STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315352	A. BUILDING _____ B. WING _____	04/24/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ALARIS HEALTH AT ST MARY'S	135 SOUTH CENTER STREET ORANGE, NJ 07050

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 -** Immediate jeopardy **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, a review of records and other pertinent facility documents, it was determined that the facility failed to ensure: a.) an appropriate cohort tracking/surveillance system for residents that were non-ill and non-exposed to COVID-19, b.) available gowns were easily accessible to nursing and housekeeping staff and were appropriately donned c.) staff assignments were cohorted appropriately to prevent the spread of COVID-19, d.) used gowns were not continuously worn on a staff assignment between caring for residents that were confirmed positive for COVID-19 and residents that were not symptomatic, e.) hand-hygiene was performed after handling soiled linens, f.) appropriate disinfectant agents for the use against COVID-19 were used by the housekeeping staff on the 2nd floor, and that the appropriate disinfectant products were easily accessible to all nursing and housekeeping staff to control the spread of COVID-19 on the nursing units. This deficient practice was identified during tour on 4 of 5 operational nursing units (2nd, 4th, 5th, and 6th Floors) conducted on [DATE]. On [DATE] the surveyor reviewed the facility's COVID-19 outbreak resident and staff line list, infection data tracking/surveillance sheets, and other pertinent documents the facility provided as they related to COVID-19. The documents revealed that there was no system in place to identify or track the resident cohort group who were non-ill/non-exposed to prevent their exposure to [MEDICAL CONDITION]. Upon observation and interview, it was identified that nursing staff and housekeeping staff were provided one gown and one N-95 respiratory mask at the start of their shift, and gowns were not easily accessible on the units where residents who were confirmed and presumed positive for COVID-19 resided. During tour on the designated COVID-19 unit (5th Floor), it was identified that a Certified Nursing Aide (CNA) and a Licensed Practical Nurse (LPN) shared an assignment which consisted of three confirmed positive COVID-19 residents, three residents who were exposed but asymptomatic, and two residents that were identified by the facility as non-ill, non-exposed (Resident #1 and Resident #2). The CNA and LPN were observed each wearing a pink gown coming out of the room of two residents who were identified as non-ill/ non-exposed. The interviews revealed that the CNA and LPN had been continuously wearing the same single-use gown provided to them at the beginning of the shift while caring for both confirmed positive COVID-19 residents and residents who were not ill. Resident #1 on their assignment was identified as non-ill, non-exposed and had a [MEDICAL CONDITION] (a tube surgically placed into a person's windpipe through the neck and allows air to enter the lungs), and medical history that included acute and chronic [MEDICAL CONDITION], dependence on supplemental oxygen, and diabetes mellitus type 2. In accordance with facility provided documents as of [DATE], the surveyors learned that 7 out of 20 residents (35%) who were confirmed positive for COVID-19 had expired between [DATE] to [DATE]. The facility's failure to appropriately identify and track the non-ill, non-exposed resident cohort group, provide available gowns and cleaning disinfectants effective against COVID-19 in an easily accessible manner to nursing and housekeeping staff, and their failure to cohort staff to the designated cohort groups while preventing the continual use of their one-daily allotted gown throughout the shift posed a serious and immediate threat to the safety and wellbeing of all non-ill residents. This resulted in an Immediate Jeopardy (IJ) situation that began on [DATE] at 5:10 PM. The immediacy was removed on [DATE] at 11:34 AM based on an acceptable Removal Plan that was implemented by the facility and verified by the surveyor during an on-site revisit survey conducted on [DATE]. The evidence was as follows: On [DATE] from 9:45 AM to 10:40 AM, the surveyor conducted a COVID-19 focus survey entrance conference with the Director of Nursing (DON), Licensed Nursing Home Administrator (LNHA), and the Regional Registered Nurse (RRN), and interviewed them regarding their COVID-19 outbreak and infection prevention and control measures. At that time, the DON informed the surveyor the