STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315413	A. BUILDING _____ B. WING _____	**09/24/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PEACE CARE ST ANN'S	**198 OLD BERGEN ROAD JERSEY CITY, NJ 07305**

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 0688 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and review of other pertinent facility documents, it was determined that the facility failed to ensure: a.) splints were applied in accordance with physician orders, and b.) accountability for resting hand splints, and c.) consistent accountability for a restorative exercise program. This deficient practice was identified for 2 of 3 residents reviewed for therapeutic splints (Resident #34 and #48). The evidence was as follows: 1. On 9/16/20 at 9:53 AM during the entrance conference, the Licensed Nursing Home Administrator (LNHA) informed the surveyor that the facility had recently transitioned into using electronic medical records for physician orders and medication/treatment administration records starting in July 2020. On 9/16/20 at 11:03 AM, two surveyors observed Resident #34 sitting in a high back wheelchair in his/her room. The resident was wearing a neck splint positioned on the right side of his/her neck. The surveyors observed two Certified Nursing Aides (CNA's) applying bilateral hand splints to the resident's left and right hands. At 11:17 AM, the surveyors observed the Resident Care Coordinator/Unit Manager (RCC/UM) enter the resident's room while the two CNA's were repositioning the resident. The RCC/UM approached the resident and removed the neck splint. The RCC/UM informed the CNA's that the resident's neck splint had been discontinued by the physician, and the RCC/UM walked out of the room with the neck splint. The surveyor observed that the resident still had the resting hand splints on his/her left and right hands. On 9/17/20 at approximately 1:00 PM, two surveyors interviewed the RCC/UM who stated that yellow highlighting on a document in the resident's medical record meant that it was discontinuedand that staff did not need to follow anything highlighted in yellow. On 9/21/20 at 11:09 AM, two surveyors observed Resident #34 in his/her private room sitting in a high back wheelchair. The resident was not wearing the bilateral hand splints. The surveyors observed that the resident's fingertips were tightly clenched into the palms of the left and right hand. The surveyor attempted to interview the resident, but the resident just stared at the surveyor. The surveyor reviewed the medical record for Resident #34. A review of the Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with [DIAGNOSES REDACTED]. A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated 7/8/2020, reflected that a brief interview for mental status (BIMS) interview was not able to be conducted, so the staff assessed the resident's cognition level. The MDS reflected that the resident had a short- and long-term memory problem with a severely impaired decision-making capacity. The assessment further included that the resident had no functional range of motion limitations to the bilateral upper and lower extremity, but he/she received restorative therapy with active and passive range of motion on a daily basis performed by staff which included the use of splints daily. A review of the resident's individualized care plan dated 7/31/18 included that the resident had a self-care deficit with a goal to prevent contractures. Interventions included PROM (passive range of motion) exercises to the bilateral upper and lower extremities; and Apply bilateral resting hand splints .from 11 AM to 3 PM daily. A review of the paper Physician's Order sheet (POS) for July 2020 included a physician's order (PO) dated 12/4/19 for the bilateral hand splints at 11 AM and remove at 3 PM daily. A review of the paper Treatment Administration Record (TAR) for July 2020 included the PO dated 12/4/19 for the bilateral hand splints. The nurses signed for the accountability of the application for the resting hand splints applied at 11 AM and removed at 3 PM through the dates of 7/15/20. A review of the electronic POS/Order Recap Report for July through September 2020 did not reflect evidence for the electronic PO for the bilateral hand splints. There was no documented evidence in the electronic POS or the paper POS that reflected that the hand splints had been discontinued by the physician. A review of the electronic TAR (eTAR) for July, August, and September 2020 did not reflect documented evidence for the accountability for the bilateral hand splints after 7/15/20 when the facility switched to the electronic medical records/physician orders. A review of the electronic Progress Notes (ePN) for July, August, and September 2020 did not reflect documented evidence that the hand splints had been discontinued by the Physician or that the resident had not been tolerating the splints. On 9/23/20 at 11:20 AM and 12:45 PM, two surveyors observed Resident #34 sitting