STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315529	A. BUILDING _____ B. WING _____	**05/01/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SYCAMORE LIVING AT EAST HANOVER	**ONE SOUTH RIDGEDALE AVENUE EAST HANOVER, NJ 07936**

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 0578 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.** **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 life-sustaining treatment wishes were reviewed with the residents or their representatives and documented consistently within the medical record. This deficient practice was identified for 3 of 6 residents reviewed for advance care planning (Resident #8, #10, and #20), and was evidenced by the following: On [DATE] at 9:30 AM, the Licensed Nursing Home Administrator (LNHA) informed the survey team that all the residents in the facility had a confirmed positive COVID-19 diagnosis, and that they had started accepting new admissions on or about [DATE]. The LNHA further stated that the Licensed Social Worker (LSW) was out on medical leave as of [DATE], and that he was taking over the responsibilities of the LSW at this time. On [DATE] the surveyor reviewed the medical records for Resident #8, #10 and #20 which revealed the following: 1. A review of the Admission Record face sheet (an admission summary) for Resident #8 reflected the resident was recently admitted to the facility with [DIAGNOSES REDACTED]. The record indicated the resident was responsible for him/her-self. The section for Advance Directive was blank. A review of the electronic Medical Record (eMR) for Resident #8 revealed under the resident's profile, a section to enter the resident's life sustaining treatment wishes (i.e. full code, do not resuscitate (DNR), do not hospitalize (DNH), do not intubate (DNI)) called, Code Status was also blank. A review of the physician's orders [REDACTED]. sustaining treatment wishes or code status. On [DATE] at 10:32 AM, the surveyor interviewed the Registered Nurse (RN) assigned to the resident, who reviewed and confirmed there was no code status recorded in the resident's eMR including in the profile, physician orders [REDACTED]. She stated she did not ask the resident about life sustaining treatment wishes but that it was done upon admission but either the admission nurse or it was obtained from the hospital records. She stated that if she found the resident unresponsive, she would perform CPR, because there was no evidence of a DNR order. The RN stated that the resident was alert and oriented to person, place and time. At 10:38 AM, the surveyor observed Resident #8 in awake and in bed. The resident agreed to be interviewed by the surveyor. Resident #8 stated that he/she had not been asked about advance care planning while a resident at the facility. The resident denied having an advance directive or modified life sustaining treatment wishes and that he/she wouldn't be interested in that anyway. 2. A review of the Admission Record for Resident #20 revealed that the resident was recently admitted to the facility and was his/her own responsible party. The section for Advance Directive was blank. A review of the Universal Transfer Form sent from the hospital dated [DATE] reflected an option to put a check mark next to the resident's Code Status for DNR, DNH, DNI or out of hospital DNR attached. The code status section was not marked. A review of the physician's orders [REDACTED]. sustaining treatment wishes or code status. A review of the electronic Progress Notes (ePN) for [DATE] did not reflect documented evidence that the resident's life sustaining treatment wishes or code status were communicated with the resident. On [DATE] at 9:15 AM, the surveyor observed Resident #20 sitting upright in his/her room playing a card game on an electronic tablet device. At that time, the resident agreed to be interviewed. The resident informed the surveyor that he/she has not spoken to a social worker or anyone else in the facility regarding advance care planning. The resident stated that he/she had two children that handle everything. The resident denied having an advanced directive or modified life sustaining treatment wishes. At 9:40 AM, the surveyor interviewed the Licensed Practical Nurse/Desk Nurse (LPN). The LPN stated that when a resident is newly admitted the Desk Nurse was responsible for reviewing the hospital records and inputting information into the eMR including code status. He stated that even if a resident was a full code, that it should be specified in the eMR profile. The LPN reviewed the eMR profile, physician orders, and care plan together and confirmed the resident's life sustaining treatment wishes were not recorded in the eMR. He then looked through the hospital records and confirmed it was not in the Universal Transfer Form or addressed in the hospital records. He stated that it meant by default, that the resident must be a full code and that CPR would need to be immediately implemented if the resident's medical condition warranted it. The LPN acknowledged it should be on the resident's profile for ease of viewing. The LPN then showed the surveyor an example of an unsampled resident that had it correctly entered into the eMR profile. The LPN stated that if it was on the resident profile, it was easier to access and view in an emergency. The LPN stated that the desk nurse handles the paper work and obtaining the physician's orders [REDACTED]. He stated that he believed, it was up to the desk nurse to make sure the code status got into the eMR, but that if it wasn't in the hospital records, he wasn't sure who was responsible for that information. 