facility currently had a COVID-19 outbreak that had an initial onset date of [DATE], and that four new residents had developed symptoms that morning ([DATE]) and were subsequently added to the COVID-19 resident line list (an active cumulative tracking list of symptomatic residents during an outbreak). The DON further added that the Assistant Director of Nursing/Infection Preventionist (ADON/IP) was out sick, and that she was currently assisting in overseeing infection control in the building. The DON stated that the facility's census was currently 125 out of 188-licensed bed capacity. The DON stated that the facility had five operational nursing units which included a specialized ventilator unit on the 2nd floor with a census of 21 of 27-beds. The RRN stated that the ventilator unit was not affected by COVID-19, but all the residents on the unit were on droplet precautions (transmission based precautions in which personal protective equipment including a gown, gloves, mask, and eyewear is used to avoid the spread of infection) as a heightened measure of precaution. The surveyor inquired how the facility was cohorting (treating as a group) their residents and staff assignments. The RRN stated that the 5th floor was designated for residents that were confirmed positive for COVID-19. The DON added that they were monitoring residents that were also symptomatic and presumed positive for COVID-19, and that their roommates were considered possibly exposed to COVID-19. The DON stated that the line list they started included a cumulative list of all residents that were confirmed positive for COVID-19, residents that were symptomatic/presumed positive for COVID-19, and residents that were identified as exposed to [MEDICAL CONDITION] but asymptomatic (no symptoms). The DON stated any resident not on the list was by default, considered non-ill and non-exposed to [MEDICAL CONDITION]. The DON acknowledged that the facility was not tracking the non-ill, non-exposed residents unless they developed symptoms or became exposed by a roommate or staff member, then they would be added to the line list and tracked. The DON could not speak to identifying where the residents that were non-ill, non-exposed were housed throughout the building and their proximity to residents that were confirmed or presumptive positive for COVID-19. The DON suggested that many residents had symptom resolution. The DON provided the surveyor a COVID-19 data tracking sheet dated [DATE], which included that the facility had a cumulative total of 18 residents that were confirmed positive for COVID-19. The sheet included the following data: 15 residents were currently hospitalized , and seven (7) of the 18 residents confirmed positive for COVID-19 had expired. A review of the COVID-19 resident line list updated [DATE] reflected that there was a cumulative total of 20 residents that were confirmed positive for COVID-19. This conflicted with the surveillance data. The DON could not speak to the discrepancy but stated that she knew there were only six (6) residents in the building that were confirmed positive for COVID-19 and 2 of the 6 residents were in recovery. The RRN added that in recovery meant that the resident was asymptomatic for 14 days following their confirmed positive COVID-19 test. The DON continued and stated that the two recovered residents were on the 6th floor in private rooms, and the other four (4) residents who were confirmed positive for COVID-19 and were symptomatic resided on the 5th floor. The DON added that two of the positive COVID residents shared a room, and the other two residents each had their own private room. The RRN added that three groups of residents were placed on droplet precautions: 1. The exposed/asymptomatic residents; 2. The symptomatic residents; 3. The residents were who confirmed positive for COVID-19. The RRN continued that the facility had an adequate supply of personal protective equipment (PPE) including gowns, gloves, surgical masks, N-95 respirator masks, and they had adequate re-usable goggles for eyewear. She stated that at the beginning of each shift Certified Nursing Aides (CNAs), nurses, and housekeepers were provided with PPE by an individual from central supply. She added that gloves and goggles were provided on the unit. The RRN added that to optimize PPE supplies, staff could go from one room that was on droplet precautions to another room that was also on droplet precautions

