STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315290	A. BUILDING _____ B. WING _____	05/01/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BUCKINGHAM AT NORWOOD, THE	100 MCCLELLAN STREET NORWOOD, NJ 07648

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 and review of other pertinent facility documentation, it was determined that the facility staff failed to provide a safe environment to prevent the potential spread of infection by assuring that infection control practices were followed in accordance with the Centers for Disease Control during an outbreak of a [MEDICAL CONDITION] Covid-19 by; a.) safeguarding residents from the risk of infection by utilizing appropriate personal protective equipment (PPE); and b.) obtaining and providing staff with appropriate PPE during care and services for a resident with transmission based precautions to prevent the spread and exposure to the Covid-19 virus. On 04/29/2020 at 9:30 am, the surveyor toured the 1st floor of the facility and observed beauty shop services being provided to a resident. The beauty shop was located off the resident's living unit in a common area. The resident (Resident #1) was receiving beauty shop services in close proximity to the service provider (Beautician). The Beautician was observed curling Resident #1's hair and wearing a surgical mask pulled under her chin not covering her nose or mouth. The surveyor observed that the resident was not wearing a face-mask. According to the facility this service continued to be provided 2 to 3 times a week to 18 various residents from 3/24/2020 to 4/29/2020. There was no policy or adherence to abate these services during this time of possible Covid-19 virus exposure. On 04/29/2020 at 11:16 am, the surveyor toured the 3rd floor Penthouse Unit and observed two Certified Nursing Assistants (CNA's) applying (donning) large clear plastic garbage bags in preparation to enter a resident's room (316) who was reported to the care staff as being presumptive positive for the Covid-19 virus infection. The facility has adequate supply of PPE, however no request was made by the Licensed Practical Nurse (LPN) or CNA's to ensure that there was provision and proper utilization of appropriate PPE. The LPN stated to the surveyor that he entered the room earlier in the day with only a mask and gloves, but still did not request PPE provision. In accordance with a facility document dated 04/29/2020, titled: (Covid-19 Facility Outbreak Reporting Daily Survey) the surveyor learned that the facility had 28 Covid-19 positive residents and 5 presumptive (PUI's) residents. The Director of Nursing (DON) stated that there were 9 resident deaths associated with [MEDICAL CONDITION] and 45 staff members who contracted [MEDICAL CONDITION]. She also added that 44 staff members recovered and 1 remained hospitalized . The facilities failure to ensure residents and staff safety from exposure to a [MEDICAL CONDITION] Covid-19 during an outbreak by not applying and implementing appropriate PPE during care or services and not following infection control protocols for PPE, posed a serious and immediate threat to the safety and well-being of residents residing in the facility and staff caring for residents who could transfer the infection This resulted in an Immediate Jeopardy (IJ) situation began on 04/29/2020 at 5:32 pm, and the immediacy was removed on 04/30/2020 at 12:30 pm, based on acceptable IJ Removal Plan. This deficient practice was identified during a tour on 1st floor common area and on 1 of 6 nursing units (3rd floor Penthouse) conducted on 04/29/2020 and was evidenced by the following: a.) During a tour of the 1st floor common area on 04/29/2020 at 9:30 am, accompanied by the ADON, the surveyor observed a Beautician performing beauty services on Resident #1's hair. The Beautician was applying curlers in the resident's hair in closed proximity to the resident and was observed wearing a surgical mask pulled under her chin with her mouth and nose exposed. The surveyor observed the resident was not wearing a face-mask. On 04/29/2020 at 9:32 am the surveyor interviewed the ADON who stated that the Beautician should be wearing the mask appropriately to cover her nose and mouth while performing beauty services. She also stated that the resident should also be wearing a mask. At this time the ADON asked the Beautician to apply the mask correctly to cover her nose and mouth and then offered Resident #1 a mask to wear which the resident accepted. On 04/29/2020 at 9:40 am, the surveyor interviewed the Beautician who stated that the facility did educate