3. A review of the Admission Record for Resident #10 reflected that the resident had [DIAGNOSES REDACTED]. The section for Advance Directive was blank. A review of the hospital Discharge Summary dated [DATE] reflected that the resident was a Full Code status. A review of the eMR profile for Resident #10 reflected a blank section for Code Status. A review of the physician's orders [REDACTED]. On [DATE] at 9:06 AM, the surveyor observed Resident #10 awake in bed. At that time, the resident agreed to be interviewed. The surveyor asked the resident about his/her advance care planning, and the resident stated that he/she had a partial living will. The surveyor asked the resident what he/she meant by a partial living will, and the resident stated that he/she had a living will but in the wishes he/she only wanted partial treatment adding that I have a DNR. The resident denied speaking to anyone in the facility about this, or providing the facility with the supporting documents of the DNR. The resident stated that he/she would tell the nurse today. The surveyor continued to interview the facility staff on [DATE], which revealed the following: On [DATE] at 8:20 AM, the surveyor interviewed a Certified Nursing Aide (CNA) who stated that if she found a resident unresponsive, she would immediately call out for a nurse. The CNA stated that the nurse would be CPR certified and could perform CPR on the resident if it was needed. At 8:25 AM, the surveyor interviewed a Registered Nurse (RN) who stated that she was a new nurse and new to the eMR system. The surveyor asked the RN how each resident's designated code status/life sustaining treatment wishes was communicated. The RN stated that it would be in the eMR. The surveyor asked the RN where she would find it in the eMR, and the RN pulled up an unsampled resident and stated it would be in the profile section. She stated it could be in the profile, physician's orders [REDACTED]. The RN stated that if she couldn't find it in the profile or physician's orders [REDACTED]. The RN confirmed that the code status was not easy accessible on the eMR system, but stated that the admitting nurse was responsible for putting the information into the eMR. The RN stated that if she searched quickly and could not verify the code status on the eMR she would immediately implement CPR. At 8:30 AM, the surveyor interviewed the the medication LPN who stated that she was new to the eMR system but that she had an orientation on the system when she started. She stated that she thought the code status should be documented in the profile screen, but that if it wasn't there it would be in the physician's orders [REDACTED]. warranted it, and call a Code Blue for a medical emergency. She stated that emergency code cart would be provided during the code and was at the desk with the Desk Nurse.

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 0578 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) The LPN could not speak to who was responsible to put the resident's code status into the eMR or who addressed the resident's wishes on admission, if it wasn't addressed in the hospital records. On [DATE] at 2:45 PM, the LNHA who was covering for the LSW acknowledged in the presence of another surveyor, that the code status should be consistently recorded in the eMR but that the life sustaining treatment wishes information was put in based on information from the hospital. He stated that if the resident was full code it should also be documented as a full code and it shouldn't be a full code by default, because it wasn't in the eMR. On [DATE] the LNHA was unable to provide documented evidence that the resident's life sustaining treatment measures were addressed upon admission and documented appropriately in the resident's eMR. A review of the facility's Advance Directive policy effective [DATE] include that upon admission, the resident will be provide with written information concerning the right to refuse or accept or surgical treatment and to formulate an advance directive if he or she chooses to do so . Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record .The plan of care for each resident will be consistent with his or her documented treatment preferences and/or advance directive .The resident has the right to refuse treatment, wether or not he or she has an advance directive. A resident will not be treated against his or her own wishes . The Director of Nursing Services or designee will notify the Attending Physician of advance directives so that the appropriate orders can be documented in the resident's medical record and plan of care. A review of the facility's Do Not Resuscitate Order policy effective [DATE] included that Our facility will not use (CPR) and related emergency measures to maintain life functions on a resident when there is a (DNR) in effect. It further included that In addition to the advance directive and DNR order form, state-specific forms may be used to specify whether to administer CPR in case of a medical emergency. State-specific forms include: Physician order [REDACTED]. The Attending Physician will clarify and present any relevant medical issues and decisions to the resident or legal representative as the resident's condition changes in an effort to clarify and adhere to the resident's wishes. NJAC 8:,[DATE].1(a)2
