STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315455	A. BUILDING _____ B. WING _____	03/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ROYAL HEALTH GATE NRSG REHAB	1314 BRUNSWICK AVENUE TRENTON, NJ 08638

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

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F 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** Based on observation, interview and record review, it was determined that the facility failed to maintain a resident's personal privacy during care. This deficient practice was identified for Resident #87, 1 of 24 residents reviewed for dignity, and was evidenced by the following: On 02/26/20 at 10:33 AM, the surveyor conducted the initial tour of the first floor nursing unit. The surveyor noted that Resident #87's door was closed. The surveyor knocked on the resident's door and was invited by staff to enter the room. The surveyor entered the room and noted the curtains were not drawn around the resident's bed. The surveyor also noted that Resident #87 was lying in bed on his/her back, fully unclothed and completely uncovered. The surveyor observed two Certified Nursing Assistants (CNAs) inside the room at the resident's bedside proving him/her a bed bath while the resident was in full view of his/her roommate, and in full view of anyone that entered the room. On 02/26/20 at 11:01 at AM, the surveyor interviewed CNA #1 who stated that Resident #87's body should not have been exposed. CNA #1 stated that they should have only exposed the part of the body being washed and should have drawn the curtain. On 02/26/20 at 11:05 AM, the surveyor interviewed CNA #2 who stated that she had worked at the facility for a few years and that she knew the resident's body should have been covered during care. On 02/26/20 at 12 noon, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM #1) who stated that the curtain should have been pulled and that the resident should have been covered to protect the resident's privacy. RN/UM #1 also stated that the both CNAs were previously provided with dignity training by the facility. On 03/03/20 at 2:50 PM, the surveyor discussed the above findings with the Administrator, the Director of Nursing (DON), Assistant Director of Nursing, and Regional Director. The DON stated that she could not provide an answer as to why CNA #1 and CNA #2 did not cover the resident's body during care. A review of the facility's Residents Rights policy, dated 09/10/19, reflected that employees shall treat all residents with kindness, respect and dignity. NJAC 4.1(a)(12)
F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined that the facility failed to ensure that oxygen was administered in accordance with a physician order [REDACTED]. This deficient practice was identified for Resident #48, 1 of 2 residents reviewed for oxygen administration, and was evidenced by the following: On 02/26/20 at 2:24 PM, during the initial tour of the facility, the surveyor observed Resident #48 lying awake in bed. The resident was wore a nasal cannula that was connected to an oxygen concentrator with setting at 2 liters of humidified oxygen per minute. The surveyor interviewed the resident during the observation. The resident stated that he/she did not know how many liters of oxygen that was prescribed for him/her. As the surveyor interviewed the resident, the oxygen concentrator alarm started to sound. A Registered Nurse (RN #1) entered the resident's room, adjusted the humidifier bottle and stopped the alarm. RN #1 stated to the surveyor that the resident had an order to receive oxygen at 3 liters per minute (LPM). RN #1 did not acknowledge that the oxygen concentrator was running at two liters per minute. The surveyor reviewed Resident #48's Admission Record (an admission summary) which indicated that the resident was readmitted to the facility with [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. The POF also included an order dated 12/11/2018, to check the resident's SPO2 (oxygen level in the blood) every shift and to maintain the resident's SPO2 level at 94% or above. The Annual Minimum Data Set (MDS), an assessment tool [DATE] revealed that the resident had a Brief Interview for Mental Status (BIMS) score of 7, which indicated that the resident was severely cognitively impaired. The MDS also indicated that the resident was totally dependent on two persons for bed mobility and transfers from the bed to the wheelchair, and totally dependent on one person for personal hygiene and received oxygen therapy. The Interdisciplinary Care Plan revealed that the resident was on oxygen at 3 LPM. There was no documentation on the care plan to indicate that the resident had any behaviors related to self-removal of his/her oxygen. On 03/02/20 at 10:09 AM, the surveyor observed Resident #48 seated in a recliner chair inside the resident's room. The resident wore a nasal cannula that connected to an oxygen concentrator with oxygen running at 3.5 LPM. On 03/02/20 at 10:51 AM, the surveyor interviewed RN #1 who inspected Resident #48's oxygen concentrator in the presence of the surveyor. RN #1 adjusted the oxygen flow meter to 3 LPM. She confirmed that the oxygen flow meter was set incorrectly instead of the 3 LPM as prescribed. She further stated that the oxygen flow meter was set at 3 LPM at 9:00 AM, and that it might have accidentally gotten bumped off rate during transfer from the bed to the chair. On 03/03/20 at 10:26 AM, the surveyor observed Resident #48 seated in the recliner chair inside the resident's room. The surveyor observed that the resident was not wearing the oxygen. When interviewed, the resident stated that he/she did not have his/her oxygen on and that he/she was supposed to be wearing oxygen. The surveyor noted that the resident's oxygen tubing and nasal cannula was on the floor next to the right side of the resident's recliner chair. The oxygen cannula was attached to the concentrator and was set at 3 LPM. On 03/03/20 at 10:36 AM, the surveyor interviewed RN #1 who stated that Resident #48 was supposed to have his/her oxygen on. RN #1 further stated that she last observed Resident #48 wearing the oxygen at 9:00 AM. At that time, the Registered Nurse Unit Manager (RN/UM #2) entered the resident's room and stated that the resident must have removed the oxygen. RN/UM #2 checked the resident's pulse oximetry level (a probe applied to the finger to determine how much oxygen is in the blood). The pulse oximetry reading measured 89% and fluctuated up to 93% which was lower than what the physician ordered. On 03/03/20 at 10:40 AM, a Certified Nursing Assistant (CNA #3) entered Resident #48's room. CNA #3 stated that she got the resident up from the bed to the recliner chair at 10:18 AM. She further stated that the resident complained that he/she wanted the oxygen tubing adjusted. CNA #3 stated that the resident removed the tubing and that she instructed the resident to put the oxygen back on. CNA #3 stated that she did not know if the resident put the oxygen tubing back on and that she did not report the incident to RN #1. A review of the facility's Oxygen Administration policy, dated 12/12/19, revealed the purpose of the procedure was to provide guidelines for safe oxygen administration. The policy included to adjust the oxygen delivery device so that it was comfortable for the resident and the proper flow of oxygen was being administered. The policy also indicated to observe the resident upon setup and periodically thereafter to be sure oxygen was being tolerated and to notify the supervisor if the resident refuses the procedure. NJAC 8:39-11.2(b); 27.1(a)
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, it was determined that the facility failed to ensure that a.)

