STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315425	A. BUILDING _____ B. WING _____	05/11/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FOOTHILL ACRES REHABILITATION & NURSING CENTER	39 EAST MOUNTAIN ROAD HILLSBOROUGH, NJ 08844

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	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to ensure: a.) the portable hand hygiene dispensers contained the appropriate alcohol concentration, and b.) alcohol-based hand gel was easily accessible in accordance with the Centers for Disease Control and Prevention guidelines for infection control to mitigate the spread of COVID-19. This deficient practice was identified when touring on 3 of 4 nursing units (Magnolia, Maple and Cedar Units), and the evidence was as follows: On 5/11/2020 at 9:20 AM, the surveyor interviewed the Assistant Director of Nursing/Infection Preventionist (ADON/IP), who stated that the facility was implementing infection control measures due to a COVID-19 outbreak. The ADON/IP confirmed that all staff were in-serviced on proper hand hygiene, and the training included competencies (the ability of personnel to apply their skill and knowledge to perform a duty correctly). At 11:20 AM, the surveyor toured the Cedar unit in the presence of the Assistant Director of Nursing/Infection Preventionist (ADON/IP) and an Occupational Therapist (OT). The surveyor observed available at the nurse's station one small container of hand sanitizer wipes with 65.9% alcohol by volume. There was also another container of hand sanitizer wipes on top of the nurse's medication cart. The surveyor observed that in each resident room, there was also a hand sanitizer station secured to the wall. The product brand was visible from the dispenser on the wall, but the active/inactive ingredients of the hand sanitizer product was not visible. At 11:25 AM, the surveyor observed a Certified Nursing Aide (CNA #1) exit a room of a resident that was non-ill and not exposed to COVID-19. The surveyor observed CNA #1 activate the dispenser of hand sanitizer in the resident's room and walk down the hallway and enter another resident's room who was identified by the ADON/IP to be non-ill and not exposed to COVID-19. At 11:28 AM, the surveyor observed a Licensed Practical Nurse (LPN) standing at the nurse's station pick up the container of hand sanitizer wipes with 65.9% by volume and remove one. She then cleansed her hands using the wipe. At 11:30 AM, the surveyor interviewed CNA #1 in the presence of another CNA (CNA #2). CNA #1 stated that she was trained on infection control measures related to COVID-19, and the training included in-service competencies on hand hygiene. The CNA #1 stated that she washed her hands with soap and water between caring for residents, but that the facility also had hand sanitizer stations in each of the resident rooms that they can use as well. The CNA #2 confirmed that she also uses soap and water to wash her hands in addition to using the hand sanitizer stations in the room between residents. At 12:03 PM, the surveyor entered the Maple Unit in the presence of the ADON/IP and the OT. The surveyor observed a small container of hand sanitizer wipes with 65.9% alcohol by volume available at the nurse's station. There was a second container of hand sanitizer wipes on the medication cart. The surveyor similarly observed as on the Cedar Unit in each resident room, there was also a hand sanitizer station secured to the wall. The product brand was visible from the dispenser on the wall, but the active/inactive ingredients of the hand sanitizer product was not visible. At 12:32 PM, the surveyor entered through a closed double door which led to the designated COVID-19 wing within the Maple Unit. The surveyor observed two Certified Nursing Aides (CNA #3 and CNA #4) passing out lunch trays to the residents on the unit. The surveyor observed that both CNA #3 and #4 were not wearing gloves when passing out the trays to each individual resident room. The surveyor observed between each tray delivery and meal set up, the CNA's both performed hand hygiene using only the hand sanitizer station on the wall of each resident room. The surveyor observed there was a nursing cart at the end of the hallway with one small container of the hand sanitizer wipes with 65.9% alcohol by volume accessible on the designated COVID-19 unit. At 12:42 PM, the surveyor interviewed CNA #3 who stated that she was assigned to the COVID-19 unit and that she never wore gloves when passing out trays to the residents on the COVID-19 unit because it was a dignity issue. The CNA #3 stated that in turn, she would wash her hands using the sanitizer stations in each of the resident room's when passing out the trays between each resident. She stated that she wore gloves all other times except for passing out meal trays. The CNA #3 confirmed that she did not pass out trays on other units. She confirmed that the facility provided in-service training on hand hygiene and