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 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 1) with the same goggles and gown and that gloves are changed between residents. She did not speak to a process for delineating which rooms were droplet precaution rooms because of a confirmed positive COVID-19 report and which were droplet precautions due to the exposed/asymptomatic residents. At 11:19 AM, the RRN informed the surveyor that PPE will not be seen in bins on the units because staff are each given a brown bag with one gown and one N-95 mask when they walk in. She stated that if the gown gets soiled, then they are to ask for another one. She stated that the facility believed that gowns and masks were being stolen by staff, so they developed the brown bag supply system to prevent PPE from going missing. At approximately 12:00 PM, the DON stated that there were currently 15 of the 125 residents on the census that were currently symptomatic. a. Four (4) of the 15 were confirmed positive for COVID-19; b. four (4) of the 15 were tested for COVID-19 with results pending; c. The remaining seven (7) ill residents had not yet been tested . The DON confirmed that the facility was trying not to float staff but that the vent (ventilator unit) is designated staff. At 12:20 PM, the surveyor entered the 2nd Floor/Ventilator unit with the DON. At that time, the surveyor observed clear plastic PPE bins located on each hallway. There was no PPE stored in the bins outside the resident rooms. The surveyor observed that there were no environmental cleaning agents accessible throughout the unit. At that time, the surveyor observed Housekeeper #1 wearing a white gown, a mask and gloves standing outside a resident room with his housekeeping cart. The door to the room had a sign on it that indicated that the resident was on droplet precautions. Housekeeper #1 stated to the surveyor that he had worked as a housekeeper for [AGE] years and that each floor was assigned their own housekeeper. The surveyor asked if he was always assigned the 2nd Floor/Ventilator unit, and he stated that he was assigned today, but that he floats between floors. He stated that he was responsible for changing trash bags in resident rooms, disinfecting high-touch surfaces and cleaning the floors. The Housekeeper #1 showed the surveyor what disinfecting agents he used when cleaning. One of the products he showed the surveyor was a bottle of pink liquid which was labeled as 3M General Purpose Cleaner No. 8. Housekeeper #1 stated that he used that 3M General Purpose Cleaner No. 8 in droplet isolation rooms to disinfect the floors, resident sinks, walls, and carts. The surveyor asked Housekeeper #1 about the gown he was wearing, and Housekeeper #1 replied that a gown was provided at the beginning of the shift, and that he removed his gown and would replace it with a new one between every resident room. The surveyor asked him where he gets his gowns since they were not accessible in bins, and he stated that after he cleans each room, his supervisor would provide him with a new one from the office. He denied that the process to request a new gown from his supervisor between each resident room was a hardship. He stated that he also ensured he performed vigorous hand hygiene after cleaning each resident room. At 12:26 PM, the surveyor interviewed the Licensed Practical Nurse #1 (LPN #1) on the 2nd floor. LPN #1 stated that at the beginning of her shift, she was provided an N-95 mask and three gowns in a brown paper bag. This contradicted the RRN's statement that one gown and one mask was provided to staff at the start of their shift. LPN #1 stated that the three gowns were provided for her when she had a staff assignment of 11 residents. The surveyor asked her where she kept the other two gowns when they were not in use, and was informed the gowns stayed in the brown paper bag until she was ready to use it. She was unable to show the surveyor that she had any remaining gowns in her brown paper bag that she received that morning. LPN #1 stated that all the residents on her unit were on droplet precautions and that between every resident room used PPE including gowns were supposed to be discarded, but goggles could be disinfected and reused. LPN #1 confirmed the gowns were not accessible on the unit, but that she would ask the DON to get more from the manager's office after each resident interaction. LPN #1 stated that she would monitor the residents on her assignment by taking a set of vital signs and she cleaned the blood pressure cuff between each resident with an EPA-registered wipe. The LPN #1 showed the surveyor that she keeps the wipes locked in the medication and treatment carts on the unit. She acknowledged that they were not accessible to CNA's because they do not have access to