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) kitchen equipment was maintained in a safe and sanitary condition b.) 6 of 6 kitchen staff observed performed proper hand hygiene prior to food handling, and c.) 2 of 2 kitchen staff with facial hair wore a beard restraint during food preparation in the kitchen. This deficient practice was identified in the facility's kitchen and was evidenced by the following: On 02/26/20 from 9:35 AM to 10:00 AM, the surveyor toured the facility's kitchen in the presence of the Food Service Director (FSD) and observed the following: There were three clear colored food storage bins with white lids stored underneath a stainless-steel counter. All three containers were heavily stained and discolored. There was a stainless steel four-tiered drying rack inside the dish room. On the second shelf of the rack, there were four large stainless-steel pans wet and nesting with visible water residue. On the third shelf of the rack, there were two large stainless-steel pans that were wet and nesting with visible water residue. Inside the walk-in freezer, there was a half size stainless pan with rice dated 02/25/20 with no use by date. During a follow-up visit to the kitchen on 03/02/20 from 11:16 AM to 12:20 PM, in the presence of the facility's owner (owner), Administrator and FSD, the surveyor observed the following: A Food Service Worker (FSW #3) entered the kitchen and was not wearing a beard restraint. FSW #3 began to prepare residents' meal trays. FSW #3 placed cups, utensils and beverages on the trays. Cook #1 was observed preparing Italian bread and pasta. Cook #1 was observed with facial hair and was not wearing a beard protector. The surveyor observed Cook #1, Cook #2, FSW #1, FSW #2, FSW #3, and FSW #4 as they washed their hands at the handwashing sink inside the kitchen. The cooks and FSW wet their hands, applied soap and immediately placed their hands underneath the flow of water. None of the Cooks and FSW above scrubbed their hands away from the flow of water before their hands were rinsed. They all removed a paper towel from the paper towel dispenser and dried their hands. After drying their hands, they all used the same paper towel to turn off the faucet. The owner and FSD, who were with the surveyor at the time, stated that the kitchen staff needed more education on handwashing. On 03/02/20 at 2:06 PM, the surveyor interviewed FSW #3 and Cook #1. FSW #3 acknowledged she washed her hands underneath the flow of water instead of scrubbing her hands away from the flow of water. Cook #1 stated that he had been the facility's cook for [AGE] years. Cook #1 stated that he was nervous and washed his hands underneath the flow of water. On 03/02/20 at 2:08 PM, the surveyor interviewed Cook #2. Cook #2 stated that he did not recall washing his hands underneath the flow of water. On 03/02/20 at 2:18 PM, during interview, FSW #2 stated that she knew how to wash her hands and that she was supposed to scrub her hands away from the flow of water before she rinsed under the flow of water. A review of the facility's Handwashing policy and procedure, dated 08/13/19, revealed that handwashing was performed to prevent the spread of bacteria before, during and after preparing food, before meals. The procedure included the following: Turn water on at the sink; Wet hands and wrist thoroughly; Apply skin cleanser or soap to hands; Lather all surfaces of fingers and hand, including above the wrist producing friction for at least 20 seconds; Rinse all surfaces of hands and wrist without contaminating hands; Use a clean, dry paper towel to dry all surfaces of hands, wrist and fingers without contaminating hands; Use a clean paper towel to turn off the faucet without contaminating hands. A review of the facility's Hair Net policy, dated 09/18/19, revealed that it was the policy of the facility that no employee should enter the kitchen before they cover their head hair and/or facial hair. NJAC 8:39 17.2(g)
