STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315357	A. BUILDING _____ B. WING _____	06/24/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ALARIS HEALTH AT CEDAR GROVE	110 GROVE AVE CEDAR GROVE, NJ 07009

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.** Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed: a.) to ensure the proper use and storage of Personal Protective Equipment (PPE); b.) proper storage and care of an indwelling catheter; and, c.) proper disposal of garbage in accordance with the Center for Disease Control and Prevention (CDC) guidelines for infection control to mitigate the spread of COVID-19. This deficient practice was identified on 1 of 3 nursing units (Green Unit), and was evidenced by the following: On 6/24/2020 at 8:50 AM, the survey team interviewed the Administrator, who stated that the facility was implementing additional infection control measures due to the COVID-19 outbreak. The Administrator informed the survey team that the Green Unit was a non-COVID unit, which meant that the residents were negative with no exposure. At 8:56 AM, the surveyor and the Director of Nursing (DON) entered the Green Unit. The DON informed the surveyor that the facility had no shortages with staffing or PPE. She stated that the staff and residents were being tested for COVID-19 weekly and that they had designated staff working on the Green unit. She further noted that all staff was educated and in-serviced about COVID-19 infection control, including sanitation, handwashing, and proper PPE use. At 9:08 AM, the surveyor toured the Green unit with the Registered Nurse/Unit Manager (RN/UM) and observed the Certified Nursing Aide #1 (CNA#1) in the room of Resident#1 and 2. CNA#1's surgical mask (also called a medical mask) a loose-fitting disposable mask that protects the wearer's nose and mouth from contact with droplets, splashes, and sprays that may contain germs) was not covering her nose and mouth. The surveyor observed that Resident #1 and Resident #2 were not wearing masks. At that time, the RN/UM then instructed CNA#1 to position the mask properly to cover her nose and mouth. The RN/UM further stated that surgical masks should be worn at all times for infection control purposes. The RN/UM said that CNA#1 told her that she was not comfortable wearing the mask. At 9:10 AM, the surveyor and the RN/UM went back to Resident #1 and Resident # 2's room and observed CNA#1 with the surgical mask under her chin. Again, the RN/UM instructed CNA#1 to position the mask correctly to cover her nose and mouth. At 9:16 AM, the surveyor and RN/UM observed Resident #3 in bed with his/her eyes closed. Resident #3's indwelling urinary catheter bag on the floor and was not contained in a privacy bag. The surveyor observed a urinal with a brown colored residue at the bottom hanging on the grab bar in Resident #3's bathroom. The RN/UM stated that the catheter bag should be contained in a privacy bag and hung on the resident's bed's metal frame, not on the floor. The RN/UM further stated that the urinal should have been cleaned and stored in a plastic bag. At 9:20 AM during an interview, CNA#2 stated that Resident #3's indwelling catheter bag should have been in a privacy bag and hung on the lower metal bar of the Resident's bed and that the urinal should have been cleaned and stored in a plastic bag. At 9:26 AM, the surveyor and the RN/UM observed a Housekeeping Staff (HS) leave a room after collecting the trash and, with the same gloves, entered another Resident room bringing the garbage from the first room into the room. The HS then removed her gloves and reached into her uniform to obtain a new pair of gloves without first washing her hands and then took both bags of garbage to the soiled utility room. Simultaneously, the surveyor interviewed the HS, who stated, I did not touch anything in the residents' rooms except the garbage. That's why I didn't wash my hands. The surveyor asked the HS why she brought the garbage from one room to another. The HS did not respond. At 9:44 AM, the surveyor interviewed RN/UM, who stated that the HS should not bring garbage form one room to another and should not use gloves from her uniform pocket because of contamination. She further noted that the HS should know better because of the in-services provided to them about COVID and infection control. At 9:55 AM, the surveyor interviewed CNA#1, who stated, I know I should be wearing a mask all the time, but at times I can't help it, and I have to remove it. She indicated that she received in-services about COVID-19 and the proper use of PPE. At 10:06 AM, the surveyor interviewed the Housekeeping Manager (HM), who stated that the HS received in-services about COVID-19, infection control, proper use of PPE, and proper garbage disposal. The HM further noted that the HS did follow the facility's policy and procedure. The HS should have washed her hands before and after glove use, should not keep gloves in her uniform pockets, and should never bring garbage from one resident room to another to prevent cross-contamination. At 11:35 AM, the surveyor interviewed the RN assigned to Resident #3, who stated that the urinary catheter drainage bag should have been placed inside a privacy bag and hung on the bed railing for infection control prevention. At 11:48 AM, the survey team met with the Administrator, DON, and Vice President of Operations (VPO) and discussed the above concerns. The Administrator, DON, and VPO all verbalized that staff should wear masks when on the units and when providing resident care. The VPO stated that staff should not be storing gloves in their pockets as this was an infection control concern, and the facility provides boxes of gloves in every room. The Administrator, DON, and VPO acknowledged that the indwelling urinary catheter bag should have been inside a privacy bag and hung on the bed, not on the floor, and the urinal should be cleaned after each use and stored in a plastic bag in the Resident's bathroom. At 12:10 PM, the surveyor interviewed the Assistant Director of Nursing (ADON), who stated that she was covering for the Infection Control Preventionist Nurse. The ADON indicated that staff was provided in-service education about COVID-19, infection control, hand hygiene, proper use of PPE, and care of the indwelling urinary catheter. The ADON stated that the staff should always wear masks and not bring garbage from one room to another. Additionally, staff should perform hand hygiene in between the use of gloves, not use gloves stored in uniform pockets, and that indwelling catheter bags should be placed in a privacy bag and hung on the lower bar of the resident's bed, not on the floor. A review of the facility's COVID-19 Use of Facemask Policy with an approved date of 3/26/2020 included, All staff will be required to wear a facemask for the duration of their shift to reduce the risk of potential exposure and transmission of COVID-19 A review of the facility's Catheter Care Policy that the administrator provided, dated 8/24/11, included, Indwelling catheter care will be done at least daily following proper infection control techniques .Provide privacy bag over urinary collection bag. A review of the facility's Handwashing Policy/Procedure with a revised date of 10/2/18 did not include any information about when to change the gloves. A review of the facility's Basic Cleaning Procedures: Procedure for Emptying Trash with a revised date of 3/2016 included, Remove trash bag from the can .Place bag in a proper receptacle on Utility Cart or trash bin. A review of the Strategies for Optimizing the Supply of Facemasks About Coronavirus Disease 2019 (COVID-19) from the CDC dated 3/17/20 included, HCP should leave patient care if they need to remove the facemask. A review of the Hand Hygiene Guidance from the CDC with a review date of 1/30/20 indicated, Healthcare personnel should use an alcohol-based hand rub or wash with soap and water for the following clinical indications: after touching a patient or the patient's immediate environment or contaminated surfaces, .immediately after glove removal. At 1:00 PM, no additional information was provided by the facility. NJAC 8:39-19.4 (a) (1) (5) NJAC 8:39-19.7 (h)

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