STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315464	A. BUILDING _____ B. WING _____	**10/02/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CARE ONE AT EVESHAM	**870 EAST ROUTE 70 MARLTON, NJ 08053**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide and implement an infection prevention and control program.** **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 staff wear the appropriate personal protective equipment (PPE) for residents on contact isolation, to address the risk for infection transmission, in accordance with the facility policy and acceptable standards of infection control practice. This deficient practice was identified for Residents #85 and #56, 2 of 5 residents reviewed for infection control practices and was evidenced by the following: 1. According to the facility's Admission Record, Resident #85 was admitted to the facility in September 2020 with [DIAGNOSES REDACTED]. Review of Resident #85's Physician order [REDACTED]. During the initial tour on 09/24/2020 at 11:12 AM, the surveyor observed a stop/isolation sign on Resident #85's room door. There was no isolation/PPE kit observed near the room. During that time, the surveyor interviewed a Certified Nursing Assistant (CNA) #1 regarding the purpose of the stop/isolation sign. CNA #1 stated the sign meant that you should put on a gown and gloves before performing resident care. CNA #1 stated that there should have been a PPE kit (a kit that hung on the door containing isolation PPE) on the door. CNA #1 then entered the resident's room, donned gloves, walked across the room, and retrieved a linen cart that was near the resident's bed. CNA #1 placed the linen cart against the inside wall near the door entrance. On 09/24/2020 at 11:15 AM, the surveyor observed a housekeeper place a PPE kit on Resident #85's room door. During an interview with the surveyor at that time, the housekeeper stated that CNA #1 just reported that Resident #85 was on isolation and needed a PPE kit. The housekeeper stated that staff informs housekeeping when a resident was on isolation and the housekeeping staff would place the PPE kit on the door. During an interview with the surveyor on 09/24/2020 at 11:20 AM, a Licensed Practical Nurse (LPN) #1 stated that Resident #85 was on isolation for ESBL in the wound. LPN #1 stated that full contact isolation consisted of wearing a gown and gloves when coming into contact with Resident #85 or the linen cart. LPN #1 stated that the purpose of PPE was to protect the resident and staff from infection and if PPE wasn't worn, the illness could be spread. LPN #1 stated that the linen cart in the room of Resident #85 could have been contaminated and that CNA #1 should have been wearing a gown and gloves. During an interview with the surveyor on 09/30/2020 at 12:10 PM, the Activities Director (AD) stated that the stop/isolation sign meant that she had to see the nurse before she could enter the room. 2. According to the Admission Record, Resident #56 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #56's Physician order [REDACTED]. On 09/24/2020 at 11:27 AM, the surveyor observed a Certified Occupational Therapy Assistant (COTA) enter Resident #56's room, wearing only a mask and goggles. The COTA donned gloves once inside the resident's room but did not don a gown. The surveyor noted there was a full PPE kit on the door but there was no stop see nurse sign on the resident's door. The surveyor observed that the COTA stood right next to Resident #56 while she counted and demonstrated dumb bell therapy to the resident while the resident performed the dumb bell therapy. The COTA was not wearing a gown during this observation. On 09/24/2020 at 11:40 AM, the surveyor observed the Unit Manager (UM) stand in Resident #56's room doorway and tell the COTA to put on a yellow isolation gown. The surveyor interviewed the UM at that time. The UM stated that gown and gloves should be worn because Resident #56 had ESBL in the wound and was on contact isolation. The UM stated that the purpose of the gowns and gloves was to avoid spreading the infection. At that time, the surveyor also interviewed the COTA who stated she was aware that the resident had ESBL in the incision and that she should have been wearing a gown along with the gloves in the room to keep any type of contaminant from me and the resident. On 09/30/2020 at 11:15 AM, the surveyor interviewed CNA #2 who stated that when an isolation (PPE) kit or a stop sign was on the door that meant full PPE consisting of gowns, gloves, mask and goggles, must be worn any time staff enter the room, even if it is just to pass a food tray. CNA #2 stated that the reason for PPE was to protect yourself and the residents so infections aren't passed. During an interview on 10/01/2020 at 10:07 AM, the DON/Infection Control Nurse (IC) stated if there was an isolation stop sign and/or a PPE kit on the door, staff should always stop and see the nurse before entering the resident's room. The DON stated staff should don a gown and gloves before entering a room for anything, even if only answering the call bell, if the resident was on contact isolation. The DON stated that CNA #1 should have donned a gown and gloves before entering Resident #85's room to move the laundry bin and that the COTA should have donned a gown and gloves before entering Resident #56's room and while doing therapy with the resident. The DON stated that the purpose of always wearing a gown and gloves before entering the room was to prevent the spread of an infection, even if the infection was contained, because you never know what the resident may need when entering the room. During an interview with the survey team on 10/02/2020 at 9:55 AM, the DON stated that if there was an active physician order [REDACTED].#1 and COTAs' Personal Protective Equipment (PPE) Competency Validation, dated 08/21/2020, revealed they were both deemed competent with standard precautions and transmission based precautions and that they correctly identified the appropriate PPE for Contact/Contact [MEDICATION NAME] Precautions (gown & gloves). Review of the facility's Isolation-Initiating Transmission-Based Precautions policy, revised August 2019, revealed that when Transmission-Based Precautions were implemented, the Infection Preventionist (or designee) would determine the appropriate notification on the room entrance door. The policy reflected that the signage informed the staff of the type of CDC precautions(s), instructions for use of PPE, and/or instructions to see a nurse before entering the room. The policy included to ensure that protective equipment (i.e., gloves, gowns, masks, etc.) were maintained outside the resident's room so that anyone entering the room can apply the appropriate equipment and that Transmission-Based Precautions would remain in effect until the Attending physician or Infection Preventionist discontinued them. Review of the facility's Multidrug-Resitant Organisms (MDRO) policy, revised August 2019, revealed under Enhanced Infection Control Precautions, to implement Contact Precautions routinely for all residents colonized or infected with a target MDRO. The policy included that Because environmental surfaces and medical equipment, especially those in close proximity to the resident may be contaminated, don gowns,and gloves before or upon entry to the resident's room or cubicle. Review of the facility's Personal Protective Equipment policy, reviewed 03/04/2019, revealed that training on the proper donning, use and disposal of PPE was provided upon orientation and at regular intervals. NJAC 8:39-19.4(a)(1-2)(c)

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