that using the sanitizer stations on the wall was effective against COVID-19. At 12:55 PM, the surveyor, ADON/IP, and OT prepared to exit the designated COVID-19 wing on the Maple Unit. Upon doffing and discarding the personal protective equipment (PPE), the surveyor observed the ADON/IP and the OT perform hand hygiene by using the hand sanitizer dispenser on the wall of the resident's room at the exit, and the OT stated that the hand sanitizer dispenser secured on the wall in the resident's room by the exit was appropriate prior to exiting the unit. The surveyor applied the sanitizer foam from the wall. The surveyor noted that when the foam dried, there was a slightly sticky film left on the hands. The surveyor was unable to visualize what active/inactive ingredients were in the hand sanitizer on the wall. At 1:00 PM, the ADON/IP and the OT showed the surveyor where the hand sanitizers were kept in the central supply room. The ADON/IP stated that the Housekeeping Director was not working today, but that the facility had an acting-Housekeeping Director from the corporate office covering for the Housekeeping Director for the interim. The acting-Housekeeping Director opened the room and showed the surveyor a supply of sanitizers that he confirmed were used for the dispensers in the wall of each resident room. The ADON/IP and OT confirmed that they believed these were what was available. At that time, the surveyor observed the labeling on the hand sanitizers which reflected, Alcohol Free Foaming First Aid Antiseptic Hand Cleanser. There was one active ingredient listed, Bezethonium Chloride 0.20%. The surveyor did not use the product for hand sanitation for the duration of the survey. The surveyor showed the ADON/IP and the OT the labeling of the product and asked them what they noticed when reading the label. The OT stated, It's alcohol-free. The ADON/IP and OT acknowledged this product was in all the portable hand dispensers on the unit to their knowledge. They confirmed that the hand sanitizer was recommended by the CDC to contain at least 60% alcohol to be effective against COVID-19, and should be an alcohol-based hand gel (ABHG). The ADON/IP and OT acknowledged that they did not realize that the dispensers contained alcohol-free hand sanitizers but acknowledged it was slightly sticky. On 5/11/2020 at approximately 1:10 PM, the surveyor toured the Magnolia Unit identified as the dementia unit by the ADON/IP. The surveyor observed that in each resident room, there was a hand sanitizer station secured to the wall. The product brand was visible from the dispenser on the wall, but the active/inactive ingredients of the hand sanitizer product was not visible. The ADON/IP and the OT opened two hand sanitizer dispensers on the unit to show the surveyor what product was inside. The surveyor observed that the hand sanitizer contained the Alcohol-Free hand sanitizer in each dispenser including a portable dispenser attached to the PPE bin outside the resident's room which also contained the Alcohol-Free hand sanitizer. The ADON/IP was unable to show the surveyor a wall dispenser in a resident room or around the unit that contained ABHG. At approximately 1:13 PM, the surveyor observed the Registered Nurse/Unit Manager (RN/UM) perform hand hygiene at the sink with soap and water. The surveyor observed that there was no container of the alcohol-based hand wipes at 1 of the 2 nurses stations on the unit and there was no ABHG or wipes accessible on top of the nursing carts. At 1:18 PM, the surveyor observed a CNA #5 enter the room of a resident who was on droplet precautions for a confirmed positive COVID-19 diagnosis. The CNA #5 applied a pair of gloves without performing hand hygiene and assisted the unsampled resident to the wheelchair and then to the bathroom. After providing care to the resident, the CNA #5 removed her gloves and applied hand hygiene at the sink in the resident's room using soap and water. At 1:34 PM, the surveyor observed the ADON/IP perform hand hygiene

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

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) using the Alcohol-Free hand gel from resident room [ROOM NUMBER]. At 1:45 PM, the surveyor interviewed CNA #5 who stated that she was in-serviced on hand hygiene related to the prevention of transmission of COVID-19. The CNA #5 stated that she was trained to use soap and water or the sanitizer in the resident rooms, which stated stated that she though it had alcohol in it. At that time, the surveyor observed the RN/UM enter his office to get a container of the alcohol-based hand sanitizer wipes to put at the nurse's station. He stated that there was another container of the hand sanitizer wipes in the activity room and one container was by the other nurse's station area. At 2:01 PM, the surveyor observed a housekeeper doff and discard a gown and a pair of gloves and perform hand hygiene at the sink of a resident room using soap and water. The surveyor attempted