in his/her private room in a high back wheelchair. The resident was not wearing bilateral hand splints. The surveyor observed that the resident's fingertips were clenched into the palms of his/her bilateral hands. At 11:04 AM, the surveyor interviewed the Rehabilitation Director who confirmed that the resident was seen by OT on 8/8/20 and services were discontinued the same day. The Rehabilitation Director confirmed that the reason for the therapy evaluation was solely for the review of the neck splint, and the neck splint was discontinued at that time. The Rehabilitation Director stated that the hand splints should have been continued to prevent hand contractures. She stated that the resident had not been seen for Rehab Therapy Services since that date of 8/8/20. At 12:48 PM, the two surveyors interviewed the resident's assigned Certified Nursing Aide (CNA). The CNA informed the surveyors that the resident was awake but non-verbal and depended on staff for all activities of daily living. The surveyor asked the CNA about the resident's hands that were tightly clenched into his/her palms. The CNA stated that she performed range of motion (ROM) exercises with the resident daily and that she used to have to apply the splints to the bilateral hands, but just this past week the Resident Care Coordinator/Unit Manager (RCC/UM) informed her that the resident was receiving rehab therapy, and that she wouldn't need to apply the splints again until the resident was discharged from therapy. She stated that she had applied the splints daily to the resident's hands until the middle of last week. The CNA stated that the resident was able to open his/her hands without pain. The CNA then brought the surveyors into the resident's room, and the CNA explained to the resident that she was going to open his/her hands, and the CNA was able to open the resident's bilateral hands fully with minimal effort. The CNA confirmed that the resident grips the hands, but she stated that she believed that is what therapy was working on which is why she didn't need to apply the splint per the RCC/UM. The surveyors asked if she had to document for the ROM exercises she performed on the resident, and she pulled out a CNA binder. The CNA referred to the resident's Functional Maintenance/Restorative Nursing Flow sheet for September 2020. A review of the Functional Maintenance/Restorative Nursing Flow sheet for September 2020 included a Prescription section for ROM. The area for Type, Involved Extremities, Frequency, and Repetition was blank. The goal was highlighted in yellow and reflected, AROM (active range of motion) to bilateral upper extremities and lower extremities. The flow sheet reflected that the CNA's were signing for the accountability of 10 minutes of exercises daily in September 2020. Further, a review of the Prescription for Splint was blank but a goal was highlighted in yellow, which included Apply resting hand splint and bilateral heel boots when out of bed to wheelchair. Only one date was signed in September 2020 on 9/17/20 in which the resident tolerated three (3) hours during the day shift. On the same day on 9/23/20 at 12:50 PM, the surveyor asked the CNA why the goals were highlighted in yellow, and the CNA stated that the RCC/UM highlights them for her so it stands out and she knows she has to follow the goals very carefully. The CNA could not speak to the accountability of the splint and why it was blank for dates beyond last week, when the RCC/UM had informed her that the splinting had been discontinued. At 12:55 PM, the surveyor interviewed the Licensed

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 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) Practical Nurse (LPN) who stated that she floats between various nursing units. The LPN confirmed that the resident was not currently wearing the splints but stated that there was accountability for the splinting in the eTAR in which she signs. The surveyor asked the LPN if she could show her where she signs for the application of the splints, and the LPN pulled open the eTAR for September 2020 and she was unable to find evidence for the PO or the accountability for the splints. The LPN acknowledged to the surveyors there was no order for the splints in the electronic medical record since July 2020. At 12:56 PM, the two surveyors interviewed the RCC/UM who stated that Resident #34 was receiving occupational therapy, and that meant that all hand splints were to be discontinued while the resident was on therapy services. The surveyors requested clarification, and the RCC/UM confirmed that whenever a resident was on therapy services, if they had an order for [REDACTED]. nurses to stop applying the splints because they had been discontinued. The surveyors and the RCC/UM reviewed the resident's medical record together. The RCC/UM confirmed there was no physician's order to discontinue the hand splints. The RCC/UM stated that she thought that because there was no order in the electronic medical record