the cart keys. At 12:38 PM, the surveyor interviewed CNA #1 on the 2nd floor. She stated at the start of her shift she was given one gown and one mask in a brown paper bag and that she would ask the LPN when she needed a new gown. She acknowledged the gowns were not accessible in the PPE bins. She stated that she would wear goggles in each of the resident rooms and that they could be cleaned with a bleach wipe. The surveyor asked where the bleach wipes were kept, and CNA #1 stated they were locked up in the medication carts with the nurse. She stated that she would have to ask the nurse to get a new gown and bleach wipes to clean the goggles between each resident room. At 12:40 PM, the surveyor interviewed the Registered Nurse/Unit Manager #1 (RN/UM #1) and an Assistant Director of Nursing #2 (ADON #2). The RN/UM #1 and ADON #2 showed the surveyor the manager's office on the 2nd floor where there were 20 gowns stored in a file cabinet. The ADON #2 stated that, we keep them (the gowns) here for better control as a security measure, because the more you see, the more you use. The RN/UM #1 confirmed that gowns needed to be changed between resident rooms on the ventilator unit, and stated that if the 20 gowns ran out, staff would ask for more from the DON. At 12:53 PM, the surveyor entered the 4th Floor with the DON and observed empty, clear plastic PPE bins throughout the hallways. The empty PPE bins each had a handwritten message that read, see nurse for supplies. The surveyor asked the fourth floor RN/UM #2 why there were PPE storage bins throughout the unit if they were all empty, and the RN/UM #2 stated it was just a visual reminder for staff that PPE had to be worn when going into rooms that indicated droplet precautions. She stated that every time a staff member needed to enter the room, she would have to get a gown from her office. The RN/UM #2 indicated the gowns were preserved for source control. The RN/UM #2 informed the surveyor that they had several residents on droplet precautions on the floor, but the residents were all asymptomatic. She stated that there were no residents with a confirmed [DIAGNOSES REDACTED]. At 1:04 PM, the surveyor observed CNA #2 by the nurse's station. CNA #2 was wearing a yellow gown, but it was inappropriately donned. The strap ties used to secure the waist of the gown, were wrapped around and secured behind CNA #2's neck, causing the gown to fall forward, exposing the full back of the CNA. At that time, the surveyor interviewed CNA #2 who stated that she had an assignment of 10 residents and was given one gown and one N-95 mask in a brown paper bag at the start of her shift. This coincided with the information provided to the surveyor by CNA #1 on the 2nd floor. She stated that she applied the gown first thing in the morning and that she had been wearing the same gown continuously throughout the day because this was the only one they gave me this morning. The CNA #2 confirmed there were no gowns easily accessible on the unit. She stated that if she needed another one that she would have to ask a nurse. The CNA #2 also stated that if she needed to disinfect a surface, she would have to ask the nurse for a wipe from the medication cart because it was locked up. At 1:12 PM, the surveyor observed CNA #2 perform hand hygiene and enter a resident's room on the 4th floor who was not on droplet precautions. Because the waist tie of the gown was tied around the neck of CNA #2, the gown was not secure on her body causing the gown to fall forward when reaching. The surveyor observed CNA #2 reposition a lunch tray on the bedside table closer to the resident. As she was standing, she leaned over the resident's bedside table with the lunch tray, used a fork on the resident tray and offered the resident a bite of food. The surveyor observed the gown fall forward from her body and come in direct contact with the bedside table and lunch tray. The resident refused the bite of food, and CNA #2 removed the lunch tray from the room and performed hand hygiene. From 1:04 PM to 1:20 PM, the surveyor observed CNA #2 with the improperly donned gown in the presence of the Unit Manager and DON. CNA #2 was not corrected by the RN/UM #2 or DON regarding the proper application of the gown. At that time, the surveyor, in the presence of the DON, interviewed CNA #2 regarding the method in which she was wearing her gown. CNA #2 stated she applied the gown that way because it doesn't cover the back when she wears it the proper way. The surveyor asked CNA #2 if it was covering her back the way she was currently wearing it, and CNA #2 could not answer. In the presence