to interview the housekeeper regarding who was responsible for replacing the hand sanitizers in the resident rooms, but the housekeeper stated that she did not speak English. At 2:06 PM, the surveyor interviewed the Licensed Practical Nurse (LPN) on the Magnolia unit. The LPN stated that she was in-serviced on hand hygiene and that although the facility inservices her that it was okay to use hand sanitizers in the resident rooms, she preferred to use soap and water. The surveyor asked why she preferred using soap and water over hand sanitizer, and the LPN stated, I don't use the (sanitizer) pumps in the room because I don't like them. She added that the sanitizer in the rooms make her hands dry and hurt, so instead she used soap and water or she takes a hand sanitizer wipe form the container. She then pointed to the container of wipes at the nurse's station. The surveyor observed that it was the same wipes with the 65.9% alcohol by volume wipes. She stated that the alcohol wipes don't dry out her hands like the sanitizer in the dispensers do. She wasn't sure what the product was in the sanitizer dispensers in each of the resident rooms, confirming it was because she doesn't like to use it anyway. At 3:08 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) who acknowledged that they were not aware that the hand sanitizer dispensers in the resident rooms contained alcohol-free hand sanitizer. The DON stated that it was a shock to see the label reflected alcohol free. The LNHA further stated that they had found some packages of ABHG labeled as Foaming Hand Sanitizer with Vitamin E with 67% alcohol as the active ingredient. The LNHA reported that they had replaced the Alcohol-Free hand gels with the appropriate ABHG they had available but that it wasn't enough for all the resident rooms. At 4:01 PM, the LNHA stated that there were 107 resident rooms plus hand sanitizer dispensers on the PPE isolation carts. The LNHA stated that they had 39 ABHG available in the central supply that were replaced on the Maple Unit and the sub-acute rehab unit and the front desk. He added that they just ordered 20 more cases today, but that he reviewed the purchase orders and that the company must have delivered the wrong product. At 4:24 PM, the LNHA provided the surveyor with three purchase orders for 36 cases containing six products per case (for a total of 216 products) of the Alcohol Based hand sanitizer foam delivered on 3/17/20, 3/18/20 and 3/31/20 respectively. The LNHA acknowledged that although the correct ABHG product was ordered, it must not have been delivered appropriately, and subsequently got missed when refilling the hand sanitizer dispensers throughout the building. He stated that a designated CNA who worked in central supply was responsible to ensure accuracy of order delivery but stated that the COVID-19 outbreak may have impacted the accuracy of the delivery and the facility subsequently using the unintended product. A review of the facility's Enhanced Respiratory Outbreak Surveillance dated 2/24/20 included, In-service staff on infection control procedure and precautions, respiratory hygiene/cough etiquette and frequent hand hygiene with alcohol-based hand sanitizer or perform proper hand washing for 20 seconds. It further included that the Central Supply Coordinator to monitor supply of PPE .and alcohol-based hand sanitizer daily, and place orders timely to prevent shortages. A review of the What You Need to Know About Coronavirus Disease 2019 (COVID-19) from the CDC dated 2/21/20 and attached to a facility In-Service Record training dated 3/12/20 included, There are simple everyday preventative actions to help the spread of respiratory viruses. These include . Wash your hands often with soap and water for at least 20 seconds. Use an alcohol-based hand sanitizer that contains at least 60% alcohol if soap and water are not available. A review of the Infection Prevention and Control Program dated 1/9/2020 included, health care workers can reduce risk of infection by cleaning hands with an alcohol-based hand rub or soap and water, also known as [MEDICATION NAME] hand hygiene. It further included to, perform hand hygiene prior to wearing and after removing gloves. The facility's infection program not address the use of an Alcohol-Free hand foam with the active ingredient Benzethonium Chloride 0.20% that the facility was actively using. A review of the most recent Hand Hygiene Recommendations Guidance for Healthcare Providers about Hand Hygiene and COVID-19 provided by the CDC and last updated on 4/27/20 included, CDC recommends using ABHR with greater than 60% [MEDICATION NAME] or 70% [MEDICATION NAME] in healthcare settings. Unless hands are visibly soiled, an alcohol-based hand rub is preferred over soap and water in most clinical situations due to evidence of better compliance compared to soap and water. Hand rubs are generally less irritating to hands and are effective in the absence of a sink. NJAC 8:39-19.1, 19.2, 19.4, 19.5