and no accountability in the eTAR, that the order must have been discontinued. The surveyors and the RCC/UM reviewed the paper POS for July 2020 which reflected the order for the bilateral hand splints to be worn from 11 AM to 3 PM daily. The RCC/UM confirmed there was no documented evidence that it was discontinued from the physician either in the paper medical record or the electronic medical record. The RCC/UM showed the surveyor a physician order for [REDACTED]. The surveyor showed the RCC/UM a physician's order dated the next day on 8/8/20 which reflected that the OT services had been discontinued by the physician. The RCC/UM could not speak to if the resident was receiving OT services or if they had been discontinued. The RCC/UM stated that she could not find another Physician's order after 8/8/20 that reflected that the resident was receiving therapy, and she stated she assumed that if there was no order for the splints in the electronic medical record that it meant they had been discontinued. She confirmed when she made that assumption, she did not clarify with rehab services, assigned nursing staff, or the Attending Physician. At 1:00 PM, the surveyors and the RCC/UM reviewed the Functional Maintenance/Restorative Nursing Flow sheet for September 2020 together. The RCC/UM stated that she highlighted the restorative goals in yellow so that they would not be missed, and that the CNA's knew exactly what to follow and where to document. The RCC/UM could not speak to why she had informed the surveyor on 9/17/20 that yellow highlighting meant that something had been discontinued but on the Functional Maintenance/Restorative Nursing Flow sheet, she highlighted it in yellow for CNA's to mean the opposite, so they wouldn't forget to do it. The RCC/UM could not speak to whether the resident needed the hand splints or not. She confirmed there was no discontinue order from the physician but stated that she wasn't sure. The RCC/UM acknowledged that there was no accountability for the bilateral hand splinting for September 2020. The surveyor asked for additional accountability for the hand splints, but the RCC/UM was unable to provide documented evidence since July 2020 when the facility transitioned to electronic medical records/physician's orders. On 9/23/20 at 2:20 PM, the survey team with the LNHA and Director of Nursing (DON) to review the findings. On 9/24/20 at 10:53 AM, the surveyor interviewed the LNHA and DON. The DON stated that nurses do the rehab screening if there is a functional change, and those screenings get faxed to the therapy department. She stated that the Physician was notified and if necessary, skilled therapy would be initiated. The DON confirmed that orders for hand splints are not discontinued just because a resident may be participating in OT, and the DON could not speak to why the RCC/UM would have told the surveyors that. The LNHA stated that they believe that order was not carried over into the electronic medical record in July 2020 when they transitioned to electronic, which was why it was not in the eTAR for the nurses to sign. The DON confirmed that CNA's sign for the application of the splint during restorative programing in the Functional Maintenance/Restorative Nursing Flow sheet, and the nurses sign to verify its in place in the eTAR. The DON also confirmed that yellow highlighting should have a consistent meaning to reflect that the item was discontinued. The DON confirmed it should not mean discontinued for nursing and mean something else for the CNA's. The DON also confirmed there was no documented evidence of splinting in the eTAR, and the administrative team was unable to provide documented evidence of the Restorative exercises for July and August 2020 and evidence of the application of the splints for August and September 2020 in accordance with the physician's order. The DON was unable to speak to if the resident needed the hand splints, but confirmed she could not find a physician's order that they had been discontinued. She confirmed that the resident had not had a functional decline and the resident still did not have any functional range of motion limitations. 2. On 9/16/20 at 11:34 AM, the two surveyors observed Resident #48 with his/her eyes closed in bed on an air mattress. The surveyor observed that the resident's right elbow was in a flexed position and the right wrist and hand appeared stiff and contracted (permanent stiffening or shortening of the muscle, joint, or tendons causing deformity). The resident was not wearing a splint to the right hand or arm. The surveyor observed the resident move his/her left arm to rub his/her nose, but the resident's right arm did not extend or move. The resident did not open his/her eyes. The surveyor reviewed the medical record for Resident #48. A review of the Admission Record face sheet revealed that Resident #48 was admitted to the facility with a [DIAGNOSES REDACTED]. A review of a significant change MDS assessment dated [DATE] reflected that a BIMS