STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315015	A. BUILDING _____ B. WING _____	10/07/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MADISON CENTER	625 STATE HIGHWAY 34 MATAWAN, NJ 07747

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 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **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.) ensure that a resident was not in possession of a cigarette lighter, b.) initiate a care plan (CP) for a resident who was identified as a smoker, and c.) complete a smoking evaluation of the resident in a timely manner and in accordance with the facility policy. This deficient practice was identified for Resident #63, 1 of 1 resident reviewed for smoking and was evidenced by the following: During the tour of C-wing Unit on 9/21/20 at 11:51 AM, the surveyor observed Resident #63 lying in bed watching television. The surveyor also observed an open pack of cigarettes and a lighter on the overbed table next to the resident's bed. The surveyor made the same observation on 9/24/20 at 10:18 AM. The surveyor noted that the resident's room was closed. The surveyor did not notice any residents walking about the unit. According to the Admission Record, Resident #63 was admitted with medical [DIAGNOSES REDACTED]. Review of the Quarterly Minimum Data Set (MDS), an assessment tool dated 8/21/20, revealed that Resident #63 was cognitively intact and had no behaviors. Review of Resident #63's CP which was initiated on 9/21/20, revealed a Focus area that indicted: patient may smoke with supervision per smoking assessment. The CP further indicated to monitor patient's compliance to smoking policy. During an interview with the Registered Nurse/Unit Manager (RN/UM) on 9/24/20 at 10:05 AM, the RN/UM stated that she recently started work on C-wing unit in August 2020. When questioned about the facility's smoking evaluation process, the RN/UM stated that residents were assessed on admission and as needed. The RN/UM explained that any resident identified as a smoker would have smoking evaluation completed. The RN/UM stated the smoking evaluation assesses the resident's cognitive status, behaviors, ability to locate the designated smoking area and any history of unsafe smoking habits. The RN/UM further stated that staff also assessed whether the resident could hold, light, and discard a cigarette properly. The RN/UM stated that some residents were allowed to keep their own cigarettes, and that residents are not allowed to keep their own lighters. The RN/UM stated that the facility has a grill lighter that was kept at the front desk and that the lighter remained with staff during smoking break. During an interview with Resident #63 on 09/24/20 at 10:18 AM, Resident #63 stated that he/she had been smoking for a while and went out daily during smoking breaks. The resident did not provide specific date he/she started smoking. During a follow up interview with the RN/UM on 9/24/20 at 10:56 AM, she stated that Resident #63 recently started smoking at the beginning of September 2020 and that the 9/21/20 smoking evaluation was the only evaluation on file for the resident. On 9/24/20 at 2:33 PM, the surveyor went to the smoking area and observed residents during their scheduled smoking break time in the presence of the Assistant Director of Activities (ADA), who was assigned to monitor the afternoon smoking break session. The surveyor observed the ADA open door to the designated smoking area. The ADA then used a hand-held lighter to light the cigarettes of the first two residents in line as they entered the smoking area. The surveyor observed that the ADA did not light the cigarettes of three residents including Resident#63. Once in the designated smoke area, the surveyor observed Resident #63 remove a lighter from his/her pocket and lit his/her cigarettes and then lit the cigarettes of three other residents in the area. At that time, the surveyor interviewed the ADA who acknowledged that Resident #63 usually lit other residents' cigarettes because of social distancing. The ADA further stated that Resident #63 routinely lit his/her own cigarettes. During an interview with the Certified Nursing Assistant (CNA #2) on 9/29/20 at 10:15 AM, CNA #2 stated that she regularly worked on the C-wing unit and that assignments were switched monthly. CNA #2 stated that Resident #63 was independent and would ask staff for assistance as needed. CNA #2 further stated that Resident #63 was smoker and was able to ambulate with cane to the smoking area. CNA #2 stated that the resident was compliant with abiding by smoking schedule. During a follow-up interview with the ADA on 9/29/20 at 11:41 AM, the ADA stated that residents who smoked usually had a smoking assessment completed. The ADA further stated that he followed the smoking list (a list that documents the names and room numbers of residents who smoke) and that Resident #63 was recently added to the smoking list. The ADA stated that residents who were not listed on the smoking list were not allowed into the courtyard during smoke breaks. During an interview with the Recreation Director (RD) on 9/29/20 at 12:08 PM, the RD stated that she in-serviced staff assigned to monitor smoke break sessions about the smoking policy and