| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | **315364** | A. BUILDING _____ B. WING _____ | **06/16/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| **JERSEY SHORE CENTER** | **3 INDUSTRIAL WAY EAST EATONTOWN, NJ 07724** |

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) |
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| F 0880<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | **Provide and implement an infection prevention and control program.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, and record review, it was determined that the facility failed to appropriately disinfect multi-use medical equipment to prevent the potential exposure of COVID-19. This deficient practice was identified for 1 of 1 residents reviewed for infection control practices related to the disinfection process for multi-use medical equipment, (Resident #1) and was evidenced by the following: On 06/16/2020 from 9:27 AM to 10:08 AM, the surveyor in the presence of another surveyor conducted the Entrance Conference with the Administrator, Director of Nursing (DON), and Assistant Director of Nursing/Infection Preventionist (ADON/IP). The surveyors asked the facility staff members how they were cohorting (grouping individuals in the same conditions) the new admissions in the facility. The Administrator responded that the new admissions to the facility were quarantined for 14 days in the designated Navesink unit in the facility and monitored for signs and symptoms of COVID-19 throughout that time. The Administrator further explained that all staff caring for these residents had to wear full Personal Protective Equipment (PPE) which included a properly fit-tested N95 mask, face shield, gown, and gloves. On 06/16/2020 at 11:45 AM on the Navesink unit, the surveyor observed the door shut to Resident #1's private room. A blue sign that indicated, STOP was observed on the resident's door. The STOP sign indicated the resident was on extended contact plus airborne precautions. The sign on the resident's door depicted a picture of a person wearing a face shield, N95 respirator, a pair of gloves and an isolation gown gown. The sign further indicated to please see the nurse before entering the room and provided instructions for the staff to follow on appropriate infection control techniques when entering the resident's room and providing care. At 11:48 AM, the surveyor observed a Physical Therapy (PT) staff member exit Resident #1's room with a seated, red-colored rolling walker. The PT staff member was observed wearing a N95 mask, face shield, and gown. The surveyor observed the PT staff member apply an Alcohol Based Hand Rub (ABHR) to her hands, leave the rolling walker in front of the resident's door, and then walk to the nurses' station, where she removed a bleach wipe from the container. The PT returned to the rolling walker. The surveyor observed the PT staff member wipe down the handles and part of the seat. The surveyor did not observe the PT staff member wipe down the entire rolling walker. At that time, the surveyor interviewed the PT staff member who stated that she only needed to wipe down areas on the rolling walker that the resident touched. A review of Resident #1's Admission Record reflected that the resident was recently admitted to the facility with diagnoses, which included but were not limited to, hypertension (high blood pressure), type 2 diabetes mellitus without complications, history of falling, other malaise (discomfort/weakness), and unspecified dementia without behavioral disturbances. A review of Resident #1's most recent admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, reflected that the MDS assessment was still in progress, as the resident was admitted to the facility less than 14 days ago. A review of Resident #1's June 2020 Order Summary Report reflected a physician's orders [REDACTED]. The physicians order further indicated that this was the third time the resident was to be tested for the presence of COVID-19. On 06/16/2020 at 12:07 PM, the surveyor interviewed the Licensed Practical Nurse/Unit Manager who stated that the therapy department cleaned the entire piece of equipment before entering and after exiting a resident's room to prevent the spread of infection. At 12:24 PM, the surveyor interviewed the Registered Nurse (RN) who stated that the blue signs on the resident's doors indicated that the resident was on contact and droplet precautions. The RN further stated that if a staff member was utilizing multi-use medical equipment for a resident, the entire piece of equipment needed to be wiped down, not just the parts of the equipment that the resident touched. At 12:49 PM, the surveyor interviewed the ADON/IP who stated that when a resident had a blue sign posted on their door that meant that the resident was on extended contact and airborne precautions. The ADON/IP further explained that all residents that were identified as COVID-19 positive, presumptive, or newly admitted to the facility required a 14-day quarantine and full PPE needed to be worn by the staff caring for the residents. The ADON/IP stated that if a resident was on extended contact and airborne precautions, the multi-use medical equipment needed to be cleaned upon entering and before exiting the resident's room right outside of the resident's bedroom door with a disinfectant wipe that killed [MEDICAL CONDITION]. The ADON/IP stated that the entire piece of equipment, not just the parts that the resident touched needed to be wiped down and cleaned. At 1:38 PM, the surveyor interviewed the Occupational Therapist/Rehab Director (OT/RD) who stated that at this time the multi-use resident equipment was designated to specific units for the residents because of COVID-19. The OT/RD stated, I tell my staff to clean the entire rolling walker because you never know what part of the equipment could have been exposed because of the droplet precautions. I tell my staff to wipe down everything completely. At 1:55 PM, the surveyor interviewed the Administrator who stated that the OT/RD performed a competency related to infection control for the PT staff member today because she was not working at the facility during the Pandemic and just returned to work. A review of the facilities policy and procedure revised on 07/24/18 titled, Cleaning and Disinfecting, indicated, 5. Perform routine disinfection of items used in daily care practices with Environmentally Protective Agency (EPA) registered disinfectant. 5.1 Clean and disinfect single patient equipment with appropriate disinfectant after use with patient. 5.2 Multi-patient equipment must also be cleaned/disinfected after patient use. NJAC: 8:39-27.1 (a) |

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