interview could not be conducted so staff assessed the resident's cognition. The MDS reflected that the resident had a short- and long- term memory problem with a modified independence decision-making capacity. The assessment further included that the resident had a functional range of motion limitation to one upper extremity and one lower extremity, the resident was on rehab therapy services and on a splinting/brace program. A review of the resident's individualized care plan dated 7/22/20, included that the resident had contractures of the right hand and left knee. The goal specified that the contractures will not progress. Interventions dated 8/23/20 included to apply the right resting hand splint at 10 AM - 2 PM; and 5 PM to 10 PM; Apply elbow extension splint at 10 AM - 2 PM. It further included to perform PROM exercises on the right upper extremities and the left leg. The care plan further indicated that the resident was at risk for complications related to use of the right hand, elbow and left knee due to contractures. Interventions included to ensure splint fits properly and that it is in the correct position. The care plan also included that the resident was resistive to care. A review of the physician's Order Summary Report for September 2020, included a PO dated 8/13/20 to discontinue skilled OT services, and perform PROM exercises on the right upper extremity and right lower extremity for 3x10 reps, and AROM exercise on the left upper/lower extremity for 3 x 10 reps as tolerated. The Order summary report reflected a PO dated 8/14/20 included to apply the right elbow extension splint from 10 AM to 2 AM. There was a second PO dated 8/14/20 to apply modified resting hand splint every evening shift from 5 PM to 10 PM daily or as tolerated. The order for the modified hand splint did not specify if the splint was to be applied on the left or right hand. A review of the undated Nurse Aide Care Plan indicated that the resident was on a Restorative program which included right upper extremity splinting from 10 AM to 2 PM and 5 PM to 10 PM. On 9/23/20 at 12:50 PM, the surveyor interviewed the CNA, who was responsible for the restorative nursing book. The CNA confirmed that it was the only restorative accountability book. The surveyor asked if there was a restorative program accountability for Resident #48, and the CNA and surveyors looked through it together and it was not in the book. The CNA stated that she would have to ask the RCC/UM regarding where it is. On 9/23/20 at 12:59 PM, the two surveyors observed Resident #48 in bed, awake. The resident was not wearing the right elbow extension splint. The surveyor observed two splints stored on the resident's hamper in the room. The surveyor attempted to interview the resident, but the resident grunted and did not respond. The surveyor attempted to interview the resident's assigned CNA, but she was not available. At 1:02 PM, the two surveyors interviewed the resident's assigned LPN who stated that she was familiar with the resident and worked four days a week with Resident #48. The LPN stated that the resident was alert, confused and dependent on staff for all care. She stated that the resident had behaviors of combativeness and refusing care. The surveyor asked the LPN about the resident's splinting and restorative program. The LPN stated that she applies the resident's splints, and that only nurses apply the splints and not the CNA's. The surveyor asked her when she applies the resident's splints and she stated in the morning she puts it on, she the proceeded to walk around the resident's bed to the left side of the resident and she removed the blanklet uncovering the resident's left arm. She stated that the resident's splint was currently not on. The surveyor asked what arm she puts the splints on, and the LPN stated that she would reference the physician order. The surveyors and the LPN reviewed the eTAR for September 2020 together, which reflected that the LPN signed for the application of the right elbow extension splint from 10 AM to 2 PM for that day. She also confirmed that she was the nurse that worked on 9/16/20 during the day shift and that she confirmed that she signed for the application of the right elbow splint. She could not speak to why it wouldn't have been on the resident on 9/16/20 at 11:34 AM. The surveyor asked if the resident refuses the splint and the LPN stated that the resident will attempt to pull off the splint, move his/her arm and that sometimes his/her skin would be sensitive to touch and it would exacerbate the resident's combative behaviors. The surveyor asked how long the resident was able to tolerate the right elbow splint, and she stated that it varied day to day depending on the resident's mood. She stated that she removed the elbow splint around 12:30 PM today when she gave the resident a nutritional supplement. She stated that

