive for COVID-19. On 10/27/23, 1 facility staff who was vaccinated and 1 facility staff unvaccinated tested positive for COVID-19. On 11/06/23, 1 facility staff who was vaccinated tested positive for COVID-19. Further review of the outbreak LL for COVID-19 from 9/24/23 through 11/14/23 indicated the following: On 09/24/23, 1 resident who was unvaccinated tested positive for COVID-19. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	On 09/26/23, 1 resident who was vaccinated tested positive for COVID-19. On 09/27/23, 1 resident who was vaccinated tested positive for COVID-19. On 10/02/23, 1 resident who was vaccinated tested positive for COVID-19. On 10/04/23, 2 residents who were vaccinated tested positive for COVID-19. On 10/06/23, 1 resident who was vaccinated tested positive for COVID-19. On 10/07/23, 1 resident who was vaccinated tested positive for COVID-19. On 10/09/23, 1 resident who was vaccinated tested positive for COVID-19. On 10/13/23, 2 residents who were vaccinated tested positive for COVID-19. On 10/14/23, 2 residents who were vaccinated and 1 resident unvaccinated tested positive for COVID-19. On 10/15/23, 1 resident who was vaccinated tested positive for COVID-19. On 10/16/23, 1 resident who was vaccinated tested positive for COVID-19. On 10/22/23, 2 residents who were vaccinated tested positive for COVID-19. On 10/24/23, 2 residents who were vaccinated tested positive for COVID-19. On 10/25/23, 1 resident who was vaccinated tested positive for COVID-19. On 11/03/23, 9 residents who were vaccinated tested positive for COVID-19. On 11/05/23, 1 resident who was vaccinated tested positive for COVID-19. On 11/07/23, 1 resident who was vaccinated and 1 resident unvaccinated tested positive for COVID-19. On 11/09/23, 1 resident unvaccinated tested positive for COVID-19. On 11/10/23, 1 resident who was vaccinated tested positive for COVID-19. On 11/14/23, 1 resident who was vaccinated tested positive for COVID-19. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	The surveyors conducted an interview with the Infection Preventionist (IP) on 11/16/23 at 12:50 p.m. The IP confirmed the aforementioned cases of COVID-19. The IP stated that the facility was in contact with Local Health Department (LHD), had received guidance and had been following the recommendations. The IP also stated that the Outbreak Plan policy was reviewed but not implemented on 9/13/23 through 9/23/23 because CNA #1 and CNA #2 did not work close together so it was not considered an outbreak. The IP further stated that CNA #1 and CNA #2 were reported to the LHD, and the facility was depending on the LHD's guidance. The IP admitted that on 9/24/23, the LHD declared the outbreak, the outbreak policy continued not being followed because the facility was depending on the LHD. According to the IP, the staff were being tested and screened for signs/symptoms (s/s) of COVID-19 and the residents were being tested and monitored for COVID-19. However, the IP was unable to provide documented evidence that contact tracing was performed from 9/24/23 through 11/16/2023, when the LHD declared the facility was in an outbreak status. The facility was also unable to provide evidence that 24 staff were being tested and screened for signs and symptoms of COVID-19 prior to entering the building. Furthermore, the IP was unable to provide documented evidence in the 36 residents medical records (MR) who were exposed during the care and services by the staff who tested positive for COVID -19. The IP and DON stated that they initiated a program called police on 11/7/23. This was a monitoring process that the CNAs would check residents for signs and symptoms of COVID-19. The facility email communication from IP to the LHD on 9/13/23 at 11:37 a.m. indicated that the facility was not on an outbreak and CNA #1 was infectious on 9/11/23 and 9/12/23 (days worked). The LHD instructed the IP to identify close contacts among residents and staff .please monitor close contacts for symptoms (isolate if contacts have symptoms and test), and Targeted testing should be performed on days 1, 3 and 5 (please let me know if you have any positive cases). The facility was unable to provide documented evidence that the residents exposed to CNA #1 were being closely monitored for signs and symptom of COVID and being tested according to the guidelines. An IP communication email to the LHD on 9/21/23 at 10:41 a.m., IP reported that CNA#2 had symptoms of chest pain, cold, and chills on 9/20/23 and tested positive in the ER. The IP reported that CNA#2 was on light duty and does not provide direct patient care. The surveyors conducted an interview with CNA#2 on 11/17/23 at 10:15 a.m. CNA#2 stated that she came to work, provided care, and stayed with the 2 residents during her shift on 9/19/23 and 9/20/23. The CNA revealed that on 9/20/23, she came to work was not feeling good, had cold, cough, and sore throat, around 10:00 a.m. I took Tylenol to help with the cold or whatever I had. The CNA further revealed that on 9/20/23 during 7:00 a.m. to 3:11 p.m., she did not use a gown and/or N95 mask, she was only wearing a surgical mask. The CNA stated that she did not report the symptoms to the supervisor or to the IP because she thought it was nothing. However, she was aware of COVID-19 symptoms and should have reported it. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	According to an Email communication from facility IP to the LHD on 9/21/23 at 10:41 a.m., the LHD responded and provided guidance at 11:52 a.m. The LHD instructed the facility to follow the New Jersey Department of Health (NJDOH) guidance. The guidance under COVID-19 Patient/Resident Management in Post-acute Care Settings, dated 8/28/2023 indicated Asymptomatic patients/residents who have had close contact with someone with SARS-CoV-2 .1 Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, 48 hours after the second negative test. Testing will typically be on day 1 (where the day of exposure is day 0), day 3, and day 5 . Asymptomatic patients/residents who have had close contact with someone with SARS-CoV-2 infection and are placed in empiric TBP [Transmission Based Precaution] should be maintained in TBP for the following time periods: Patients/residents can be removed from TBP after day 7 following the exposure (count the day of exposure as day 0) if they do not develop symptoms and all viral testing (as described for asymptomatic individuals following close contact) is negative. If viral testing is not performed, patients/residents can be removed from TBP after day 10 following the exposure (count the day of exposure as day 0) if they do not develop symptoms . The facility was unable to provide documented evidence that the residents were exposed to CNA#2 were being closely monitored for signs and symptom of COVID and being tested according to the guidance on 9/21/23. The facility email communication from IP to the LHD on 9/25/23 at 10:35 a.m. indicated that the facility was on an outbreak. The LHD recommendations were included but were not limited to Recommended Actions in Response to New Cases .Conduct contact tracing on all resident and staff cases. Conduct testing of close contacts as appropriate (on days 1, 3, and 5) If the facility is unable to perform contact tracing, broad based testing of the unit/wing/facility can be conducted (every 3-7 days until no new cases are found for 14 days). Be sure to follow all applicable federal and state directives .Outbreak management Complete Outbreak Management Checklist. The Outbreak Management Checklist titled Outbreak Management Checklist for COVID-19 in Nursing Homes and other Post-acute Care Settings under II. Screening, Testing, & Response Outbreak Intervention 1. Review outbreak response plans for SARS-CoV-2 and other respiratory pathogens to support containment and response efforts . (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	Review of the policy facility titled COVID-19 OUTBREAK RESPONSE PLAN, dated 7/2/2023, under Overview [Facility] Outbreak Response Plan is following the guidelines issued by Center for Disease Control (CDC), Centers for Medicare and Medicaid Services (CMS) New Jersey Department of Health (NJDOH) [Communicable Disease Service (CDS)], and the Sussex County Department of Health. The Outbreak Response Plan is focused on infection control and prevention, surveillance, visits safely conducted, screening, testing when indicated, [Personal Protective Equipment] PPE education and availability, staff management, cohorting, transmission-based precautions, reporting, and transparency through communication with our residents and their representative(s), if any, as well as their family and loved ones. Surveillance .1. Conduct respiratory/temperature screening for residents .4. Monitor COVID-19 test results for residents and staff. 5. Monitor accurate contact tracing as required .Screening 1. Residents are screened for COVID-19 signs and symptoms with temperature check, respiratory assessments, and clinical evaluations when indicated. 2. Regardless of vaccination status, staff screening is performed prior to entering the facility by checking and writing down the temperature each time they sign in to report to work. 3. The facility logs and screens everyone (except for EMS personnel) entering the building, regardless of vaccination status, through completion of a questioner about symptoms and potential exposure .Testing The facility conducts residents and staff testing when a Testing Trigger is identified and during an outbreak investigation, in accordance with NJDOH and CDC guidance the facility works closely with NJDOH and Sussex County Health Department with respect to the frequency of testing and retesting as necessary . Residents Exposed/With COVID-like Symptoms 1. Residents exposed asymptomatic should receive a series of three viral tests. Testing is recommended immediately and, if negative, again 48 hours after the first negative test and, if also negative, again 48 hours after the second negative test. While the decision to discontinue empiric TBP may be made following second negative viral test, these residents should continue viral testing with a third viral test. These individuals should