STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315248	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ANDOVER SUBACUTE AND REHAB II	**99 MULFORD ROAD ANDOVER, NJ 07821**

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

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F 0584 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	**Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.** Based on observations, interview and record review on 2/26/20 and 2/27/20, it was determined that the facility failed to provide a clean and comfortable physical environment in 4 of 10 resident sleeping units. This deficient practice occurred on the 1st floor North & East Wing, the 3rd floor North & West Wing and was evidenced by the following findings: On 2/26/20 from 12:15 PM to 1:45 PM, the surveyor observed, in the presence of the facility's Maintenance Director, a darkened substance on the floors of 17 of 17 resident rooms on the 1st floor North Wing and 18 of 18 resident rooms on the 1st floor East Wing. The surveyor determined that the substance was dirt and old floor finish that had accumulated at the bottom corners of each doorframe to the resident's room due to ineffective floor maintenance. The facility's Maintenance Director acknowledged and confirmed this finding in an interview during the observation and stated that this was a housekeeping concern. The facility provided a monthly project schedule which indicated that floor corners and edges on the 1st floor were cleaned every Monday between 11:00 PM and 7:00 AM. According to this schedule, the last project cleaning should have occurred on [DATE] 11:00 PM to 7:00 AM (2 days prior). The degree of accumulation of dirt and old floor finish observed indicated that the scheduled cleaning did not occur or was not properly done. During a tour of the 3rd floor North Wing on 2/27/20 at 10:20 AM, the surveyor observed in the presence of the facility's Maintenance Director, the protective lens cover for the overbed lights in 3 of 20 resident rooms were missing. This was observed in resident rooms 315 (bed A), 318 (bed A) and 320 (bed A). An interview with the Maintenance Director at 1:30 PM revealed that the lens covers were discontinued, no longer available and the facility was currently in the process of upgrading all light fixtures. At 2:00 PM, the Maintenance Director provided a brochure from a vendor for new lighting. At 2:15 PM, the facility's Administrator revealed in an interview that the facility was not able to provide a purchase order or sales contract for new lighting. During a tour of the 3rd floor West Wing on 2/27/20 at 10:40 AM, the surveyor observed in the presence of the facility's Maintenance Director, the protective lens cover for the overbed lights in 1 of 20 resident rooms was missing. This was observed in resident rooms 313 (bed B). At 10:54 AM on 2/27/20 in the presence of the Maintenance Director the surveyor observed an unidentified black substance clinging to the ceramic tile ceiling in 1 of 2 community shower rooms located on the same wing. This was observed in the Female Shower room. Also, the 4 shower stalls in the same shower room was observed by the surveyor to have an unidentified blackened substance on the wall/floor juncture of the perimeter of each stall. The Maintenance Director acknowledged and confirmed this finding in an interview during the observation and stated that the shower room's poor ventilation had caused these issues. NJAC 8:39-31.2(e) and 31.4(a)
F 0623 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, it was determined that the facility failed to provide written notification of an emergency transfer to the resident or resident representative for 2 of 2 residents (Resident # 362, and #282) reviewed. This deficient practice was evidenced by the following: 1. The surveyor reviewed Resident #362's medical record. The Minimum Data Set (MDS) tracking sheet indicated that the resident was transferred out of the facility on 12/13/19. There was no evidence of written notification identified or provided. 2. The surveyor reviewed Resident #282's medical record. The Admission Record indicated the resident was transferred out to the hospital on [DATE]. There was no evidence of written notification identified or provided. On 3/4/20 at 11:21 AM, the surveyor interviewed the Director of Social Services, who stated that the aforementioned resident's representatives were verbally notified of an emergency transfer, but that this was not done in writing. On 3/4/20 at 1:30 PM, the surveyor discussed the above concerns with the Administrator and the Director of Nursing (DON). The Administrator acknowledged that the aforementioned resident's representatives were verbally notified of an emergency transfer only. There was nothing provided in writing. On 3/5/20 at 1:00 PM, no further information was provided by the facility. NJAC 8:39-27.1 (a)