of the DON, the surveyor observed CNA #2 remove the waist ties around the neck and she tied it around her waist, securing the gown to her body. The DON acknowledged that that CNA #2 did not have the gown properly donned. CNA #2 stated she would get a new gown from her manager. At 1:24 PM, the surveyor observed Housekeeper #2 wearing an N-95 mask, a gown, and gloves. The Housekeeper #2 confirmed that she was the only housekeeper assigned to the unit and the unit had rooms where residents were on droplet precautions. The surveyor asked if she had a face shield or eye wear for protection when entering the droplet rooms. Housekeeper #2 informed the surveyor that she was not given goggles or a face shield adding that they didn't tell me to wear goggles or a face shield. Housekeeper #2 further stated that she cleans the rooms that have no signs first, then cleans the rooms that have signs for droplet precautions last. She stated that she cleans high touch surface areas first in the hallways (handrails and walls) and then in the rooms (side rails, sinks, bathrooms, tables). At 1:29 PM, the Housekeeping Director reported to the 4th Floor and told the surveyor that goggles/face shields are used to protect the eyes from splashes and acknowledged that the housekeeper did not have eye protection. The Housekeeping Director stated that if she needed it, it would be provided. The Housekeeping Director added that all housekeeping staff received in-service training and had competencies regarding PPE use in droplet rooms which included the use of eye protection. At 1:33 PM, the DON and the surveyor entered the 6th Floor. At that time, the RN/UM #3 informed the surveyor that there were two confirmed positive COVID-19 residents on the floor and both were in private rooms. She added another resident tested negative for COVID-19 and was also in a private room. She

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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 2) stated that an additional five (5) residents were also on droplet precautions and in private rooms due to presumed COVID-19 symptom onset, or presumed exposure of COVID-19. She continued to state that all the other residents on the unit were non-ill, non-exposed. The RN/UM #3 stated that all CNA's, nurses and housekeepers were given one gown and one N-95 mask at the beginning of their shift, and added that we guard supplies but the facility was not low on anything; we always have enough PPE supplies. At 1:40 PM, the surveyor observed on the 6th Floor shared PPE bins in the hallway, and the bins had approximately one to two gowns available in them. At 2:08 PM, the surveyor and the DON entered the 5th Floor. At that time, the surveyor interviewed the RN/UM #4 who confirmed that the census on the floor was currently 22 residents. The RN/UM #4 stated that there were four residents on the unit that had tested positive for COVID-19 since initial onset of the outbreak. One of whom recovered on [DATE]. She and the DON continued to describe the condition of the residents who resided on the 5th Floor. They collaborated and confirmed the 5th Floor was made up of residents that were of the following cohort groups: 1. Confirmed positive for COVID-19; 2. Symptomatic and under investigation for COVID-19; 3. Exposed and asymptomatic (without symptoms) for COVID-19; 4. One resident who was confirmed negative for COVID-19 5. Two resident roommates were identified as non-ill and non-exposed to COVID-19 (Resident #1 and Resident #2). The surveyor, RN/UM #4 and DON toured the 5th floor unit. There was no evidence that a disinfectant for the use against COVID-19 was easily accessible on the unit. Further the surveyor observed that all the PPE bins in the hallways were empty and had written signs on them to see nurse for supplies. The RN/UM #4 stated to the surveyor that the reason there was no PPE in the bins was because we don't want to over-use or misuse the PPE. She stated that she could get more PPE if the staff needed it. Upon further observation and interview, the residents who were identified as confirmed positive for COVID-19, presumed positive, and residents who were exposed/asymptomatic all had signs on their door to stop and see nurse and that droplet precautions were needed before entering, however there was no method to delineate the confirmed positives, the symptomatic and under investigation residents, and the residents who were exposed and asymptomatic from each other. At 2:13 PM, the surveyor observed CNA #3 wearing an N-95 mask, a gown and no gloves exiting the room for Resident #1 and Resident #2. CNA #3 was carrying