procedures. The RD further stated that smoking list was updated as needed and that Resident #63 recently decided to pick up smoking this month of September. The RD stated that the facility policy indicated that residents were not allowed to keep personal lighters. The RD further stated that if a resident was found with a lighter, that staff should confiscate the lighter immediately and educate the resident on policy. The RD stated that nursing staff should complete a smoker's assessment and update the care plan. The RD added that Resident #63's assessment was initiated on 9/21/20. The surveyor reviewed Resident #63's 8/26/20 Care Plan Meeting note (note) with the effective date of 8/26/20. The note reflected that Resident #63 was a smoker and followed the facility smoking policy. The note also indicated that the CP was reviewed and was appropriate. There was no smoking care plan initiated until 9/21/20. During an interview with the Center Nurse Executive (CNE) on 9/29/20 at 1:20 PM, she stated that smoking evaluation was completed for smokers on admission, quarterly, and if there was a change in condition. The CNE further stated that smoking CP was initiated once a resident started to smoke and was usually addressed during the IDCP (interdisciplinary care plan meeting). The CNE confirmed that Resident #63's smoking CP was initiated on 9/21/20 and not on 8/26/20. On 9/24/20, the CNE stated that social services (SS) met with the resident and discussed the rules and informed that residents were not allowed to keep lighters after surveyor inquiry. The CNE stated if staff saw a resident with a lighter, she expected them to confiscate the lighter. During an interview with the Social Service Director (SSD) on 9/29/20 at 1:30 PM, the SSD stated that smoking assessments were generated by nursing on admission and as needed. The SSD further stated that staff supposed to review the facility smoking policy with the resident to make sure the resident understood. During an interview with the Center Executive Director (CED) on 9/30/20 at 11:47 AM, in the presence of the CNE and other surveyors, the CED stated that Resident #63 was fairly new to the smoker's club and was not educated properly. When the surveyor questioned about the 8/26/20 Note where the resident was identified as a smoker. The CNE stated she was unable to locate any previous smoking evaluation or CP for Resident #63. A review of the facility's OPS137 Smoking policy, with the review date of 11/4/19, revealed patients would be assessed on admission, quarterly, and with change in condition for the ability to smoke safely. The policy further revealed that a patient's smoking status would be documented in the CP and updated as necessary. The policy reflected that patients were not allowed to maintain their own lighter or matches. NJAC 8:39-27.1(a)
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.**

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 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and review of facility documentation, it was determined that the facility failed to ensure that all drugs and biologicals used in the facility are stored in accordance with professional standards, including removing of expired medications and biologicals from the medication room cabinets. This deficient practice was identified in 1 of 2 medication rooms inspected and was evidenced by the following: On 09/21/2020 at 12:28 PM, the surveyor inspected the Medication Room (med room) on C- wing unit in the presence of a unit nurse - Licensed Practical Nurse (LPN#1). The surveyor observed the following: 1. A box containing two vials of Evencare glucometer control solutions (a reagent used to check the functionality of glucometer). The vial with a blue top was labeled high and had an expiration date of 9/12/20. The vial with a white top was labeled low and had an expiration date of 9/11/2020. The outside of the box was dated 7/15. When interviewed regarding 7/15, LPN#1 who was with the surveyor during the inspection, stated that 7/15 was the open date of the solutions, and clarified that the solution was opened on 7/15/2020. The review of manufacturer's guide on Evencare control solutions indicated not to use expired solutions and to discard unused solutions three months after the vial was opened. 2. There was a plastic Ziploc bag with 12 [MEDICATION NAME] of Hema- screen (this is a substrate used to test for blood in stool). The surveyor noted that 4 of 12 [MEDICATION NAME] expired in August 2020, while 8 [MEDICATION NAME] were not yet expired. All the [MEDICATION NAME] were mixed together in one Ziploc bag. 3. Fifteen [MEDICATION NAME] of hema-screen were found in a basket inside a cabinet in which 13 [MEDICATION NAME] expired on 6/2019 and two [MEDICATION NAME] expired on 3/2019. 4. One Ziploc bag containing [MEDICATION NAME] lock flush solution in 3 ml syringes. ([MEDICATION NAME] lock flush is an anti-coagulation medication used to keep intravenous central line access open to prevent the line from clotting). There were 17 syringes of the [MEDICATION NAME] inside the bag. Seven of 17 syringes were not yet expired, while 10 syringes expired on 8/31/20. All the syringes were stored together in one zip lock bag. 5. One odor shield dressing pad (used for wound covering) which expired in June 2020, was found in a basket on the shelf among other items. 