F 0814 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Dispose of garbage and refuse properly.** Based on observation, interview and document review, it was determined that the facility failed to maintain the trash compactor area in a sanitary manner. This deficient practice was identified for 1 of 1 trash compactor area inspected and was evidenced by the following: On 02/26/20 at 10:10 AM, in the presence of the Food Service Director (FSD), the surveyor observed the facility's outside trash compactor area. The trash compactor did not have a lid and the gate was open. The FSD and surveyor observed three large green bags of trash and assorted cardboard boxes inside the trash compactor. The contents inside the trash compactor had not been compacted. On 03/03/20 at 11:45 AM, in the presence of the facility's owner, the Administrator, and FSD, the surveyor observed the outside facility trash compactor area. The trash compactor did not have a lid and the gate was open. When interviewed, the owner stated that the trash compactor did not have a lid and that a lid, and agreed that the compactor should have a lid to prevent infestation of pests. During an interview on 03/03/20 at 3:40 PM, the owner stated that the facility did not have a trash compactor policy and that it was the kitchen staffs' responsibility to compact the trash. On 03/04/20 at 10:49 AM, following surveyor inquiry on 03/03/20 at 3:40 PM, the owner provided the surveyor with a Trash Compactor policy and procedure dated 03/20/20. The policy reflected that the trash compactor area shall be kept clean and safe. The housekeeping staff shall clean and monitor the trash compactor and the area surrounding it on a daily basis. After the trash was deposited in the compactor, the crushing mechanism shall be left in a closed position to restrict entry by wildlife and prevent anyone from falling into the compactor. The safety and cleanliness of the compactor shall be monitored by housekeeping, the Dietary Manager and the Administrator. NJAC 8:39-17.2(g)
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, it was determined that the facility failed to a.) follow the appropriate infection control protocol for hand hygiene on 02/28/20 and on 03/02/20 during meal service on the first floor nursing unit, and b.) follow appropriate infection control procedures regarding donning Personal Protective Equipment (PPE) while caring for a resident on contact isolation precautions and cleaning/disinfecting equipment used on a resident in a contact isolation room. This deficient practice was identified for 4 of 4 staff members observed, and for Resident #79, 1 of 1 resident reviewed for transmission-based precautions and was evidenced by the following: 1. On 02/28/20 from 12:06 PM to 12:36 PM, the surveyor observed three staff members, Licensed Practical Nurse (LPN #1), Certified Nursing Assistants (CNA #1) and CNA #2, as they served lunch to residents in the rooms on the first floor. The surveyor observed the following: LPN #1 stood beside the lunch truck outside the residents' rooms and inspected the trays before handing them to the CNAs. At 12:06 AM, CNA #2 took a tray to a resident in room [ROOM NUMBER]. Without wearing gloves or performing hand hygiene, CNA #2 removed a slice of bread from the lunch tray and then buttered the bread for the resident. CNA #2 did not offer hand hygiene to the resident and did not perform hand hygiene before returning to the food truck. While the surveyor was still in room [ROOM NUMBER] with CNA #2, CNA #1 entered the room with a tray for the roommate. Without wearing gloves or performing hand hygiene, CNA #1 retrieved a slice of bread from the plastic wrapping, held the bread in her bare hands, buttered the bread, set it on the resident's tray, and then left the room. CNA #1 did not offer hand hygiene to the resident and did not perform hand hygiene before returning to the food truck. At 12:10 PM, both LPN #1 and CNA #2 wheeled the food truck to the front of room [ROOM NUMBER]. After LPN #1 inspected the trays, CNA #2 retrieved a tray from the lunch truck and took the tray to the resident in room [ROOM NUMBER]. Without wearing gloves or performing hand hygiene, CNA #2 set up the tray for the resident, which included, using her bare hands to hold a slice of bread while she buttered the bread. CNA #2 did not offer hand hygiene to the resident and did not perform hand hygiene prior to returning to the food truck. At 12:11 PM, CNA #2 took a lunch tray to room [ROOM NUMBER]. Without performing hand hygiene, CNA #2 set up the food for the resident, which included, cutting up the food, and opening and inserting a straw into the resident's milk without performing hand hygiene. CNA #2 did not offer hand hygiene to the resident and did not perform hand hygiene before returning to the food truck. At 12:12 PM, CNA #2 and LPN #1 wheeled the food truck to room [ROOM NUMBER]. CNA #2 took a tray into room [ROOM NUMBER]. Without performing hand hygiene, CNA #2 set up the food for the resident, which included, cutting up the food, and opening and inserting a straw into the resident's milk without performing hand hygiene. CNA #2 did not offer hand hygiene to the resident and did not perform hand hygiene before returning to the food truck. At 12:16 PM, CNA #2 wheeled the lunch truck to room [ROOM NUMBER]. She took a tray into