F 0640 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, it was determined that the facility failed to complete and transmit a Minimum Data Set (MDS) in accordance with federal guidelines. This deficient practice was identified for 1 of 1 resident (Resident #1) reviewed for resident assessment and was evidenced by the following: On [DATE] at 9:30 AM, the surveyor reviewed the facility assessment task that included the Resident's MDS Assessments. The MDS is a comprehensive tool that is a federal mandated process for clinical assessment of all residents that must be completed and transmitted to the Quality Measure System. Resident #1 was triggered under the survey facility task as MDS record over 120 days old. Review of Resident #1's medical record revealed that the resident expired in the facility on [DATE]. The surveyor reviewed the MDS 3.0 assessment tool, including all the completed MDS assessments for the resident. The MDS assessment history revealed that the Death in Facility tracking record for Resident #1 was not submitted until [DATE]. MDS Death in Facility assessments must be submitted no later than 21 days after expiration. On [DATE] at 2:00 PM, the surveyor discussed the above concern with the Administrator and the Director of Nursing (DON). The DON acknowledged that the assessment was not submitted timely in accordance with the federal regulations. NJAC 8:,[DATE].2
F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined that the facility failed to ensure that the Registered Nurse (RN) assessed the resident after the resident fell , as per the nursing standards of clinical practice. This deficient practice was identified for 3 of 6 residents (Resident #298, 130, and 361) reviewed for falls. This deficient practice was evidenced by the following: Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board The Nurse Practice Act for the State of New Jersey stated, The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally

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F 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) authorized physician or dentist. Reference: New Jersey Administrative Code, Title 13, Law and Public Safety, Chapter 37, New Jersey Board of Nursing, under 13:37-6.5 Non-Delegable Nursing Tasks, includes: A registered professional nurse shall not delegate the physical, psychological, and social assessment of the patient, which requires professional nursing judgment, intervention, referral, or modification of care. Reference: New Jersey Statutes, Annotated Title 45, Chapter 11. Nursing Board The Nurse Practice Act for the State of New Jersey stated, The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case-finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist. 1. On 2/26/2020 at 10:01 AM, the Licensed Practical Nurse (LPN) informed the surveyor that Resident #298 was cognitively intact and on fall precautions. On 2/28/2020 at 12:09 PM, the surveyor observed the resident seated in a wheelchair in front of the nursing station with other residents. On 2/28/2020 at 11:18 AM, the Fall Coordinator/Licensed Practical Nurse (FC/LPN) informed the surveyor that resident #298 had fallen twice on [DATE] at 3:25 AM and 7:20 AM. The 3:25 AM fall occurred when the resident slid off the wheelchair while trying to go to the bathroom. The resident sustained [REDACTED]. The second fall at 7:20 AM was documented that the resident was found sitting on the floor in their room. The resident sustained [REDACTED]. Both falls were investigated, and it was an LPN who assessed the resident at the time of the fall. On that same date and time, the FC/LPN told the surveyor an RN should have completed the fall assessment. The FC/LPN could not speak as to why the RN did not assess the resident at the time of the fall or after the fall. A review of Resident #298 Face Sheet (an admission summary), identified that the resident had [DIAGNOSES REDACTED]. A review of the 1/16/2020 Significant Change Minimum Data Set (SMDS), an assessment tool used to facilitate the management of care, indicated a Brief Interview for Mental Status (BIMS) score of 15, which reflected that the resident's cognition was intact. The SMDS also documented that the resident had fall incidents. A review of the Occurrence Report for the fall incident provided by the Director of Nursing (DON), reflected that the resident had fall incidents on [DATE] at 3:25 AM and 7:20 AM. A review of the above Occurrence Report showed that the Fall Assessments were both completed by an LPN. Further review of the medical records, reflected there was a lack of documentation that the resident was assessed by an RN on [DATE] at 3:25 AM or 7:20 AM, after the resident's fall. On [DATE] at 12:37 PM, the LPN informed the surveyor that Resident #298 had a fall incident on [DATE], and he was the assigned nurse at that time of the fall. He stated, I called Code 99, and the LPN Supervisor came, and we both assessed the resident. The LPN could not speak to why the resident was not assessed by an RN at the time of the fall or post-fall. On that same date and time, the LPN informed the surveyor that there was no injury at the time of the fall. 2. On 2/26/2020 at 10:30 AM, the surveyor observed Resident #130 independently ambulating in the hallway. A review of the resident's Face Sheet indicated that the resident had [DIAGNOSES REDACTED]. Review the Quarterly MDS, dated [DATE], reflected that the resident had a BIMS score of 00, which indicated severe cognitive impairment. Review of Resident #130's Care Plan revealed that the resident had been pushed onto the floor by another resident on 2/9/20. A review of the Investigation Report dated 2/9/20, provided by the DON, revealed that a Certified Nursing Assistant (CNA) witnessed another resident push Resident #130 who had been walking in the hallway at the time. The Investigation Report indicated that an LPN assessed Resident #130. The report further indicated that Resident #130 did not sustain any injuries. 