F 0658 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**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: a.) take a blood pressure in accordance with manufacturer specifications, and b.) obtain a physician's orders [REDACTED]. This deficient practice was identified for 2 of 16 residents reviewed for professional standards of practice (Resident #10 and #14). Reference: New Jersey Statutes Annotated, Title 45. Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as casefinding, 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 authorized physician or dentist. Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of casefinding; 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. The evidence was as follows: 1. On 4/30/2020 at 8:25 AM, the surveyor observed Resident #14 sitting upright in the bed, awake. The resident was unable to be interviewed due to a language barrier. At that time, the surveyor observed the Registered Nurse (RN) prepare to administer medications to the resident. The RN removed a portable electronic blood pressure cuff from the bottom of the medication cart. The RN applied to blood pressure cuff to the resident's left forearm and obtained a reading of 122/63. The RN returned to the medication cart to remove the medications for the resident, which included a medication to control high blood pressure. The surveyor asked the RN about the method in which she took the resident's blood pressure on the forearm. The RN stated that she had to take the blood pressure on the forearm because the blood pressure did not fit on the upper arm which was where the blood pressure was intended to be taken. The surveyor and the RN viewed the manufacturer instructions on the blood pressure machine together which included instructions to take the blood pressure on the upper arm. The RN confirmed the machine instructions did not address taking the blood pressure on the forearm. The surveyor asked the RN if the physician had approved for the blood pressure to be taken in the left forearm and the RN stated she was not aware of it. The RN stated that she would go ask the nurse on the other cart to see if she had a large blood pressure cuff. The RN returned and stated that the other nurse did not have a large blood pressure cuff, so she would just have to use the one she had. She acknowledged that blood pressures were supposed to be taken on the upper arm, but that she did not have the appropriate sized cuff right now. At 8:50 AM, the surveyor observed the RN administer the medications to the resident including the medication to control high blood pressure ordered on [DATE] ([MEDICATION NAME] 12.5 milligrams). A review of the physician's orders [REDACTED]. There was no evidence of a physician's orders [REDACTED]. On 4/29/2020 at 3:30 PM, the surveyor informed the Licensed Nursing Home Administrator (LNHA) of the surveyors findings related to improper use of the blood pressure cuff, and the availability of a large cuff. On 5/1/2020 at 08:10 AM, the surveyor observed another RN (RN #2) take a blood pressure on an unsampled resident using a brand new electronic vital sign machine, which included the storage of a large red blood pressure cuff. The RN #2 stated that the new vital sign machines were here when she started her shift and that she understood how to use them. She confirmed they had a large blood pressure cuff if one was needed. She stated blood pressures were routinely taken on the upper arm, unless there was a clinical contraindication. On 5/1/2020 at 2:15 PM, the Chief Operating Officer informed the surveyor that the facility had the vital sign machines available but that they had not yet been dispersed on that unit. He couldn't speak to why they were not available to the staff on 4/30/2020. The acting-Director of Nursing/Registered Nurse (RN) and the Licensed Nursing Home Administrator (LNHA) acknowledged that the nurse should be taking the blood pressure on the upper arm of residents (unless contraindicated) and using the appropriate sized blood pressure cuff for the most accurate blood pressure reading. The LNHA was unable to provide documented evidence to refute the surveyor's findings from the manufacturer. 2. On 5/1/2020 at 8:14 AM, the surveyor observed Resident #10 in bed awake. The surveyor observed the resident's left foot wrapped with kling wrap. There was no date or time on the dressing. The resident stated that he/she had a skin impairment to the left toes, and that he/she believed that the nurse changed the dressing to the foot daily. The resident denied pain to the foot during the dressing changes. The surveyor reviewed the medical record for Resident #10. A review of the Admission Record face sheet (an admission summary), reflected that the resident was admitted with a [DIAGNOSES REDACTED]. A review of the physician's orders [REDACTED]. A review of the electronic Treatment Administration Record (eTAR) for April 2020 reflected that the corresponding PO dated 4/28/20 for the left foot. The eTAR revealed that on 4/28/20 and 4/29/20, the nurse did