STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315434	A. BUILDING _____ B. WING _____	06/18/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FAMILY OF CARING HEALTHCARE AT RIDGEWOOD	**304 S. VAN DIEN AVE RIDGEWOOD, NJ 07450**

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 pertinent facility documents, it was determined that the facility failed to ensure the proper storage, disposal of surgical and nebulizer masks in accordance with the Center for Disease Control and Prevention guidelines for infection control to mitigate the spread of COVID-19. This deficient practice was identified on 2 of 4 nursing units (South Ground and South 1), and was evidenced by the following: On 6/18/2020 at 8:46 AM, the survey team interviewed the Assistant Administrator (AA), who stated that the facility was implementing infection control measures due to a COVID-19 outbreak. The AA confirmed that all staff was in-serviced on proper hand hygiene and proper use of Personal Protective Equipment (PPE). She further stated that South Ground and South 1 were designated non-COVID units. At 9:38 AM, the surveyor toured the South 1 unit. The surveyor observed the Registered Nurse (RN) enter Resident #1's room. At that time, the resident was in bed, eating breakfast. On top of the overbed table, there two unused surgical masks (also called a medical mask), a loose-fitting disposable mask that protects the wearer's nose and mouth from contact with droplets, splashes, and sprays that may contain germs) directly touching the surfaces of the alcohol wipe pack. Also, there was one unused surgical mask lying directly on the window sill. At that time, the RN stated that the surgical masks inside Resident #1's room should have been in a plastic bag for infection control and should not be placed directly on top of surfaces. At 10:26 AM, the surveyor toured South Ground (South G) and observed a Licensed Practical Nurse (LPN) enter Resident #2's room to administer medications. The surveyor noted two used surgical masks on the resident's bed. At that time, the LPN and surveyor observed Resident #2's roommate, Resident #3, seated in a wheelchair with a surgical mask in use. There were two unused surgical masks on top of the window sill and one unused surgical mask directly touching the side table near the resident's footbed. The surveyor also observed a nebulizer mask (neb mask) on top of the resident's nightstand sitting on top of the nebulizer machine. The LPN checked Resident #3's nightstand drawer and found a second neb mask inside the drawer, not in a plastic bag. The nurse stated that the masks should have been placed in plastic bags for infection control purposes. During an interview, the LPN stated that Resident #2 was cognitively intact and that the neb masks should have been inside a plastic bag when not in use. She further noted that surgical masks should not be directly touching the surfaces for infection control. The LPN did not dispose of the surgical masks or the neb masks before leaving the resident's room. At 10:47 AM, the surveyor observed Resident #4 on the South G unit seated in a wheelchair in their room with a surgical mask in use. There was one unused surgical mask lying directly on top of the side table in front of the resident. The Registered Nurse/Supervisor (RN/S) was inside Resident #4's room attending to the resident. The RN/S did not dispose of the unused surgical mask before leaving Resident #4's room. At 10:49 AM, the surveyor interviewed Resident #2, who stated that the two surgical masks on their bed were from Tuesday and Wednesday. Resident #2 said he/she was not provided a new surgical mask today and therefore had to reuse the mask sitting on their bed. The resident further stated that no one provided them with a bag to store the surgical mask. At 10:52 AM, the surveyor observed Resident #5 on the South G unit in bed with one unused surgical mask directly touching the surface of the side table near his/her bed. At 10:55 AM, the surveyor asked the RN/S to accompany her to the rooms of Resident #2,3, 4, and 5. The RN/S stated that the surgical masks were provided by nursing daily and should have been in a bag for infection control. She said that when the neb masks were not in use, they should be placed in a plastic bag for infection control. The surveyor observed the RN/S disposed of all of the surgical masks in Resident #2, 3, 4, and 5's room. The RN/S did not dispose of the neb masks in Resident #3's room. At 11:10 AM, the surveyor interviewed the Certified Nursing Aide (CNA), who stated that she was assigned to South 1. The CNA said that she had seen surgical masks on top of Resident #1's table and window sill and was not something new. She further stated that even in the South G unit, there were multiple residents with surgical masks on top of their tables. She noted that the nurse puts the surgical mask in each resident's room. At 12:20 PM, the survey team interviewed the Director of Nursing (DON), who was also the Infection Control Preventionist. The DON stated that the neb masks should be kept in a plastic bag when not in use for infection control purposes. She further noted that per facility practice, the nurse on the unit provided surgical masks to the residents on South G and South 1 when they leave their room for therapy and stated that it was the nurse or transporter's responsibility to dispose of the used surgical masks when residents go back to their room. The surveyor interviewed the DON who stated that the surgical masks and neb masks should be placed in plastic bags when not in use. At 1:01 PM, the survey team met with the Administrator and the DON. The Administrator stated, I agree with the unused surgical mask not to be placed on top of surfaces. The Administrator confirmed that the neb mask should be placed inside a plastic bag when not in use. The Administrator and the DON both stated that the facility had no policy with regards to resident's use, storage, and disposal of surgical masks. A review of the facility's Oxygen/Nebulizer Care Policy provided by the DON with an effective date of 10/2018 included, All tubing and masks shall be placed in a plastic bag for storage when not in use. A review of the Strategies for Optimizing the Supply of Facemasks About Coronavirus Disease 2019 (COVID-19) from the CDC dated 3/17/20 included, Not all facemask can be reused. Facemasks should be carefully folded so that the outer surface is held inward and against itself to reduce contact with the outer surface during storage. The folded mask can be stored between uses in a clean, sealable paper bag or breathable container. A review of the World Health Organization Advice on the Use of Masks in Context of COVID-19 (Interim Guidance) dated 6/5/2020 included, Masks should not be shared .and should be appropriately disposed of whenever removed and not reused. It further added, The following potential harms and risks should be carefully taken into account when adopting this approach of targeted continuous medical mask use, including .self-contamination due to the manipulation of the mask by contaminated hands .for any type of mask, appropriate use and disposal are essential to ensure that they are as effective as possible and to avoid any increase in transmission discard single-use masks after each use and dispose of them immediately upon removal. NJAC 8:39-19.3 (a) NJAC 8:39-19.4 (a) (1)

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.