3. On 2/26/20 at 10:17 AM, the surveyor observed Resident # 361 independently ambulating in and out of the room. A review of the resident's face sheet indicated that the resident had [DIAGNOSES REDACTED]. A review of the Quarterly MDS dated [DATE], reflected that the resident had a BIMS score of 99, which indicated severe cognitive impairment. A review of the Investigative Report dated 12/25/19, provided by the DON, revealed that Resident #361 was observed by a Certified Nursing Assistant to be sitting in the dayroom with their upper lip bleeding. A unit LPN assessed the resident to have a laceration of the upper lip. The resident was then sent to the emergency room for treatment. The facility investigation concluded that the resident was unable to explain what had happened due to their cognition and that a fall could not be ruled out. On [DATE] at 1:31 PM, the survey team met with the DON and the Administrator and discussed the above observations and concerns. The DON informed the surveyors that an RN should have completed the fall assessment. The DON further stated that the staff probably forgot to call the RN at the time of the fall or injury. The DON suggested that this most likely why the RN didn't complete the assessment. A review of the Occurrence Report for Fall Policy with a revised date of 12/11/19, provided by the DON, indicated that a Licensed Nursing Staff would assess a resident for injuries before moving the resident in case of fall. The Occurrence Report for fall Policy did not specify that an RN would be responsible for assessing the resident at the time of the fall or post-fall. NJAC 8:39-11.2 (b); 27.1(a)
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, it was determined that the facility failed to consistently apply pressure ulcer prevention boots as ordered by the physician. This deficient practice was identified for 1 of 2 residents (Resident # 363) reviewed for Pressure Ulcer/Injury, and was evidenced by the following: The surveyor reviewed the medical record for Resident # 363. According to the face sheet (an admission summary), the resident was admitted to the facility on [DATE] and had [DIAGNOSES REDACTED]. A review of the Quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated 12/11/19, reflected that the resident had a brief interview for mental status (BIMS) score of 00 out of 15 which indicated severe cognitive impairment. A review of the Braden Scale (an assessment tool used to determine the risk for pressure ulcer) dated 1/9/20 reflected a score of 12, indicating the resident was at high risk for the development of pressure sores. A review of the physician's orders [REDACTED]. May remove for hygiene and skin check. A review of the resident's individualized care plan dated 1/28/10 reflected that the resident had a potential for impairment to skin integrity related to incontinence and impaired mobility. The care plan had interventions to maintain skin integrity, which included heel booties at all times. The corresponding physician order [REDACTED]. On 3/2/20 at 10:09 AM, the surveyor observed the Certified Nursing Assistant #1 (CNA #1-primary CNA for Resident #363)) and the Registered Nurse (RN) remove the covers from resident to position the resident for a wound care treatment. The Medi boots were not in use when the CNA #1 and RN uncovered the resident. During the conclusion of the 3/2/20 wound care treatment observation, CNA #1 and the RN did not apply the Medi boots to the resident's feet. On 3/3/20 at 10:16 AM, the surveyor observed Resident #363 sitting in a Geri-chair with both feet exposed and resting on the surface of the footrest. There were no Medi boots observed on the resident. On 3/3/20 at 10:18 AM, the surveyor interviewed the unit manager Licensed Practical Nurse (UM/LPN), who confirmed that resident #363 should have bilateral Medi Boots on at all times. She accompanied the surveyor to the resident room and acknowledged that the Medi boots were not applied. On 3/3/20 at 10:19 AM, the surveyor and the CNA#2 (a floater- assigned to different units and not familiar with the resident) entered Resident #363's room to search for the boots and found one boot hanging on the wall, and one boot was in the closet. She stated that she did not see any boots in the room when she provided AM care this morning and that she was not aware that the resident had to have boots in place. She further stated that she could have checked the care plan or asked the nurse. On 3/4/20 at 10:32 AM , the surveyor interviewed the CNA#1, who stated that she had forgotten to apply the boots the day she was observed in wound care and that she always applies the boots after AM care. On 3/5/20 at 9:09 AM, the survey interviewed the Director of Nursing, who stated that if there was a physician order [REDACTED]. NJAC: 8:39.27(a)