her on Covid-19 and that she should always wear a mask when in contact with a resident because masks help stop the spread of infection. She said that only one resident was allowed in the beauty salon at a time. She also added that she was not aware that resident was required to wear a mask during beauty services and that she did not have extra mask in the beauty salon to offer residents. She admitted that she put her mask down and had her mouth and nose uncovered because she sometimes gets hot. On 04/29/2020 at 9:45 am, the surveyor interviewed the ADON who stated that the beautician should have followed infection control and surveillance and that the hairdresser and the resident were to be wearing masks. On 04/29/2020 at 10:10 am, the surveyor interviewed the Administrator who stated that residents were able to get their hair done and that only one resident is allowed in the hair salon at a time. He added that services have not stopped since the outbreak of Coronavirus. He further stated that beauty shop services were decreased and that residents were still able to get beauty shop services 2-3 times a week at various times. He stated that the beautician was in-serviced on infection control multiple times and that she should always have had the mask on appropriately and she should also be applying masks to the residents when performing services. I'm really surprised because as she was just in serviced yesterday on infection control. On 04/29/2020 at 12:30 pm, the surveyor interviewed the DON, who was also the Infection Preventionist, who stated that the beautician was educated on infection control. Wearing a mask while performing services on residents and ensuring residents wear a mask was reviewed. She also stated that all staff were educated on wearing masks, appropriate handwashing, donning (applying) and doffing (removing) PPE and wearing gloves. The staff had to do return demonstration to assure that it was done correctly. The DON added that there was not a facility policy on hairdressing. On 04/29/2020 at 3:05 pm, the surveyor interviewed Resident #1 who stated that when he/she was in the beauty salon this morning she was not offered a mask until surveyor inquiry. The facility provided the surveyor with a list of dates that the Beautician provided beauty services to the residents. Residents were provided with beautician services on the following dates: On 3/21/2020, services were provided to 3 residents On 4/1/2020, services were provided to 6 residents. On 4/23/2020, services were provided to 5 residents. On 4/28/2020, services were provided to 2 residents. On 4/29/2020, services were provided to 2 residents. The facility Administrator and DON provided the surveyor with a resource guide that the facility was following titled, Covid-19 Toolkit of Resources for Long Term Care Facilities Version 2 1 dated April 10,2020. -The resource guide page 5 indicated that resident movement in the facility should be restricted to the extent possible and that all communal dining and all group activities such as internal and external group activities (e.g., physical therapy, beauty shop) be canceled. It also indicated that all residents whether they have Covid-19 or not should cover their nose and mouth when around others. Alternate means of entertainment should be explored to engage residents and comply with social distancing orders. -The resource guide page 12 indicated that facility was to restrict visitors and non-essential healthcare personnel, except in certain [MEDICATION NAME] care situations. -The resource guide page 14 indicated that the facility was to implement use of universal facemask (i.e., source control) for staff while in the facility. b.) On 04/29/2020 at 10:10 am, the surveyor interviewed the Administrator who stated that he was in constant contact with the Local Health Department (LHD) and the Office of Emergency Management (OEM) in regard to obtaining PPE. He stated that he had received boxes of PPE from OEM such as gowns, face shields, N95 mask, surgical mask and hand sanitizer. On 04/29/2020 at 10:30 am, the surveyor accompanied the Administrator to the storage areas and observed boxes of PPE such as gloves, gowns, face mask and face shields that were available for staff use. On 04/29/2020 at 11:16 am, the surveyor toured the 3rd floor Penthouse Unit and observed one CNA wearing a clear plastic trash bag and another CNA donning