a bag of soiled linen with her bare hands down the hall to the soiled utility room, she punched a numerical key code to open the door, and placed the bag of soioled linen in the soiled laundry container. The CNA #3 stated to the surveyor that the linens were soiled from the resident's room. The CNA #3 then walked down the hallway without performing hand hygiene and turned the corner. At 2:15 PM, the surveyor interviewed CNA #3, who stated that she was employed through a staffing agency, and she believed this was her first time working on the 5th Floor. The surveyor asked CNA #3 about her assignment, and she stated that she had seven residents on her assignment which included Resident #1 and Resident #2 (non-exposed, asymptomatic), two residents that were identified by the RN/UM #4 as being exposed/asymptomatic, and three residents that were confirmed positive for COVID-19. CNA #3 was able to identify the three confirmed positive COVID-19 residents on her assignment and stated one of them was coughing. CNA #3 could not speak to what she would do differently when she cares for the other resident rooms that were on droplet precautions for being exposed/asymptomatic, or when caring for Resident #1 and Resident #2 also on her assignment. The surveyor asked CNA #3 about PPE provisions and utilization. The CNA #3 stated that when she arrived at the facility, they provided her with a brown paper bag with one N-95 mask and one gown. She stated that when the staffing agency sent her to work at this facility she was told the facility would provide the necessary PPE. She stated that because the facility only gave her one gown, I used the same one (gown) all day, because there is only one. The CNA #3 confirmed with the surveyor that she had worn the same gown all day while providing care to the COVID-19 residents, the residents that were exposed and asymptomatic and the non-ill/non-exposed residents (Resident #1 and Resident #2) throughout her shift. She acknowledged that she had just come out of the room for Resident #1 and Resident #2 wearing the same gown she had worn all day. CNA #3 stated that Resident #1 and Resident #2 were not sick and that one of them had a [MEDICAL CONDITION] for breathing. The surveyor asked the CNA #3 when she would change her gown, and she stated only if it ripped or was visibly soiled or after five times. The surveyor asked for clarification of what after five times meant and she stated usually after five times it would be considered soiled. CNA #3 could not answer if the gown she had worn throughout the day was considered soiled. The surveyor asked the CNA #3 how she would get a new gown if she needed one, and the CNA #3 confirmed there were no gowns accessible on the unit, and she stated she would have to ask the nurse. CNA #3 confirmed that she didn't perform hand hygiene after bringing the soiled linens to the soiled utility room, but that she would do it now. At 2:20 PM, the surveyor observed LPN # 2 wearing an N-95 mask covered by a surgical mask, a gown, and gloves, exit the room for Resident #1 and Resident #2. There was no evidence that these residents were on transmission-based precautions. LPN #2 went to the sink by the nurse's station and washed her hands. At that time, the surveyor interviewed LPN #2. LPN #2 stated that her assignment included the same assignment as CNA #3, and consisted of three confirmed positive COIVD-19 residents, two residents who were exposed/asymptomatic and Resident #1 and Resident #2 who were non-ill and non-exposed. She stated that one of the resident's that was confirmed positive was displaying symptoms of active coughing. The surveyor asked LPN #2 about PPE provisions and utilization. The LPN #2 stated that she was given one gown and one N-95 mask at the beginning of the shift. She stated that when she goes into the droplet precaution rooms, she would apply goggles, gloves and that she already had her gown and N-95 mask on. She further stated that when she was done in the droplet precaution room, she would remove the gloves and goggles and perform hand hygiene. She stated that the goggles were kept at the nurse's station with the RN/UM #4 and were disinfected between use. The surveyor asked about the gown. The LPN #2 stated that, if it's soiled, then we have to change it. The surveyor asked what she means by soiled and the LPN #2 clarified that if anything poured on it, like urine--something visible--you can see it, then it's visibly soiled. She stated then it would get changed, but otherwise you don't have to change it. The LPN #2 continued that she had been wearing the same gown all day because it was the