room [ROOM NUMBER]. Without wearing gloves or performing hand hygiene, CNA #2 removed the slice of bread from the plastic wrapping, and placed it in her bare hand as she buttered the bread. As CNA #2 was setting up the resident's tray, she accidentally spilled the resident's coffee onto the lunch tray. CNA #2 removed a paper towel from the dispenser and dried off the coffee spill. She then finished setting up the resident's tray. CNA #2 did not offer hand hygiene to the resident and did not perform hand hygiene before returning to the food truck. At 12:18 PM, LPN #1 and CNA #2 proceeded to the front of room [ROOM NUMBER] with the food truck. CNA #2 delivered a tray to the resident in room [ROOM NUMBER]. Without performing hand hygiene, CNA #2 set up the tray. CNA #2 did not offer hand hygiene to the resident and did not perform hand hygiene before returning to the food truck. At 12:20 PM, CNA #2 took a lunch tray to the roommate in room [ROOM NUMBER]. Without performing hand hygiene, CNA #2 set up the food for the resident. CNA #2 did not offer hand hygiene to the resident and did not perform hand hygiene before returning to the food truck. At 12:23 PM, CNA #2 delivered a tray to a resident in room [ROOM NUMBER]. CNA #2 moved a wheelchair out of the way, moved the bedside table closer to the bed, and then set the food tray on the table. CNA #2 did not offer hand

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) hygiene to the resident and did not perform hand hygiene before returning to the food truck. At 12:25 PM, CNA #2 took a lunch tray to a resident in room [ROOM NUMBER]. Without wearing gloves or performing hand hygiene, CNA #2 cut up the resident's food, picked up the resident's bread with her bare hands and buttered the bread. CNA #2 did not offer hand hygiene to the resident and did not perform hand hygiene before returning to the food truck. At 12:29 PM, CNA #2 took a lunch tray to a resident in room [ROOM NUMBER]. CNA #2 set the tray on the resident's table and stated to the surveyor that she would return to feed the resident later. At 12:30 PM, CNA #2 took a lunch tray to the roommate in room [ROOM NUMBER]. Without wearing gloves or performing hand hygiene, CNA #2 removed a slice of bread from the tray, held it in her bare hand, and buttered the bread. She then removed the straw wrapper and placed the straw into the mild container. CNA #2 did not offer hand hygiene to the resident and did not perform hand hygiene before returning to the food truck. At 12:32 PM, CNA #2 took a lunch tray to a resident in room [ROOM NUMBER]. Without wearing gloves or performing hand hygiene, CNA #2 removed a slice of bread from the tray, held it in her bare hand, and buttered the bread. CNA #2 did not offer hand hygiene to the resident and did not perform hand hygiene before returning to the food truck. At 12:34 PM, CNA #2 took a lunch tray to a resident in room room [ROOM NUMBER]. Without wearing gloves or performing hand hygiene, CNA #2 removed a slice of bread from the tray, held it in her bare hand, and buttered the bread. CNA #2 did not offer hand hygiene to the resident and did not perform hand hygiene before returning to the food truck. At 12:36 PM, CNA #2 took a lunch tray to the roommate in room [ROOM NUMBER]. CNA #2 moved a resident's wheelchair out of the way, set the tray on the table, and then cut up the resident's food. CNA #2 did not offer hand hygiene to the resident and did not perform hand hygiene after touching the wheelchair and before returning to the food truck. The surveyor could not interview the residents due to their impaired cognitive status. When CNA #2 finished passing out the trays, she returned to room [ROOM NUMBER]. Without performing hand hygiene, she sat in a chair near the resident. She was about to start feeding the resident when the resident requested that CNA #2 scratch his/her back. CNA #2 got up, donned gloves, scratched the resident's back, removed the gloves, and then washed her hands. On 03/02/20 from 12:20 to 12:30 PM, the surveyor observed CNA #2 and LPN #1 as they distributed meals to residents who ate in their rooms on the first floor. The surveyor observed the following: CNA #2 removed a lunch tray from the food truck and delivered it to a resident in room [ROOM NUMBER]. CNA #2 set the tray on the resident's overbed table, moved the resident's wheelchair out of the way, and then set up the resident's tray. With her bare hands, she removed the straw wrapper and placed the straw into the milk container. CNA #2 did not offer hand hygiene to the resident and did not perform hand hygiene after touching the wheelchair and before returning to the food truck. CNA #2 delivered a tray to a resident in room [ROOM NUMBER]. CNA #2 moved a walker out of the way, she then set up the resident's lunch tray. Using her bare hands, she unwrapped a straw and inserted it into the milk container. CNA #2 did not offer hand hygiene to the resident and did not perform hand hygiene after touching the walker and before returning to the food truck. CNA #2 delivered a tray to a resident in room [ROOM NUMBER]. CNA #2 picked up a towel that was on the resident's bed and placed the towel to the side. She then cleared the resident's table and placed the tray on the table. CNA #2 did not offer hand hygiene to the resident and did not perform hand hygiene before returning to the food truck. CNA #2 delivered a tray to a resident to room [ROOM NUMBER]. CNA #2 set up the tray, which included unwrapping a straw and inserting it into a milk container. CNA #2 did not offer hand hygiene to the resident and did not perform hand hygiene after leaving the resident's room. The surveyor could not interview any of the residents due to their impaired cognitive status. On 03/02/20 at 12:30 PM, the surveyor interviewed CNA #2. She stated that her practice was to wash her hands after all trays had been served to the residents. CNA #2 stated that it would take too long if she had to stop and perform hand hygiene between residents. When asked about touching residents' bread and straw with her bare hands, she stated that they were told not to wear gloves when they served meals to residents. CNA #2 stated that she only performed hand hygiene if she touched something soiled such as urinal. When asked about cleaning residents' hands before meal service, CNA #2 stated that she had seen hand sanitizing wipes in the facility but that she did not usually offer the wipes to residents. When asked if her practice was based on facility protocol, CNA #2 stated that it was partly facility protocol and partly her own practice. On 03/02/20 at 12:40 PM, the surveyor interviewed LPN #1. When asked about the facility's protocol for infection control during meal service, LPN#1 stated that she had not had infection control training related to meal service since she was hired in July 2019. LPN #1 stated that staff were not supposed to touch the residents' food with their bare hands and that she knew this from her previous experience. LPN #1 also stated that staff was supposed to wash their hands if they touched the residents' furniture or other items in the residents' rooms, before continuing to serve the meal trays. When asked about hand hygiene for residents, LPN #1 stated that she was not provided with hand sanitizer for residents. On 03/03/20 at 02:28 PM, the surveyor informed the facility of the above findings. During an interview with facility administration on 03/04/20 at 10:53 AM, the Director of Nursing (DON) stated that the facility did not have a separate policy regarding infection control during meal service. Both the DON and Regional Director stated that the facility provided general infection control to all staff members. The DON stated that staff should know not to touch residents' food with their bare hands and should provide hand hygiene to residents as part of general infection control. Review of the facility's undated Handwashing policy revealed that there were no protocols to address handwashing for food handling during dining meal service. The surveyor reviewed an infection control in-service, dated 01/16/20, which revealed that LPN #1 received general infection control education. The surveyor noted the infection control in-service did not address dining meal service. The list of in-service attendees did not include CNA #1 or CNA #2. 2. On 02/26/20 at 10:26 AM, while standing at the resident's room doorway, the surveyor observed Resident #79 seated in his/her wheelchair. The surveyor noted that Resident #79 had a [MEDICAL CONDITION] Collar (a medical device used to secure a [MEDICAL CONDITION]). The surveyor observed that there was a white and black colored sign posted outside the resident's room door. The sign indicated that visitors were to report to the nurse prior to entering the room. The surveyor observed a clear, plastic, two-drawer container outside the resident's room, which contained PPE (items such as gloves, gowns, and face masks designed to protect individuals from exposure to or contact with infectious agents). At this time, a facility staff member who was later identified as an Admission's Department Worker (ADW) entered the room without applying any PPE. The ADW, with her bare hands, repositioned the resident in his/her wheelchair and adjusted the resident's blanket that was covering the