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F 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) there should be documentation in the progress notes if the resident refuses the splinting or if he/she does not tolerate the full 4 hours. The LPN confirmed there was no documentation or ePN on 9/16/20 that the resident was refusing the splint, and she stated that today she would add documentation that she removed it at 12:30 PM because the resident was becoming agitated with it on. She stated that the resident gets routine pain medication and that the resident had received his/her pain medication as scheduled to promote tolerance. The LPN confirmed that the order for the resting hand splint should be clarified to reflect what hand it goes on at 5 PM. At 1:25 PM, the surveyor interviewed the RCC/UM who stated that the resident was transferred to the long term care floor from the rehab unit on 9/15/20. She confirmed there was only one Functional Maintenance/ Restorative Nursing Flow sheet book for the floor. The CNA and RCC/UM confirmed there was no flow sheet with the resident's name in the accountability book. The surveyor asked where the form was, and the RCC stated in the presence of two surveyors that the resident was transferred to the floor on 9/15/20, and because the surveyors came the next day on 9/16/20, she didn't have a chance to make one yet. She confirmed she did not have it for the days in which the resident resided on the Long Term Care unit. At 1:30 PM, the surveyor interviewed the Rehabilitation Director who stated that Resident #48 was very combative for rehab services, and splinting was recommended as only as tolerated due to his/her behaviors. On 9/24/20 at 10:37 AM, the surveyor interviewed the DON and the LNHA in the presence of the survey team. The DON stated that the CNA's apply the hand splints and the LPN's sign that they are in place on the eTAR. If a resident refuses a splint or cannot tolerate it for the length of time it was ordered, that it should be documented in the ePN. She stated the ePN did not address why there was no splinting on 9/16/20. The DON provided the surveyor a copy of the Functional Maintenance /Restorative Nursing Flow sheet for September 2020, which reflected that the resident had the right elbow extension splint on at 10 AM and off at 2 PM daily while on the LTC unit. The surveyor asked where the sheet came from when the RCC/UM admitted to both surveyors that she had not created one while the resident had been on the floor. The DON and LNHA could not speak to it. There was no documentation provided as to why the date of 9/16/20 was circled by staff. At 11:23 AM, the surveyor interviewed the Occupational Therapist (OT) who confirmed that the resident was able to move his/her right arm slightly but that it was contracted, and he/she would often use the non-dominant left arm to remove or attempt to remove the splint on the right arm. The OT stated that splinting is recommended as tolerated due to the resident's behaviors, and that therapy had screened him/her again on 9/17/20 to ensure the splinting program and restorative program was appropriate for the resident. The OT confirmed the resting hand splint was for the right hand which was contracted. The OT stated that there was no unplanned functional decline in the resident's right arm. A review of the facility's Increase/Prevent Decrease in ROM/Mobility policy revised 4/2018 did not include a process or procedure including notification, documentation, accountability or assessment procedures. A review of the facility's undated Splinting Program policy included to follow instructions for the use of the device, apply the device according to the resident's plan of care . It did not include who was responsible for application of the splint, accountability of the splinting, and a process as to what to do in the event splinting is refused or not tolerated. NJAC 8:39-27.1(a)
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, record review, and review of pertinent facility documentation, it was determined that the facility failed to follow the Centers for Disease Control (CDC) guidance with regards to the use of Transmission Based Precautions (TBP) for new admissions or re-admissions from the hospital to mitigate the spread of COVID-19 for 6 of 6 residents newly admitted in the last 14 days (Resident #24, #42, #132, #133, #234 and #235). This deficient practice was evidenced as follows: 1. On 9/16/20 at 9:53 AM, during the entrance, the Licensed Nursing Home Adminstrator (LNHA) and the Director of Nursing (DON) confirmed that there were no residents with an active COVID-19 infection, and no residents on transmission based precautions/identified to be persons under investigation (PUI) for COVID-19 currently in the facility. The surveyor reviewed the medical records for 6 of 6 residents that were admitted to the facility less than 14 days, Resident #24, #42, #132, #133, #234 and #235. On 9/16/20 at approximately 9:54 AM prior to the initial tour of the facility's subacute rehab unit, the surveyor questioned the second floor Resident Care Coordinator/Unit Manager (RCC/UM) if any residents on the unit were COVID-19 positive or if any of the residents were on Transmission Based Precautions (TBP). The RCC/UM stated that there were not any residents that were COVID-19 positive or on TBP. On 09/16/20 at approximately 10:00 AM during initial tour of the facility's second floor unit, the surveyor observed Resident #42's room, which did not contain any signage to stop and check with the nurse before entering or signage to indicate TBP in place or any bin containing personal protective equipment (PPE) to be used to enter the room. On 9/17/2020 during review of Resident #42's medical record, the surveyor reviewed the Progress Notes which indicated that Resident #42 had been readmitted to the facility following a hospitalization on [DATE]. On 9/17/2020 at 11:00 AM, during surveyor interview, the Registered Nurse (RN) stated that Resident #42 returned from a hospital in the evening on 9/15/2020 at approximately 10:00 PM. The RN further stated that Resident #42 had a COVID-19 nasal swab test performed on 9/16/2020 with a negative result that was communicated to the facility on [DATE]. On 9/17/2020 at 11:05 AM, during surveyor interview, the RCC/UM stated that residents that are admitted or readmitted from the hospital will have a COVID-19 nasal swab test performed within 24 hours of admission. She further stated that they are not placed on TBP, but that all residents from the hospital are cohorted in private rooms on this unit for observation for 14 days and if they have no symptoms and two negative COVID-19 tests, the residents will be transferred to the other units after the 14 days is complete if they are long term care. She stated that the first test is performed within 24 hours and that the second test is performed in 7 to 10 days following the first test. A review of the U.S. Centers for Disease Control and Prevention (CDC) Responding to COVID-19, Considerations for the Public Health Response to COVID-19 in Nursing Homes guidance updated on 4/30/20, revealed the following under the section titled, Considerations for new admissions or readmissions to the facility: All recommended COVID-19 PPE (personal protective equipment) should be worn during care of residents under observation, which includes use of an N95 (respirator mask) or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown Testing residents upon admission could identify those who are infected but otherwise without symptoms and might help direct placement of asymptomatic COVID-19 infected residents into the COVID-19 care unit. However, a single negative test upon admission does not mean that the resident was not exposed or will not become infected in the future. Newly admitted or readmitted residents should still be monitored for evidence of COVID-19 for 14 days after admission and cared for using all recommended COVID-19 PPE. Testing should not be required prior to transfer of a resident from an acute-care facility to a nursing home. New residents could be transferred out of the observation area or from a single to a multi-resident room if they remain afebrile and without symptoms for 14 days after their last exposure (e.g., date of admission). Testing at the end of this period could be considered to increase certainty. 2. On 9/16/2020 at 11:43 AM, during the initial tour of the facility, the surveyor observed that there were no signs or PPE outside the room to indicate that Resident #24 was under TBP. Administration had provided the surveyor with a Matrix for Providers that indicated that Resident #24 had been admitted to the facility on [DATE]. The surveyor reviewed the resident's nursing progress notes from 9/9/2020 and 9/10/2020, which revealed that Resident #24 had been sent to the hospital on [DATE] at 7:00 PM for reinsertion of a feeding tube. The resident was readmitted to the facility on [DATE] at 4:30 PM. The facility provided a copy of the COVID-19 tests performed at the hospital on [DATE] and at the facility on 9/11/2020. Both of these laboratory results showed that Resident #24 was negative for the COVID-19 virus. On 9/16/2020 at 11:51 AM, the surveyor observed Resident #132 sleeping in bed. The Matrix for Providers revealed that Resident #132 was admitted to the facility on [DATE]. Review of the resident's census in the electronic medical record revealed that Resident #132 was transferred to the hospital on [DATE] and returned to the facility on [DATE]. There was no sign hanging or PPE located outside the resident's room to indicate that the resident was under any special precautions. Review of the resident's Covid-19 testing in the hospital on [DATE] and at the facility on 9/14/2020 reflected that Resident #132 tested negative for [MEDICAL CONDITION] on both occasions. On 9/16/2020 at 1:19 PM, the surveyor observed Resident #133 in his/her room. The resident spoke to the surveyor regarding several recent hospitalization s. The Matrix for Providers indicated that Resident #133 was admitted to the facility on [DATE]. The surveyor reviewed the resident's medical record which revealed that Resident #133 was originally admitted to the facility on [DATE] and readmitted on [DATE]. There were no signs or PPE outside the resident's room to indicate that extra precautions needed to be taken when visiting a resident who had been admitted to the facility less than 14 days prior. Review of the resident's Covid-19 tests in the hospital on [DATE] and at the facility on 9/10/2020 revealed that Resident #133 tested negative for [MEDICAL CONDITION] each time. On

