STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315330	A. BUILDING _____ B. WING _____	**05/19/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MARCELLA CENTER	**2305 RANCOCAS ROAD BURLINGTON, NJ 08016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide and implement an infection prevention and control program.** Based on observation, interview, and review of other pertinent facility documents, it was determined that the facility failed to follow appropriate infection control practices and handle soiled personal protective equipment in a safe and sanitary manner during a COVID-19 Focused Survey. This deficient practice was identified for 2 of 3 nursing units (Unit #2 and Unit 3), as was evidenced by the following: On 05/19/20 at 11:03 AM, during the initial tour of the facility, the surveyor interviewed the Unit Manager (UM) of Unit #2 regarding Personal Protective Equipment (PPE) (specialized clothing or equipment worn by employees for protection against safety hazards) required to care for residents who tested positive for COVID-19. The UM stated that all staff was required to wear an N-95 mask (a mask that filters out 95% of airborne particles), gown, protective eyewear, and gloves when entering the room of a COVID-19 positive resident and were not permitted to wear gowns in the hallway. At 11:16 AM, the surveyor observed signage outside of a resident room, which revealed that the resident was on Extended Contact and Airborne Precautions for particular respiratory circumstances. Further review of the signage revealed that staff was required to perform hand hygiene before and after patient contact, contact with the environment, and after removal of PPE. The surveyor observed a female caregiver open the closed door of the resident's room before removing her gloves and discarding them in a trash can. She exited the room without first performing hand hygiene or removing an orange gown that covered her uniform. She pulled back the outside curtain that covered the front of the linen cart and obtained a blanket from the shelf. When interviewed, the caregiver identified herself as a Hospice Aide (health care professional who provided personal care to the terminally ill) who was employed by an outside agency. She stated that she already provided AM (individual) care to the resident. She further said that she removed her gloves and just stepped out into the hall for a second to get a blanket from the linen cart. She stated that she was not supposed to wear a gown outside of the resident's room. She further noted that she was required to remove her gown and dispose of it in the trash can inside the room when she finished with the care of the resident. At 11:21 AM, the surveyor interviewed the UM of Unit #2, who stated that the Hospice Aide should have removed both her gown and her gloves and performed hand hygiene before exiting the resident's room and accessed the linen cart. She stated that the linen cart was contaminated. She further noted that the linen cart would be removed from the unit, decontaminated, and exchanged to prevent the potential spread of infection. At 11:26 AM, the surveyor observed the Hospice Aide come out of the room with two bags of trash, which she placed in the soiled utility room. She then turned on the faucet, wet her hands, applied soap, and washed her hands for 15 seconds. When interviewed, the Hospice Aide stated that she was required to wash her hands for 15 to 20 seconds. At 11:32 AM, the surveyor interviewed the UM of Unit #2, who stated that staff was required to turn on the faucet, wet their hands, apply soap, and scrub for 20 seconds. At 11:35 AM, the surveyor observed CNA #1, who wore an orange gown over her uniform as she walked through the hallway. She entered a resident room that contained external signage and cautioned that the resident was on Extended Contact and Airborne Precautions. The surveyor interviewed CNA #1, who stated that the resident was presumed to be positive for COVID-19 due to refusal of testing. She noted that the facility required her to doff her gown and place the disposable gown in a plastic bag, tie the bag shut and dispose of it in the designated area near the nurse's station. CNA #1 removed her gown and accessed a plastic PPE cart in the hallway that contained plastic bags but did not obtain a plastic bag. She stated that she needed a small bag and closed the cart. She then proceeded to the soiled utility room and disposed of the orange gown directly into a bin within the room without first placing it in a secured plastic bag as described. The surveyor noted a sign affixed to the door of the soiled utility room, which cautioned that all discarded gowns must be put in a clear garbage bag, tied, and placed in the bins. At 11:49 AM, the surveyor interviewed the UM of Unit #2, who stated that all gowns should be bagged, tied, and disposed of in the bins provided in the soiled utility room. At 12:26 PM, the surveyor toured Unit #3 of the facility and observed CNA #2 exit the room of a resident who had signage outside of the room to indicate that Extended Contact and Airborne Precautions were required. The surveyor observed that CNA #2 placed a pair of gloves into a trash bag located in the hallway. When interviewed, CNA #2 stated that she performed hand hygiene with alcohol-based hand rub before she left the resident's room but then carried her gloves to the trash bag in the hall to discard them. She then applied gloves without performing hand hygiene and pushed the lunch truck down the hall. At 12:45 PM, the surveyor interviewed the Unit Manager In-Training of Unit #3, who stated that once gloves were removed, staff were required to perform hand hygiene and before the application of new gloves. She further noted that handling soiled gloves after hand hygiene was performed would make your hands dirty again. At 2:01 PM, the surveyor interviewed the Center Nurse Executive (CNE), who stated that hand hygiene was required after resident care was provided, and gloves were to be discarded. She further noted that failure to do so before accessing a linen cart would render the cart contaminated. She stated that after glove removal, the staff was required to throw them in the trash and wash their hands for 20 seconds. When the staff changed their gloves, they were also required to perform hand hygiene. The CNE stated that extended use gowns were permitted to be worn from room to room, providing that all residents were positive for COVID-19. She said that when staff finished with resident care, they should doff their gowns, place them in a plastic bag, tie it shut and place it in the receptacle provided. She further stated that all gowns should be bagged and tied shut when carried through the hallway; and that the purpose of bagging soiled gowns was to prevent transmission of infection. The surveyor reviewed the facility policy, IC203 Hand Hygiene (Reviewed 11/15/19) which revealed the following: Purpose: To improve hand hygiene practices and reduce the transmission of pathogenic microorganisms. Process: Perform hand hygiene: Before resident care .after patient care, after contact with the patient's environment. Hand hygiene techniques: To wash hand with soap and water: Wet hands with warm (not hot) water, apply soap to hands and rub hands vigorously outside the stream of water for 20 seconds covering all surfaces of the hands and fingers. Rinse hands with warm water and dry thoroughly with a disposable towel. Use a clean, dry, disposable towel to turn off the faucet. Surveyor review of the facility policy titled, IC303 Droplet Precautions and Respiratory Hygiene/Cough Etiquette (Revised 06/15/19) which revealed the following: 4.3 Before exiting the room, remove and bag PPE and wash hands. 4.3.1 Remove bagged PPE from the room and discard in soiled utility. NJAC 8:39-19.4 (a) 1 and 2

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