F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, it was determined that the facility failed to maintain the necessary respiratory care and services of a resident who was receiving continuous high flow oxygen according to the standard of practice. This deficient practice was identified for 1 of 2 residents (Resident #21) and evidenced by the following: A review of the resident's Face Sheet (an admission summary), reflected that the resident was admitted to the facility with [DIAGNOSES REDACTED]. A review of the 11/22/19 Quarterly Minimum Data Set, an assessment tool used to facilitate the management of care, indicated that the resident's cognitive skills for daily decision making were independent, which meant that the resident's cognition was intact. The QMDS indicated that the resident was on oxygen therapy. On 2/27/2020 at 8:55 AM, the surveyor observed Resident #21 seated in bed awake and with oxygen in use at 6 liters per minute (6 LPM) via nasal cannula (NC) attached to a concentrator. There were two concentrators in use at 6 LPM via NC attached to one nasal cannula via Y tubing going to the high flow humidified machine. The resident informed the surveyor that the facility used two oxygen concentrators (both concentrators) set at 6 LPM via NC for a long time and said, I'm comfortable, and I need it. On 2/28/2020 at 12:15 PM, two surveyors observed the resident in their room utilizing oxygen via NC with the same set up

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F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) observed on 2/27/2020. On that same date and time, the surveyors interviewed the Licensed Practical Nurse (LPN). The LPN informed the surveyors that the resident was on hospice, on continuous oxygen, and tolerating it well. The LPN further stated that the resident should have been monitored for oxygen saturation. Resident #21 was using an AIRVO-2 high flow oxygen machine. The AIRVO-2 manual indicated that appropriate patient monitoring must be used at all times. The surveyor reviewed the February 2020 physician's orders [REDACTED]. The corresponding physician order [REDACTED]. Further review of the resident's medical records showed that there was no documented evidence that the resident's oxygen saturation was monitored and documented. On [DATE] at 1:31 PM, the survey team met with the Administrator and the Director of Nursing (DON) and discussed the above observations and concerns. On that same date and time, the DON stated that the oxygen saturation of the resident should have been monitored and documented every shift in the Medication Administration Record [REDACTED]. On 3/4/2020 at 1:29 PM, the survey team met with the Administrator and the DON. There was no additional information provided. A review of the Oxygen Therapy via Concentrator Policy, having an update date of [DATE], provided by the DON did not contain information about monitoring of oxygen saturation. NJAC 8:39-11.2 (b); 27.1(a)
F 0880 **Level of harm** - Minimal harm or potential for actual harm **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 record review, it was determined that the facility staff failed to: a.) adhere to accepted standards of infection control practices for the proper storage of a nebulizer mask for 1 of 1 resident (Resident #425) reviewed for respiratory treatment; b.) proper handling and storage of indwelling catheter bag for 3 of 3 residents (Resident #163, 425 and 455) reviewed for a catheter; and, c.) use the required personal protective equipment (PPE) and perform handwashing to prevent the spread of infection on a resident with transmission-based precautions for 1 of 1 resident (Resident #363). This deficient practice was evidenced by the following: 1. On 2/27/2020 at 8:36 AM, the surveyor observed Resident #425 seated in bed with a nebulizer mask directly touching the top of the nightstand. The nebulizer mask was dated 2/10/2020. A review of Resident #425's Face Sheet (an admission summary), reflected that the resident was admitted to the facility with [DIAGNOSES REDACTED]. A review of the 1/31/2020 Quarterly Minimum Data Set (QMDS), an assessment tool used to facilitate the management of care, indicated a Brief Interview for Mental Status (BIMS) score of 11, which reflected that the resident's cognition was moderately impaired. The QMDS indicated that the resident was on respiratory treatment and had an indwelling urinary catheter. On 2/27/20 at 8:36 AM, the Certified Nursing Assistant (CNA) was inside the resident's room and informed the surveyor that the resident was cognitively impaired. The CNA stated that the resident was probably on a nebulizer treatment as needed. On 2/28/2020 at 8:36 AM, the surveyor observed Resident #425 lying in a low bed with an indwelling catheter directly touching the floor without a privacy bag. Also, the nebulizer mask dated 2/10/2020 was observed directly touching the nightstand table. On 2/28/2020 at 8:38 AM, the Licensed Practical Nurse #1 (LPN#1) informed the surveyor that the resident was cognitively impaired, required total assistance with activities of daily living (ADLs), and unable to move without staff assistance. On that same date and time, LPN#1 and the surveyor went inside the resident's room. LPN#1 stated, I don't know why the catheter bag was on the floor, and it should be inside a privacy bag for infection