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) (applying) a trash bag to enter a resident's room. The surveyor stopped the CNA at this time to be interviewed. The CNA stated that she was the primary care CNA for the resident in room [ROOM NUMBER] (private room). She indicated that she did not have any isolation gown to put on and that she was wearing the trash bag to be safe. She then added that there was a sign on the door of room [ROOM NUMBER] and that the nurse told her that the resident in that room may have the Coronavirus. The nurse didn't give me an isolation gown and did not set up an isolation cart, so I wear a trash bag when I go into the residents room. They should give us gowns to be safe. I wear a mask and gloves all the time. On 4/29/2020 at 11:20 am, the surveyor interviewed the Licensed Practical Nurse (LPN) who was assigned to the resident in room [ROOM NUMBER] who was demonstrating symptoms of Covid-19. The LPN stated that the resident developed a productive cough and had presumptive signs and symptoms (s/s) of [MEDICAL CONDITION] Covid-19 during the 11 pm to 7 am shift. The LPN could not give a specific reason why there was not an isolation cart set up in front of the resident's room with appropriate PPE such as isolation gowns, gloves, and masks if the resident had presumptive s/s of [MEDICAL CONDITION]. The LPN then stated that the CNA's never asked him for PPE and that he did not know why they were wearing trash bags as PPE instead of the proper isolation gowns. He said that the Administrator or the DON supplied the PPE but admitted that he did not notify them that PPE was needed for this resident. The LPN then revealed that he went into the room earlier with only a face mask and gloves and stated he should have worn the appropriate PPE such as an isolation gown. He further stated, I did not apply an isolation gown when I went into the room, I only wore a mask and gloves. I guess I should have gotten the PPE or called someone to get it. On 04/29/2020 at 12:30 pm, the surveyor interviewed the DON who provided the surveyor with a timeline of events that described the failure of the nurse to obtain appropriate PPE on 4/29/2020 for staff usage in the care of a resident with potential Covid-19 to prevent the spread of infection. The timeline indicated that on 4/29/2020, the 7 am-3 pm nursing staff did not request gowns upon arrival to the unit and that the CNA's opted to wear the garbage bags as PPE because they were aware that this resident had symptoms for Covid-19. The DON stated that all staff were educated on hand hygiene, wearing mask and donning and doffing (removing) PPE. The DON also added that the facility had plenty of PPE if they needed it. On 04/29/2020, the surveyor reviewed the facility's Infection (Outbreak Response and Investigation) which indicated that symptomatic residents will be considered potentially infected, assessed for immediate needs, and placed on empiric precautions while awaiting physician's orders [REDACTED]. The resource guide page. 5 indicated that for suspect or confirmed Covid-19 cases Standard and Transmission-based precautions including use of a N95 respirator (or facemask, if unavailable), gown, gloves and eye protection is recommended. This IJ situation that began on 04/29/2020 at 5:32 pm, and the immediacy was removed on 04/30/2020 at 12:30 pm, based on acceptable Removal Plan which included the following: 1.) Beauty shop services were suspended as of 04/29/2020, and the Beautician was re-educated on the proper utilization of PPE during care and services with residents that mask must always be worn properly during such interaction. The Beautician demonstrated competency of wearing mask appropriately during care services with residents. The employee was given written warning and suspended pending investigation for non-compliance of wearing mask appropriately on 04/29/2020. 2.) The Assistant Director of Nursing (ADON) provided education with staff regarding the importance of safeguarding all residents with the risk of Covid-19 while providing care and services on 4/29/2020. 3.) The CNA's were given proper PPE and verbally re-educated by the ADON on the process of obtaining PPE in a timely manner and appropriate use of PPE on an undiagnosed presumptive infected resident on 04/29/2020. Re-education was confirmed by return demonstration (donning and doffing PPE) on 04/29/2020. 4.) All staff is re-educated on the proper utilization and use of PPE on 04/29/2020. The implementation of the Removal Plan was verified on site on 05/1/2020 at 11:15 am. On 5/1/2020 at 9:10 am, the surveyor toured all the units and verified though observation, interviews with facility staff and review of in-service education that the IJ Removal Plan had been implemented. NJAC 8:39-19.4; 27.1 (a)