also continue wearing source control (high-quality masks) for 10 days after exposure . The facility was unable to provide documented evidence of contact tracing that the staff who were exposed to Resident #14 were tested according to the guidelines. The surveyors conducted an interview with the DON and Administrator on 11/16/23 at 1:25 p.m. The DON stated that on 9/12/23 and 9/20/23, the outbreak plan was not initiated because the facility was depending on the LHD guidance. They further stated that on 9/24/23 the outbreak plan was reviewed, however, it was not implemented because the LHD was providing the facility guidance on managing the outbreak. During the interview with the IP on 11/17/23, 11/20/23, and 11/21/23, the IP stated that the guidance from the LHD recommendation was followed, however, she failed to open the link provided by the LHD on which included but not limited, implementing the outbreak response plan and review and completed the checklist. The IP stated that she was depending on the guidance from the LHD and failed to open the link provided on the email communication because as per IP I didn't think I needed to. The facility failed to initiate and implement the recommendation from the LHD. The failed to initiated and implement the aforementioned recommendations. During an interview with LPN #1 on 11/20/23 at 10:30 a.m., the LPN stated that she was not tested for COVID-19 after being exposed to 2 of her assigned residents who tested positive for COVID-19 on 11/5/23 involving Resident #8 and Resident #11 on 11/9/23. The LPN revealed that the residents were being screened for COVID-19 symptoms by the Quality Assurance Certified Nursing Assistant (QACNA), she also added that the COVID-19 screening tool was not part of the residents MR. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315044	A. Building B. Wing	11/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mohawk Meadows	1 O'Brien Lane Lafayette, NJ 07848

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 to resident health or safety Residents Affected - Many	During an interview with the Administrator on 11/21/23 at 11:28 a.m., the Administrator stated that when the first resident tested positive, the facility was declared on an outbreak on 9/23/23 by LHD. The Administrator further stated that the outbreak plan was not reviewed and implemented because they were in contact with the local health department and relying on them. The Administrator admitted that the outbreak plan was reviewed and implemented on 11/16/23. The Administrator was aware that failure to initiate and implement the policy during an outbreak the highly contagious virus would be difficult to contain. A review of the Job Description titled Employee Health/Infection Control Nurse under .II. Infection Control A. General Responsibilities 1. Plan and organize all aspects of the Infection Control Department. Develop, review, and updated Infection Control Policies and Procedures . A review of the facility's policy titled Covid-19 Positive Resident reviewed on 1/7/23 states, It shall be the policy of the [Facility] that any resident testing positive for COVID-19 .contact tracing will be initiated . Procedure .i.) Residents and staff will be immediately monitored for SARS-CoV-2 and tested for SARS-Cov-2 no earlier than 24 hours after the exposure and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5 . A review of the facility's policy titled Covid-19 Positive Staff Member reviewed on 1/3/23 states, It shall be the policy of the [Facility] that any resident testing positive for COVID-19 .contact tracing will be initiated . Procedure .i.) Residents and staff will be immediately monitored for SARS-CoV-2 and tested for SARS-Cov-2 no earlier than 24 hours after the exposure and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5 . A review of facility's policy and procedure titled COVID-19 Contact Tracing Policy and Procedure reviewed on 12/23/22, under Procedure instructed, If a new case of COVID -19 is identified among staff .contact tracing is initiated. Further review of the policy and procedure instructed, Close contact staff (within 6 feet of an infected individual for a cumulative total of 15 minutes or more unmasked over a 24-hour period) are considered exposed and will be appropriately monitored and tested per NJ DOH, CMS, and CDC protocol. Closed contact residents (within 6 feet of an infected individual for a cumulative total of 15 minutes or more unmasked over a 24-hour period) are considered exposed and will be appropriately monitored and tested per NJ DOH, CMS, and CDC protocol . A review of facility's policy titled COVID-19 Testing of Staff reviewed on 4/6/23, states, under Policy It shall be a policy of the facility [facility] to test symptomatic or exposed staff via rapid antigen testing as per NJDOH, CMA, and CDC guidelines. A review of facility's policy and procedure titled COVID -19 Positive Staff Member reviewed on 1/3/23 states, It shall be a policy of [facility] that any staff member testing positive for COVID-19 .contact tracing will be initiated . N.J.A.C. 8:39-19.4 (a)(e)