control. He further stated that the nebulizer mask should also be inside a plastic bag for infection control when not in use. At that same time, the surveyor observed LPN#1 grab the mask that was directly on the top of the nightstand and placed it inside a plastic bag. He told the surveyor that 2/10/2020 was the date this particular mask was first used. On that same date at 8:50 AM, the CNA had no answer to why the indwelling catheter bag was directly touching the floor. She stated that the catheter bag should not be on the floor as that is an infection control issue. On [DATE] at 8:52 AM, LPN#2 informed the surveyor that she was the 11-7 shift nurse who was responsible for changing the nebulizer mask every Monday and Thursday for Resident #425. She further stated, We nurses are not perfect. I probably missed and forgot to change the neb mask of the resident. She indicated that the indwelling catheter bag should be inside a privacy bag for infection control. 2. On 2/26/2020 at 10:12 AM, the surveyor observed Resident #163 lying in bed and that the resident had an indwelling urinary catheter bag. The collection bag was hung on the left, lower side of the bed rail, and was not contained in a privacy bag. The CNA informed the surveyor that the resident was cognitively impaired, required extensive assistance with ADLs, and preferred to stay in bed. She further stated that the resident had a urinary catheter for a long time. A review of the resident's Face Sheet reflected that the resident was admitted to the facility with [DIAGNOSES REDACTED]. A review of the 11/22/19 QMDS indicated a BIMS score of 5, which reflected that the resident's cognition was severely impaired. The QMDS indicated that the resident had a catheter. On 2/27/2020 at 8:38 AM, the surveyor observed Resident #163 lying in bed. The tubing and the urinary catheter bag were in direct contact with the floor. On 2/28/2020 at 8:40 AM, the surveyor observed Resident #163 in bed with an indwelling catheter bag layered over the bed, directly touching the bed linen. The catheter drainage bag was above the level of the resident's bladder. This position allowed the urine in the collection bag to flow back into the bladder, which increased the possibility of a Urinary Tract Infection. The resident stated, I don't know when the surveyor asked who placed the indwelling catheter bag on top of the bed. On 2/28/2020 at 8:48 AM, the surveyor showed the Director of Nursing (DON) the indwelling catheter bag and discussed the above concerns and observations. The DON stated that the indwelling urinary catheter should have been hung on the bed rail with a privacy bag for infection control. 3. On 2/26/2020 at 9:47 AM, the surveyor observed Resident #455 seated in a wheelchair in their room. The resident was unable to remember what they had for breakfast and did not know the date and time. On 2/27/2020 at 8:42 AM, the surveyor observed the resident lying in a low bed with an indwelling urinary catheter directly touching the right floor mat. The catheter collection bag was not contained in a privacy bag. A review of the resident's Face Sheet reflected that Resident #455 was admitted to the facility with [DIAGNOSES REDACTED]. (is an illness that affects the part of your brain that controls how you move your body). A review of the [DATE] Significant (S) MDS indicated a BIMS score of 99, which reflected that the resident's cognition was moderately impaired. The SMDS indicated that the resident had a catheter with a [DIAGNOSES REDACTED]. On that same date and time, the Hospice CNA and the surveyor went to the resident's room, and both observed the indwelling catheter lying on top of the floor mat. The Hospice CNA stated, sometimes I see the catheter bag on top of the mat when I come in. She further stated, the catheter bag should be in a privacy bag. The Hospice CNA could not answer if the catheter on the floor mat was or wasn't appropriate. On [DATE] at 1:31 PM, the surveyor spoke to the Administrator and DON regarding the above concerns. The DON informed the surveyors that the indwelling catheter bag should be in a privacy bag and not be directly touching the floor due to infection control. The DON stated, the nurses were provided a warning and written up with regards to the problem. She further stated that LPN#1 should have discarded the neb mask because it was considered contaminated because it touched the surface of the nightstand. On 3/5/2020 at 9:29 AM, the Infection Control Nurse/RN (ICN/RN) informed the surveyors that the indwelling catheter bag should not be directly touching the floor and should be in a privacy bag for infection control. On that same date and time, the ICN/RN informed the surveyors that the nebulizer mask should not be directly touching the surface and should be inside the plastic bag when not in use for infection control. She stated that the nebulizer mask should be changed twice a week, and it was the 11-7 shift nurse responsible for changing the neb mask. She further stated that when the mask touches a surface, it should be discarded and considered contaminated. A review of the Urinary Catheters Policy and Procedure with a review date of 2/26/16, provided by the DON, indicated, Always place drainage bags in a privacy bag; Keep privacy bag off the floor. A review of the Use of Oxygen and Disposable Respiratory Equipment Policy with a review date of 11/11/16, provided by the DON, indicated, Professional nursing staff on 11-7 shall routinely change units every Monday and Thursday night; when temporarily not in use, the mask, cannula or nebulizer is covered lightly with non-airtight covering. 