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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) 9/17/2020 at 12:42 PM, the surveyor observed a Certified Nursing Aid (CNA) assisting Resident #133 with lunch in his/her room. The CNA was wearing a surgical mask. She was not wearing a gown or face shield. On 9/21/2020 at 9:31 AM, the surveyor observed that Resident #133 was out of his/her room. The CNA stated to the surveyor that Resident #133 was out to the Physical Therapy Department. On 9/22/2020 at 10:56 AM, the surveyor observed the CNA enter the room of Resident #133. She stated to the resident that she was returning with his/her toothbrush and tooth paste. The CNA was not wearing a gown over her scrubs. She assisted the resident in the bathroom by adjusting his/her chair near sink, so that Resident #133 could perform personal hygiene independently. The CNA was wearing a face mask. She was not wearing a shield, goggles or gloves. On 09/22/20 at 11:07 AM, the surveyor observed that on 9/16, 9/17, 9/21 and 9/22/2020, on the second floor, where the residents who were admitted to the facility less than 14 days prior resided, there was no use of PPE other than surgical face masks. The surveyor observed all staff go in and out of rooms wearing surgical face masks, including nurses, CNA's and housekeepers. No other PPE was worn by staff such as gloves, gowns, face shields or goggles. Residents were transported to the Rehabilitation Department by staff wearing surgical face masks and no other PPE. On 9/22/2020 at 11:39 AM, the surveyor observed the Rehabilitation Department. There were eight residents exercising, using various pieces of equipment. All of the residents were wearing either surgical or cloth face masks and were spaced more than six feet apart. Once durable medical equipment and exercise equipment was used, including reachers, barbells and stacking cups, the staff would bring them to the sink area. The rehabilitation staff were observed sanitizing the small equipment with a liquid in a bottle labeled hdqC2. Three staff members were assisting residents in the Rehabilitation Department. The only PPE that the Rehabilitation staff were wearing were surgical masks. On 9/22/20 at 11:44 AM, the surveyor interviewed the Rehabilitation Director. She stated that the majority of patients who were brought to the Rehab Department were past 14 days of admission to the facility. The Director of Rehabilitation stated many of the residents seen from the Second Floor were admitted to the facility 20 to 30 days prior. She stated that she had not seen Resident #133 in the Rehab Department, lately. When the surveyor stated that Resident #133 was in the Rehabilitation Department on 9/21/2020, the Director stated that the resident was admitted two weeks ago. Then she checked her computer and stated that the resident was admitted on [DATE] and that today (9/22/20) was the resident's 14th day. She also stated that she had asked the Director of Nursing (DON), who indicated that if the residents didn't have any active signs of COVID-19, no symptoms and they negative when they came from the Hospital, they could be seen in the Rehab Department. When asked again if Resident #133 was seen in the Rehabilitation Department on 9/21/2020, 13 days after admission from the hospital, the Director stated, Yes. The Director of Rehab also explained the methods the staff used to sanitize equipment between uses. She stated that they sprayed some equipment with the hdqC2 spray and let it air dry. The bikes and other large pieces of equipment were wiped with Micro Kill bleach wipes. The Rehab Director stated that everyone in the department wore a surgical face mask and no other PPE. She stated that there was alcohol hand sanitizer available in the department. 