only one given to her at the beginning of the shift. She confirmed it was not visibly soiled, so she didn't need to change it today. The LPN #2 confirmed there were no gowns easily accessible on the unit and stated that she would have to get a new gown from the RN/UM #4 if she needed another one. The LPN #2 acknowledged there was nothing she would do different between the resident rooms, except that Resident #1 and Resident #2 didn't need droplet precautions because they were not sick. LPN #2 confirmed that Resident #1 had a [MEDICAL CONDITION] and needed access for supplemental oxygen delivered through a wall portal. At 2:30 PM, the DON confirmed with the surveyor that Resident #1 had a [MEDICAL CONDITION] and required access for supplemental oxygen. She stated that not all units had an oxygen wall portal, but she confirmed the facility had oxygen tanks and other means to provide supplemental oxygen if an oxygen wall portal was not available. The DON confirmed Resident #1 and #2 were roommates and were not on the infection line list, and therefore by default, were non-ill, non-exposed. The surveyor asked the DON about staff assignments, and the DON acknowledged that CNA #3 and LPN #2 should not have three different cohort groups on the same assignment. At 2:38 PM, the surveyor interviewed the RN/UM #4 a second time in the presence of the DON. The RN/UM #4 stated that all staff receive one gown and one N-95 mask at the start of their precautions on my floor. She further stated they need to be disinfected and re-used between staff often. The surveyor asked about the gown use on the floor, and the RN/UM #4 stated that the staff were given a gown at the beginning of their shift, and she would replace their gown if it became visibly soiled, wet, broken, torn, or dropped on the floor. She continued that the gowns don't have to be removed .they keep it on except if it was broken. The RN/UM #4 added that all residents are quarantined in their rooms, and CNA #3 and LPN #2 were to start their assignment with the residents who were well first, specifically Resident #1 and Resident #2, then end with the residents that had symptoms or were positive for COVID-19. The RN/UM #4 confirmed that there would be times that staff would need to re-enter the rooms for Resident #1 and Resident #2 after assisting the residents who were confirmed positive for COVID-19. At 2:42 PM, the RN/UM #4 and the DON acknowledged that if CNA #3 and LPN #2 weren't removing their used gowns before re-entering the rooms and assisting Resident #1 and Resident #2 in any way, those residents may now be exposed to [MEDICAL CONDITION]. A review of the 5th Floor Assignment Sheet dated [DATE] reflected CNA #3 and LPN #2 had the assignment for the two non-exposed, asymptomatic residents (Resident #1 and Resident #2) and two residents that were identified by the RN/UM #4 as being exposed/asymptomatic, and three residents that were identified as confirmed positive for COVID-19, one of which was reported to be actively coughing. The surveyor reviewed the Admission Record face sheet (an admission summary) for Resident #1, who was identified to be non-exposed and asymptomatic as of [DATE]. The record indicated that the resident had [DIAGNOSES REDACTED]. A review of the [DATE] electronic Medication Administration Record [REDACTED]. The resident was also on a medication for [MEDICAL CONDITION] (irregular heart rate that causes poor blood flow). The surveyor reviewed the Admission Record face sheet for Resident #2 who was the roommate of Resident #1 and was identified to be non-exposed and asymptomatic as of [DATE]. The record indicated that the resident had [DIAGNOSES REDACTED]. A review of the [DATE] eMAR for Resident #2 revealed that LPN #2 administered medications to Resident #2 in accordance with the LPN's assignment at 8 AM and 9 AM, respectively. At 3:40 PM, the surveyor observed the central supply of PPE located in the office of the Licensed

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ALARIS HEALTH AT ST MARY'S	**135 SOUTH CENTER STREET ORANGE, NJ 07050**

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 -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 3) Nursing Home Administrator (LNHA). The LNHA stated in the presence of the DON and RRN that they have an adequate supply of gowns, and there were shipments of gowns from various sources every other day. The LNHA stated that they currently had approximately 300 gowns on hand which was plenty. The surveyor asked why the gowns weren't available on the units, specifically the 5th floor where there were residents of various cohorts and shared st