resident's legs. The ADW then exited the room without performing hand hygiene. Review of the Admission Record revealed that Resident #79 was admitted to the facility with [DIAGNOSES REDACTED]. Review of an initial Minimum Data Set (MDS), an assessment tool dated 12/12/19, revealed that Resident #79 had a Brief Interview for Mental Status (BIMS) of 13, which indicated the resident was cognitively intact. The MDS also showed that the resident required extensive assistance from staff for all activities of daily living. Review of Resident #79's isolation care plan (CP), dated 12/20/19, reflected that the resident was on isolation precautions for carbapenem-resistant [MEDICATION NAME] (CRE), which is a bacteria resistant to carbapenem, a class of antibiotic used to treat severe infections, as well as most other antibiotics. CRE is transmitted through direct and indirect contact with an infected person and the person's environment. The CP interventions included to maintain contact isolation precautions. The CP also reflected to place a stop sign to instruct family/visitors/caregivers to see the nurse prior to entering the room. Review of a physician's orders [REDACTED]. Review of the Lab Results Report, dated 02/19/20 at 12:19 PM, revealed that Resident #79 tested positive for CRE. On 02/26/20 at 11:30 AM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM #1). When RN/UM #1 was questioned as to the type of PPE needed in order to enter the resident's room. RN/UM#1 stated that no PPE was required to enter the room. RN/UM stated that the infection was in the resident's urine and that the urine was contained in a urine collection bag. On 02/27/20 at 9:44 AM, the surveyor donned (put on) a gown and gloves and knocked on the resident's door. The resident shook his/her head in an up and downward motion giving the surveyor permission to enter the room. When interviewed, Resident #79 stated that he/she had a Urinary Tract Infection [MEDICAL CONDITION] and was on isolation precautions. On 03/02/20 at 9:31 AM, the surveyor observed two Certified Nursing Assistants (CNAs) standing inside the resident's room. CNA #1 was not wearing any PPE. CNA #2 was wearing a gown and gloves. The CNAs were using a mechanical lift to transfer Resident #79 from the bed into the wheelchair. When they finished transferring the resident, CNA #1 wheeled the mechanical lift out of the resident's room and down the hallway where it was then stored in a corner. The surveyor noted that CNA #1 continued to walk down the hallway to a nurse. CNA #1 did not sanitize the mechanical lift after using it for Resident #79. When interviewed on 03/02/20 at 10:00 AM, CNA #2 stated that it was the facility's policy to wear PPE if she was providing direct care to the resident. CNA #2 stated that she was only helping CNA #1 to transfer Resident #79 from the bed to the chair. At that time, the surveyor interviewed CNA #1 who stated that she stored the mechanical lift without sanitizing it and that she should have cleaned the lift after using it on a resident on contact

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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** - Some	(continued... from page 3) isolation precautions. On 03/02/20 at 12:30 PM, the surveyor observed Licensed Practical Nurse (LPN #1) standing inside Resident #79's room administering medication. LPN #1 was not wearing any PPE. When interviewed, LPN #1 stated that it was the facility's policy to only wear PPE when providing personal care to the resident. LPN #1 stated that the infection was in the resident's urine and because the resident had an indwelling urinary collection bag, there was no risk of transmission. During an interview with the Director of Nursing (DON) on 03/03/20 at 9:18 AM, the DON stated that it was the facility's policy for staff to wear PPE if they were providing direct care or in contact with a resident's bodily fluids. During an interview on 03/03/20 at 10:55 AM, the ADW stated that Resident #79 was her family member. The ADW stated that she received isolation precaution training and should have worn PPE. Review of the facility's Contact Isolation policy, dated 09/18/19, showed that the facility used contact precautions in addition to standard precautions for residents known or suspected to have serious illnesses easily transmitted by direct resident contact or by contact with items in the resident's environment. The policy included that dedicated care equipment should be considered for the resident and if use of common equipment or items was unavoidable, the items should be adequately cleaned and/or disinfected before use on another resident. NJAC 8:39-19.4 (a)