not perform the wound treatment with the [MEDICATION NAME] solution. There was no documented evidence in the eTAR for the accountability of an alternative order or treatment for [REDACTED]. A review of the electronic Progress Notes (ePN) dated 4/28/20 at 12:15 PM reflected that the the [MEDICATION NAME] solution was on order and waiting for pharmacy to deliver. A subsequent note timed at 2:52 PM included that the foot dressing cleaned and changed. It did not specify how it was cleaned and changed and there was no documented evidence of communication with the physician regarding an alternate treatment for [REDACTED]. A review of the ePN dated 4/29/20 at 10:33 AM included a note from another LPN that the [MEDICATION NAME] solution dressing was not done because the medication was not available. There was no documented evidence that the physician was notified and an alternate treatment was ordered or performed while awaiting delivery. At 11:10 AM, the surveyor observed the Licensed Practical Nurse (LPN) prepare to perform the wound treatment to the resident's left toes. The LPN removed the old dressing and acknowledged the dressing was not dated because sometimes the pen does not work. The LPN told the surveyor that the dressing on the resident was not the same dressing she applied the previous day. Resident #10 confirmed to the LPN and surveyor that another nurse during the evening shift did a dressing change after the physician looked at the wound. The LPN stated that the Wound Consultant had been in to give new orders for the left foot skin impairment on 4/30/20 and stated that the new order was to cleanse the left toes with normal saline solution, pat it dry, and cover with a dry dressing daily. At that time, the surveyor observed that the resident's three small toes on the left foot were blackened in color, and the resident denied pain. The LPN changed the dressing in accordance with the physician's orders [REDACTED]. She stated that she had cleansed it with Normal Saline and dried it and covered it with Kerlix just like the new order had specified to do. She acknowledged she did not call the physician to get an alternate physician's orders [REDACTED]. She stated that she told the desk nurse that the [MEDICATION NAME] was not available, and that the desk nurse contacted the pharmacy. She acknowledged she should have called the Physician to get an alternate order while the [MEDICATION NAME] was not available. She acknowledged that the nurse on the subsequent day (4/29) also did not perform a treatment to the foot in accordance with the eTAR or progress notes. On 5/1/2020 at 2:40 PM, the

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F 0658 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) surveyor informed the Registered Nurse/acting-Director of Nursing (RN), LNHA and Chief Operating Officer of the surveyor's findings. The RN acknowledged that when the [MEDICATION NAME] solution was not available, the nurse should have called and informed the physician and obtained an alternate treatment order to apply a different dressing until the [MEDICATION NAME] was available in accordance with professional standards of nursing practice. The RN acknowledged that there was no evidence in the eTAR that a treatment to the left toes was done on 4/28 and 4/29. The LNHA was unable to provide documented evidence that a treatment was performed to the left toes on 4/29/20. NJAC 8:39-27.1(a)
F 0759 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure medication error rates are not 5 percent or greater.** **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 all medications were administered without error of 5% or more. During the medication pass on 4/30/2020, the surveyor observed four (4) nurses administer medications to five (5) residents. There were 37 opportunities and three (3) errors observed which calculated to a medication administration error rate of 8%. This deficient practice was identified for 1 of 4 nurses and 1 of 5 residents (Resident #13) and was evidenced by the following: On 4/30/2020 at 8:11 AM, the surveyor entered the South Neighborhood and observed staff passing out breakfast trays to all the residents on the unit. On 4/30/2020 at 10:10 AM to 10:17 AM, the surveyor observed the Licensed Practical Nurse (LPN) administer medications to Resident #13. The surveyor observed the LPN prepare six medications to be administered by mouth to the resident. Three of the medications included a medication used to prevent heartburn, [MEDICATION NAME] 20 milligrams (mg); a supplement to treat low potassium levels in the blood, Potassium Chloride ER (extended release) 20 milliequivalents (meq); and a medication to control high blood sugar, [MEDICATION NAME] 500 mg. The order for the [MEDICATION NAME] specified to administer two (2) tablets by mouth two times a day with breakfast and dinner for a [DIAGNOSES REDACTED]. After the nurse administered the medications to the resident, the surveyor interviewed Resident #13 in the presence of the LPN and asked when he/she ate breakfast. The resident stated that it had to be sometime between 8:00 AM to 9:00 AM because he/she ate and then had already completed a physical therapy session. There was no breakfast tray or food in the resident's room at the time of medication administration. The surveyor then stepped out of the