STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315387	A. BUILDING _____ B. WING _____	06/23/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ALLAIRE REHAB & NURSING	115 DUTCH LANE ROAD FREEHOLD, NJ 07728

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of pertinent facility documentation the facility failed to: 1. ensure contracted staff wore the proper Personal Protective Equipment (PPE) in an isolation, new admission COVID quarantine room; and 2. appropriately disinfect multi-use medical equipment to address the risk of cross-contamination. This deficient practice was identified for 2 of 2 isolation residents reviewed for infection control practices (Resident #1 and Resident #2) and was evidenced by the following: 1. On 06/23/2020 at 12:27 PM, the surveyor observed Resident #1's door with several signs that indicated to stop and see nurse and instructions on how to don (put on) and doff (take off) a PPE gown, mask, face shield, and gloves. The surveyor observed a plastic, 3-drawer bin which contained PPE gowns and gloves, next to Resident #1's door. The surveyor observed a staff member, wearing a respirator type mask and gloves, enter Resident #1's room. The staff member did not don a gown or face shield before entering the room. During an interview with the surveyor on 06/23/2020 at 12:30 PM, the staff member was identified as a contracted hospice aide. The hospice aide stated she did not know why Resident #1 had been on isolation and that she had not donned a gown or face shield PPE because the type of PPE worn would depend on the type of infection the resident had. She further stated that nobody had told her to wear PPE into the resident's room. The hospice aide stated that she had been trained by her company and knew how to identify isolation rooms by the signs on the door such as the stop see nurse sign. The hospice aide confirmed that there was a stop sign on the the resident's door and a PPE bin outside of the room door. The hospice aide stated that the PPE was for both the resident's protection and her protection. During an interview with the surveyor on 06/23/2020 at 12:38 PM, the Licensed Practical Nurse Unit Manager (LPN/UM) stated that Resident #1 had been an admission from the hospital and that the facility policy was for Resident #1 to be quarantined on isolation for 14 days to be observed for any signs of COVID-19. The LPN/UM stated that all staff who enter the isolation room should be in full PPE - mask, gown, face shield, and gloves. During an interview with the surveyor on 06/23/2020 at 12:42 PM, the Director of Nursing (DON) stated the hospice aide should have asked the nurse what the isolation was for and should have followed the signs on the door and worn full PPE. During an interview with the surveyor on 06/23/2020 at 2:16 PM, the Registered Nurse (RN) Infection Preventionist (IP) stated that the hospice and agency staff were to report to the nurses upon arrival and would be told if a resident was on isolation and that the stop signs on the resident doors would alert all staff. The RN/IP stated that she would make rounds on the floors but that the UM would be responsible to inform the hospice and agency staff about isolation. During an interview with the surveyor on 06/23/2020 at 2:49 PM, RN #1 stated she was assigned to Resident #1 and that she had informed the hospice aide that the resident was on isolation. RN #1 stated that the hospice aide had cared for Resident #1 multiple times since the admission. Review of Resident #1's Admission Record reflected the resident was recently admitted and had diagnoses, that included but were not limited to, chronic [MEDICAL CONDITION], diabetes mellitus (elevated blood sugar), [MEDICAL CONDITION], hypertension (elevated blood pressure), and other diseases of the circulatory system. Review of the facility's COVID-19 Policies and Procedures, dated 06/03/20, revealed that all new and readmissions: isolation precautions should be implemented for the first 14 days following any hospitalization s. Review of the Certificate of Completion, provided by the hospice agency to the facility, revealed the hospice aide had the following training: COVID-19 on 04/09/2020; Personal Protective Equipment on 03/18/2020; Infection Control Essentials on 03/05/2020. Review of the hospice aide sign-in sheet revealed that she had cared for Resident #1 on 06/10-06/12; 06/15-06/19; 06/22; and 06/23/2020. Review of the Hospice Care Agreement, dated 08/2013, revealed 3.5 Coordination with Hospice Regarding Plan of Care, the facility shall designate a member of the interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the hospice resident provided by the facility and the hospice. 2. On 06/23/2020 at 11:56 AM, the surveyor in the presence of another surveyor, observed RN #1 properly don PPE which included a mask that she was already wearing, a gown and gloves. On Resident # 2's door there were several signs that indicated the resident was on transmission-based precautions (used to help prevent the spread of germs from one person to another) and indicated that a mask, a gown and gloves were required to enter the room. RN #1 then entered Resident #2's room with a multi-use blood pressure (BP) machine that was attached to a rolling pole with a basket. The BP machine included a pulse oximetry probe with wire (used to measure oxygenation in the blood), BP cuff attached to pneumatic tubing and thermometer used to obtain the residents' vital signs. The surveyor observed that the BP machine required RN #1 to touch buttons on the faceplate of the machine to turn it on and to start the action of obtaining a BP. At 12:10 PM, the surveyor, in the presence of another surveyor, observed RN #1 exit Resident # 2's room with the BP machine. RN #1 donned a pair of gloves and removed a disinfecting wipe from the container that was in the basket. RN #1 wiped down the BP cuff and the pulse oximetry probe with the disinfecting wipe. The surveyor did not observe RN #1 use the disinfectant to wipe down the pneumatic tubing attached to the BP cuff, the pulse oximetry probe, the faceplate, or the outside of the BP machine. The surveyor interviewed RN #1 who stated that Resident #2 was on transmission-based precautions for [MEDICAL CONDITION]-resistant Staphylococcus aureus (MRSA), an infectious bacteria that is resistant to many antibiotics. RN #1 further stated that the BP machine was not dedicated to Resident #2 and that she only needed to wipe down areas that came in contact with the resident. The surveyor reviewed the medical record for Resident #2. Review of the resident's Admission Record reflected that the resident was recently readmitted to the facility with diagnoses, which included but were not limited to,[MEDICAL CONDITION]. Review of the resident's June 2020 Order Summary Report reflected a physician's orders [REDACTED]. On 06/23/2020 at 12:17 PM, the surveyor, in the presence of another surveyor, interviewed the LPN/UM who stated that there was not a policy for dedicated equipment use for a room with transmission-based precautions. The LPN/UM then stated that the procedure for cleaning the equipment was to wipe down the whole machine, not just the portion that comes into contact with the resident to prevent the spread of infection. The LPN/UM also stated that the nurse will press the buttons on the machine and that needs to be cleaned and that everything needs to be cleaned since it (the BP machine) was in the room. At 12:40 PM, the surveyor, in the presence of another surveyor, interviewed the DON who stated that the entire piece of equipment needed to be wiped down, not just the parts of the equipment that touched the resident. The DON further stated they (the staff) know that. At 2:15 PM, the surveyor in the presence of another surveyor, interviewed the RN/IP who stated that the entire piece of equipment, not just the parts that touched the resident needed to be wiped down and cleaned. Review of the facility's Cleaning and Disinfection of Resident-Care Items and Equipment policy and procedure, revised on 12/2018, indicated reusable items are cleaned and disinfected or sterilized between residents (e.g. stethoscopes, durable medical equipment). Review of the facility's Isolation-Categories of Transmission-Based Precautions policy and procedure, revised on 12/2018, indicated, Resident-Care Equipment for each category of precautions; airborne, contact and droplet: a. When possible, dedicate the use of non-critical resident-care equipment items such as a stethoscope, sphygmomanometer (BP cuff/machine) bedside commode, or electronic rectal thermometer to a single resident (or cohort of residents) to avoid sharing between residents. b. If use of common items is unavoidable, then adequately clean

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 -** Few	(continued... from page 1) and disinfect them before use for another resident. N.J.A.C.: 8:39-19.4 (a) (1,2)