4. Review of the face sheet (an admission summary) for Resident # 363 reflected the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the QMDS, dated [DATE], reflected that the resident had a brief interview for mental status (BIMS) score of 00 out of 15, which indicated severe cognitive impairment. Review of section M of the MDS indicated the resident was coded for one stage 4 pressure ulcer. On 3/2/20 between 10:09 AM and 10:37 AM, the surveyor observed Resident #363's wound care treatment with the following staff: Certified Nursing Assistant #1 (CNA #1), Registered Nurse (RN) and Wound Care Coordinator Licensed Practical Nurse (WCCLPN). The CNA#1 and RN positioned the resident for the treatment, and the WCCLPN performed the actual wound treatment. A review of the physician's orders [REDACTED]. Change once daily for wound care. The surveyor observed the WCCLPN prepare the over-bed table with the needed wound care supplies. The WCCLPN did not wash her hands or don gloves before the preparation of the over-bed table. The surveyor then observed the WCCLPN wash her hand for thirteen seconds. After washing her hands, she pushed the lever on the paper towel dispenser to get a towel. She dried her hands and wiped the sink surface with the same towel. The WCCLPN then donned gloves and removed Resident #363's wound dressing and proceeded to rewash her hands. The surveyor observed the WCCLPN wash her hands for

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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	(continued... from page 3) sixteen seconds. She then touched the paper towel dispenser lever to dispense the paper towel. The WCCLPN donned gloves and cleansed the wound. Afterward, she removed her gloves and washed her hands for seven seconds. She then touched the paper towel dispenser lever to dispense the paper towel. The RN who was assisting the WCCLPN had to leave the room to get Medi Honey (a medication ointment used to treat wounds). The RN removed her gown and gloves in the room but did not wash her hands before exiting the room. She returned with the Medi Honey, donned a clean gown, and did not don gloves. She opened the Medi Honey for the WCCLPN and then donned gloves to assist with the repositioning of the resident. The WCCLPN applied the Medi Honey to the wound, removed the absorbent pad under the resident, and removed her gown and gloves, and washed her hands for seven seconds. After washing her hands, she touched the lever of the paper towel dispenser with her wet clean hands to dispense the paper towel. The surveyor then observed the WCCLPN clean up the dirty treatment supplies on the over-bed table with un-gloved hands and placed the dirty treatment supplies in the garbage receptacle inside the resident's room. She exited the room without washing her hands and stated she was done. She did not wash her hands after she left the room. On 3/2/20 at 10:39 AM, the surveyor interviewed the WCCLPN, who stated that she usually washed her hands for 30 seconds and sang Happy Birthday. She stated she was nervous and maybe did not wash her hands long enough. She also stated that she should have worn gloves to remove the treatment supplies from the over-bed table and then wash her hands. Lastly, she stated that she should not have touched the paper towel dispenser for the paper towels after washing her hands. On 3/2/20 at 10:55 AM, the surveyor interviewed the DON, who stated that all staff was expected to wash their hands for 20 seconds and not touch the paper towel dispenser when getting a towel to dry their hands. She also stated that the WCCLPN should have washed her hands before she left the resident's room and should have had gloves on to clean up the treatment supplies. Lastly, the DON stated that the RN who left the room to get the Med Honey, should have washed her hands before leaving the room. Review of the Hand Hygiene policy and procedure dated 4/2016 revealed the following: Purpose: to decrease the risk of transmission of infection by appropriate hand hygiene; Handwashing: Wash hands for twenty seconds; wash hands before and after the care of each resident and during care procedures as necessary. Review of the Contact precautions policy and procedure dated 7/2015 revealed the following: Contact precautions shall be used in addition to Standard Precautions (used for all residents) for residents with infections that can be easily transmitted by direct and indirect contact; gloves should be removed before leaving the resident's room, and hands should be washed immediately. Review of the undated VRE ([MEDICATION NAME]-Resistant [MEDICATION NAME]) policy and procedure indicated the following: gloves should be worn to enter a room of a resident who is VRE infected; gowns and gloves should be removed before leaving the resident's room, and hands must be washed immediately with an antiseptic soap. NJAC 8:39-19.4 (a) (1, 2)