STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315524	A. BUILDING _____ B. WING _____	06/22/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LAUREL BROOK REHABILITATION AND HEALTHCARE CENTER	3718 CHURCH ROAD MOUNT LAUREL, NJ 08054

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.** Based on observation, interview, and review of pertinent facility documents, it was determined that the facility failed to follow proper infection control practices for hand hygiene, personal protective equipment (PPE) use, and laundry processing to control the spread of infection in a facility with COVID-19 (COVID) positive residents. This deficient practice occurred for 1 out of 2 units identified as COVID positive units and during clean laundry processing in the laundry department, and was was evidenced by the following: On 06/22/2020 at 11:15 AM, during a tour of the laundry department, in the presence of the Housekeeping Director (HKD), two surveyors observed a laundry room employee (LRE) enter the clean laundry area. The LRE walked over to a large clean laundry cart and removed a clean linen item. During this process, a washcloth fell on to the floor. The LRE picked up the washcloth from the floor and placed it back into the clean laundry cart which contained the remaining clean linen items. The LRE proceeded to fold the linen that was removed from the cart and then place the folded linen onto the folding table. The LRE removed the washcloth, that had fallen on to the floor, from the clean laundry cart and placed it on the folding table next to the folded clean laundry. The LRE removed a white towel from the clean laundry cart, held it against her black shirt, folded it and then placed it on the folding table containing the clean laundry. The LRE removed a white blanket from the clean laundry cart and began folding it. During the folding process, the LRE held the blanket up in the air and the corner of the blanket was dragging on the floor. While folding the blanket in half, the LRE held the blanket against her shirt. She then placed the folded blanket in a pile on the folding table along the side of the clean folded laundry. Upon interview with the surveyors, at that time, with the HKD and LRE, the LRE stated she was sweeping the floor on the washing machine/dryer side before she entered the clean side to fold the laundry. The LRE stated that the hand sanitizer that was normally on the folding table and should be used prior to folding the laundry. The surveyors did not observe hand sanitizer on the folding table and both the LRE and the HKD could not locate the hand sanitizer. The LRE added that she typically wouldn't pick up clean laundry from the floor and place it back in the clean laundry bin because the floor was dirty. The HKD stated that hand sanitizer should be used prior to folding the laundry. At 11:40 AM, the surveyors interviewed the Acting Administrator (AA). The AA stated that hand hygiene should be preformed prior to folding clean linen, and that if linen touches the floor or a staff members uniform, it should not have been placed with the clean linen. If the linen was placed with clean linen and it would all be considered contaminated and should be re-washed. At 11:55 AM, the surveyors interviewed the Infection Prevention Control Nurse (IPCN) who stated that hand hygiene should be performed when entering the laundry room clean side from the washer/dryer side to prevent contamination. The IPCN stated that if laundry touched the floor or a staff members clothing, it would be contaminated and should not be placed in with the clean linen. On 06/22/2020 at 2:00 PM, the surveyors toured the East Unit and interviewed the East Unit Unit Manager (UM). The UM stated there was a plastic zippered wall divider that separated the COVID positive residents from the observation, new admission, and re-admission residents. At 2:15 PM, while on the COVID positive side of the zippered wall divider, the surveyors observed a rehabilitation technician (RT), wearing a N95 respirator mask, enter through the zippered wall divider. The RT pulled the zipper down with his bare hand, donned an isolation gown and gloves, and then entered a resident's room. There were three signs affixed to the outside of the residents closed door. There was a red sign that indicated to, Please see nurse prior to entering room, and two pink signs that read, Special Droplet/Contact Precautions with a stop sign and In addition to Standard Precautions. The Special Droplet/Contact Precautions sign indicated that everyone must clean hands when entering and leaving the room, wear mask, wear eye protection (face shield or goggles), gown and glove at the door. The sign on the door also indicated that PPE should be put ON in the following order: 1. Wash or Gel hands (even if gloves used), 2. gown, 3. mask and eye cover, 4. gloves. At 2:30 PM, the surveyors observed the RT exit the resident's room. During an interview with the surveyors, the RT stated that he assisted the physical therapist to have the resident sit on the edge of the bed. The RT stated that hand hygiene should be performed prior to donning gloves. He also stated, you should have a gown, gloves, mask, and if you have eye protection it should be worn prior to going into the COVID positive rooms. The RT confirmed that he did not have eye protection and he did not wear eye protection when he went into the resident's room. He further stated he was done with his shift for the day and left the unit. At 2:38 PM, the surveyors interviewed the IPCN, who stated that the red signs indicated COVID positive residents were in the room and anyone entering a room with a red sign should perform hand hygiene, put on a gown, wear a face shield or goggles and wear gloves. The IPCN stated that the zipper on the zippered plastic divider wall was potentially contaminated and hand hygiene should be performed after touching it. Review of the Handwashing/Hand Hygiene policy and procedure, revised October 2016, revealed under Policy: that all personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents and visitors. Under Procedure, Applying and Removing gloves: 1. perform hand hygiene before applying non-sterile gloves. Review of the Departmental (Environmental Services)-Laundry and Linen, adopted April 2016, revealed the purpose of the procedure was to provide a process for the safe and aseptic handling, washing, and storage of linen. Under Washing Linen and other Soiled Items: 7. Clean linen will remain hygienically clean (free of pathogens in sufficient numbers to cause human illness) through measures designed to protect it from environmental contamination. 12. perform hand hygiene before handling clean linen (i.e., moving from dryer to sorting table, and through the sorting process). 8:39-19-49 (a)1-2

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