resident's room and interviewed the LPN at her medication cart. The LPN stated that the [MEDICATION NAME] was supposed to be administered before breakfast on an empty stomach to prevent heartburn, and the medications Potassium Chloride and [MEDICATION NAME] were supposed to be administered when the resident was eating a meal in accordance with the individual manufacturer specifications. The LPN further stated that the breakfast trays arrived on the unit around 8:00 AM and the resident had already eaten his/her breakfast meal. The LPN acknowledged that the medications were given after 10 AM. The surveyor reviewed the medical record for Resident #13. A review of Resident #13's April 2020 electronic Medication Administration Record [REDACTED]. A PO dated 4/13/2020 for the medication [MEDICATION NAME] tablet delayed release 20 mg, give one tablet two times a day for [MEDICAL CONDITION] reflux disease (GERD; heartburn). The medication was plotted to be administered at 8 AM and 5 PM. There were no pharmacy cautionary warnings on the eMAR that the medication needed to be administer before meals. 2. A PO dated 4/28/2020 for the medication [MEDICATION NAME] 500 mg tablets, give two tablets by mouth two times a day for diabetes mellitus with breakfast and dinner. The medication was plotted to be administered at 8AM and 5 PM daily. 3. A PO dated 4/19/2020 for the medication, Potassium Chloride ER 20 meq, give one tablet by mouth every morning and at bedtime for [DIAGNOSES REDACTED] (low potassium in the blood). The medication was plotted to be administered at 9 AM and 9 PM daily. There were no cautionary warnings on the eMAR that the medication needed to be administered in accordance with food or during meals. On 4/30/2020 at 2:38 PM, the surveyor discussed the findings with the Licensed Nursing Home Administrator (LNHA) and Chief Operating Officer. On 5/1/2020 at 10:53 AM the surveyor conducted a phone interview with the Consultant Pharmacist (CP) who stated that she was consulted to come in monthly to do the medication chart reviews and observe a nurse perform a medication pass. The CP further stated that she had been reviewing the resident's medications remotely from home and had not been to the facility to do a medication pass observation since it opened. The CP further stated that the medication [MEDICATION NAME] should be administered on an empty stomach (Error #1) and the medications [MEDICATION NAME] and Potassium Chloride needed to be administered with food (Error #2 and Error #3). A review of the manufacturer specifications for [MEDICATION NAME] indicated that the medication should be administered 30 to 60 minutes before a meal. A review of the manufacturer specifications for [MEDICATION NAME] indicated that the medication should be taken with meals. A review of the manufacturer specifications for the Potassium Chloride indicated that the medication should be taken immediately after a meal or with a meal to prevent an upset stomach. A review of the facility's Medication Administration Guidelines Policy and Procedure dated 10/2017 indicated, Medications will be administered in a safe and accurate manner. The Medication Administration Guidelines Policy and Procedure further indicated, Cautionary information will be adhered to. (e.g. do not crush, take with food, etc.). On 5/1/2020 at 2:45 PM, the LNHA and acting Director of Nursing/Registered Nurse (RN) were unable to provide further information regarding the three errors observed on the medication pass observation. NJAC 8:39-11.2(b), 29.2(d), 29.4(c)
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**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 failed to: a.) perform hand hygiene in accordance with nationally accepted standards for infection control, and b.) ensure a shared rolling walker was disinfected by a therapist after use by a resident with infectious diarrhea. This deficient practice was identified for 2 of 16 residents reviewed with infections (Resident #1 and #2), and was evidenced by the following: 1. On 4/29/2020 at 9:30 AM, the Licensed Nursing Home Administrator (LNHA) informed the survey team that all the residents in the facility had a confirmed positive COVID-19 diagnosis. On 4/29/2020 at 12:20 PM, the surveyor observed Resident #2 in bed, awake. The resident confirmed to the surveyor that he/she had been admitted to the facility due to an infection of COVID-19. At 12:30 PM, the surveyor observed a Certified Nursing Aide (CNA) knock and enter the resident's room. The CNA was wearing an N-95 respirator mask, a face shield, a hair covering, shoe protectors, a gown and gloves. At that time, the surveyor observed the CNA reorganize the resident's belongings in the room and readjust the resident's bedside table. The CNA then doffed her gloves and walked passed an alcohol-based hand rub (ABHR) dispenser in the room and went to the sink to perform hand hygiene. The CNA turned on the faucet and applied soap and rubbed her hands for three (3) seconds outside of the water, then placed her hands under the running water for another three (3) seconds. Then with the water still running in the middle of her hand hygiene, the CNA picked up a body wash soap that was on sink counter, touched a curtain, and placed the body wash soap in a stall. She then returned to the sink, rinsed her hands under the running