3. On 9/17/20 at 9:19 AM, the surveyor observed the LPN, during the medication pass, administer six (6) medications to Resident #235. The surveyor observed the LPN enter the resident's room and the resident was sitting in a wheelchair with a disposable breakfast tray on the overbed table. The resident stated that he/she was going to be going to therapy. Upon returning to the medication cart, the surveyor observed the LPN perform hand hygiene with an alcohol based hand rub (ABHR). The LPN was wearing a surgical mask and no gown or eye protection. On 9/17/20 at 9:26 AM, the surveyor observed the same LPN, during the medication pass, administer medications to Resident #234. The surveyor observed the LPN enter the resident's room and the resident was in bed with a disposable breakfast tray on the overbed table. The surveyor observed the LPN administer three (3) medications which included a subcutaneous (SC) injection of [MEDICATION NAME] (a medication used to prevent blood clots). The surveyor observed the LPN perform hand hygiene with soap and water before putting gloves on, to administer the SC injection into the resident's left abdomen, and after removing the gloves. The surveyor did not observe any signage for TBP to stop before entering either of the resident's rooms. In addition, the surveyor had not observed bins containing personal protective equipment (PPE) to be worn in close proximity of the doors of either resident rooms. The surveyor reviewed the medical records for Resident #234 and Resident #235. A review of the Admission Records reflected that both residents were admitted to the facility less than 14 days prior to 9/17/20: Resident #234 was admitted to the facility on [DATE]. Resident #235 was admitted to the facility on [DATE]. A review of the Physician Orders and Interdisciplinary Plan of Care (IDCP) for both residents reflected that there was no physician orders or plan of care indicating that either resident was on transmission based precautions. A review of the Covid testing done for Resident #234 reflected negative results dated 8/31/20 (prior to admission to the facility) and 9/14/20. A review of the Covid testing done for Resident #235 reflected negative results dated 8/25/20 (prior to readmission to the facility) and 9/15/20. 4. On 9/22/20 at 12:10 PM, the surveyor interviewed the Registered Nurse/Infection Preventionist (RN/IP), who stated that she has been the facility's RN/IP for two years. The RN/IP stated that the facility was using the U.S. CDC guidelines for the prevention/responding to COVID-19 in nursing homes. She stated that there were no residents with active COVID-19 in the facility and that there was no current outbreak at the facility. She stated that the facility was currently not able to accept residents that were COVID-19 positive, so they ensure the hospital tests the residents for COVID-19 before admission to the facility. She stated that upon admission, the facility tests the residents within 24 hours for COVID-19 and all the residents were currently negative for COVID-19 and no residents were symptomatic for [MEDICAL CONDITION]. The surveyor asked how residents are managed the first 14 days of admission to the facility, and the RN/IP stated that they are placed in private rooms and cohorted on the second floor for observation for 14 days. She stated the significance of the 14 days was because it was the understood incubation period of [MEDICAL CONDITION]. She stated at that time, residents were monitored every shift for signs and symptoms of [MEDICAL CONDITION]. The RN/IP confirmed that while staff monitored the residents for signs of [MEDICAL CONDITION], it was known that individuals can be asymptomatic and test positive for COVID-19. The RN/IP stated that this was why the facility tested all the residents on admission to ensure they were negative. The surveyor asked about TBP for the new admission, and the RN/IP stated that they do not implement TBP for new admissions because they are cohorted on the second floor unit in private rooms for 14 days and that because they test them on admission, TBP were not indicated. She stated that that facility did not consider new admissions to the facility as PUI. The surveyor asked the RN/IP to provide document evidence from the U.S. CDC regarding what the facility was using for the guidelines for new admissions. On 9/23/20 at approximately 1:50 PM, the RN/IP provided the surveyor a copy of the U.S. CDC guidelines for new admissions. The RN/IP acknowledged the guidelines to place new admissions on TBP and the recommended guidance to test the newly admitted residents at 14 days to ensure the resident was not asymptomatic positive. She stated that it all made sense and that they were working toward a resolution. She confirmed that their COVID-19 response plan did not address a rationale as to why the facility may not be aligning with the U.S. CDC guidelines for new admissions. The RN/IP stated that the facility tries to restrict therapy use for new admissions less than 14 days and confirmed that therapy services were not necessarily performed in the resident's individual rooms during the quarantine period. On 9/24/20 at 11:00 AM, the LNHA and DON acknowledged that new admissions were not placed on TBP for the 14 days. A review of the facility's Coronavirus / COVID-19 Preparedness and Response Plan revised 8/10/20 included, Quarantining new Admissions/Returning Residents Staff will follow standard precautions and wear a face mask at all times. and when staff enter the resident's room-practice extended use of PPE per CDC guidelines, if necessary. It did not address the implementation of TBP for the first 14 days of admission. NJAC 8:39-19.4(a)(1-6)