water a second time without re-applying soap, and activated the paper towel dispenser to dry her hands. She then turned off the faucet with a paper towel and donned a new pair of gloves and exited the resident's room. At that time, the surveyor interviewed the CNA who stated this was her first shift at the facility but knew from working at other facilities that she was supposed to wash her hands before and after resident contact. She did not speak to the proper procedure in which hand hygiene was to be performed. On 5/1/2020 at 2:33 PM, the surveyor informed the Registered Nurse and the LNHA of the surveyor's findings. The RN confirmed that the CNA should perform hand hygiene with friction for 20 seconds outside of running water before rinsing. A review of the facility's Handwashing/Hand Hygiene policy effective 12/1/19 included to use an ABHR or alternatively, soap and water for the following situations .after contact with objects in the immediate vicinity of the resident; after removing gloves and included a method of procedure: Vigorously lather hands with soap and run them together, creating friction to all surfaces, for a minimum of 20 seconds (or longer) under a moderate stream of running water, at a comfortable temperature . According to the Centers for Disease Control and Prevention's (CDC) Guidance for Healthcare Providers about Hand Hygiene and COVID-19, updated 4/27/2020 included, CDC recommends using ABHR with greater than 60% [MEDICATION NAME] or 70% [MEDICATION NAME] in healthcare settings. Unless hands are visibly soiled, an alcohol-based hand rub is preferred over soap and water in most clinical situations due to evidence of better compliance compared to soap and water. Hand rubs are generally less irritating to hands and are effective in the absence of a sink. Hands should be washed with soap and water for at least 20 seconds when visibly soiled, before eating, and after using the restroom. It further included, that hand hygiene should performed .after touching a patient or the patient's immediate environment .and immediately after glove removal. 2. On 4/29/2020 at 12:15 PM, the surveyor observed a plastic bin with drawers outside the room of Resident #1. The bin contained personal protective equipment including extra gowns, gloves, and masks. On top of the plastic bin there was a container of disinfecting wipes. The surveyor reviewed the information on the container which indicated that the

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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 -** Few	(continued... from page 3) disinfecting wipes was effective against the bacteria Clostrioides Difficile (formerly called [MEDICAL CONDITION]; infectious diarrhea). The surveyor observed a Physical Therapist (PT) inside the resident's room holding a rolling walker and speaking to the resident. At 12:40 PM, the surveyor observed the PT fold the rolling walker while inside of the resident's room with his hands. The surveyor observed the PT touch the top of the rolling walker with both hands and then glide his hands down the side of the rolling walker to fold it in half. There was no evidence that the PT disinfected the rolling walker after it was used by Resident #1. At 12:41 PM, the surveyor observed the PT leave the room of Resident #1 and enter the room of Resident #9 with the same rolling walker that was not disinfected. At 12:47 PM, the surveyor observed Resident #9 sitting on the edge of his/her bed, gripping the handles of the rolling walker while performing leg exercises with the PT. The surveyor reviewed the medical record for Resident #1. A review of the Admission Record revealed that the resident was recently admitted to the facility and had [DIAGNOSES REDACTED]. A review of the April 2020 Order Summary Report reflected a physician's orders [REDACTED]. On 4/29/2020 at 2:43 PM, the surveyor interviewed the PT in the presence of the Director of Rehabilitation who stated that Resident #1 was positive for COVID-19 and had a CDI. The PT stated that he wiped down the rolling walker with the hand sanitizer he put on his hands prior to exiting the resident's room. At 2:45 PM, the Director of Rehabilitation stated that the PT should have used the bleach wipe to disinfect the shared rolling walker prior to exiting the room of Resident #1 who had a CDI. She confirmed that the rolling walker should be disinfected between each resident, using the appropriate equipment wipes available on the unit. On 4/30/2020 at 10:21 AM, the surveyor interviewed the resident's CNA who stated that the resident had a CDI. The CNA added that because a CDI was infectious by means of contact transmission, she would never remove an item from the resident's room without first disinfecting it with a bleach wipe. At 10:23 AM, the surveyor interviewed the resident's RN who stated that all multi-use equipment was to be wiped down using a disinfecting bleach wipe to prevent the spread of infection to other residents. A review of the facility's undated Cleaning and Disinfecting of Resident-Care Items and Equipment Policy and Procedure included, 4. Reusable resident care equipment will be decontaminated and/or sterilized between residents using appropriate disinfectant approved by (the) CDC. Follow directions according to manufacturers' instructions. NJAC 8-39:19.1,2,4,5; 21.1