6. Three stool specimen bottles (para-Pak C&S) that expired in March 2003 (this is container with reagent used to collect stool sample). There were four other bottles of the same stool specimen bottles that expired in July of 2020. On 09/21/20 at 01:07 PM, the surveyor interviewed LPN#1 who is a unit medication nurse. He stated that staff rarely used the supplies in the medroom and that the supplies were stored in the med room just in case staff needed them. LPN#1 stated that staff usually obtained their supplies from the central supply room on the second floor. LPN#1 added that laboratory staff occasionally obtained supplies from the medroom if they ran out of their own supplies and all staff members were irresponsible for checking the medroom to ensure that medical supplies were not expired and remove expired items from the medroom. On 09/24/20 at 10:07 AM, the surveyor interviewed RN#1 on B-wing unit. When asked about the use of medical supplies from the medication room, RN#1 stated that she usually obtained supplies from the medroom, and if there wasn't any, she would then go to the central supply. On 09/29/20 10:52 AM, the surveyor interviewed the resident's nurse, LPN #2 regarding the use of medication room. LPN#2 stated that she would obtain supplies from the medroom if she needed supplies for resident's care. She also stated that the night shift nurses were responsible for checking and removing expired items from the shelf. The surveyor reviewed the medroom storage policy dated 12/02/2017 and titled: Storage and expiration Dating of medications, Biologicals, Syringes and Needles. The policy reflected that the facility should ensure that medications and biologicals that had been retained longer than recommended by manufacturer, should be stored separate from other medications/biologicals until destroyed or returned to the pharmacy. The Policy also indicated that the facility should destroy outdated/expired medications or biologicals. On 09/30/20 at 11:38 AM, during interview with the Director of Nursing (DON), she stated that staff was supposed to remove expired items from the medication cabinet in accordance with facility policy. NJAC8:39-29.4(h)
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observation, interview and review of facility documentation, it was determined that the facility failed to a.) store, label and date potentially hazardous foods in a manner to prevent food-borne illness and b.) maintain and record refrigerator temperatures. This deficient practice was observed on 09/21/2020 at 09:55 AM, during the initial kitchen tour in the presence of the Food Service Director (FSD), and was evidenced by the following: 1. On a stainless steel shelving unit in the center of the kitchen was one plastic scoop in a 10 pound bag of flour that was half full and one plastic scoop in a 10 pound bag of sugar that was less than half full. 2. Walk in refrigerator temperatures not checked or documented on the logs in the evening of 9/20/2020 or the morning of 9/21/2020. 3. In the walk in refrigerator on the top shelf were two 32 ounce jars of chopped garlic that were opened and half used with no received, opened or use by date. 4. In the walk in refrigerator on the second shelf was one opened gallon container of relish with no received, opened or use by date, and one opened gallon container of Italian salad dressing with no received, opened or used by date. 5. In the walk in refrigerator on the bottom shelf was one deep plastic gray tray that contained five clear storage bags of completely thawed chicken pieces. In the bottom of the tray was approximately one quarter inch of light red liquid. There were no pull dates or use by dates on the chicken. On 09/21/2020 at 10:30 AM, the surveyor interviewed the Food Service Director (FSD) regarding dating of items. The FSD told the surveyor stickers are available for the staff to use and all items should be dated. The FSD told the surveyor that the chicken that was observed was pulled from the freezer by the cook that morning of the initial tour and should have been dated. On 09/21/2020 at 10:38 AM, the surveyor interviewed the cook regarding the thawed chicken. The cook told the surveyor that normally he would label it with apull date when it is taken out of the freezer but that he forgot to put a label on the chicken that particular day. On 09/21/20 at 01:18 PM, the surveyor reviewed the policy titled Use by dating guidelines. The policy had a revision date of 12/1/15. Under the section of refrigerator it was written that chicken that is placed in the refrigerator to thaw would be dated with a use by date of 1-2 days. On 09/23/20 at 12:47 PM, the surveyor reviewed the policy titled Refrigeration/freezer temperature standards. The policy was revised 12/1/2015. The policy indicated that the FSD or designee observes and records the temperatures of refrigerators and freezers on using the refrigerator/freezer temperature log. The surveyor then interviewed the FSD who told surveyor the facility checks the refrigerator temperatures every morning and every evening. The FSD could not say why the logs were not checked for the two dates and times. On 09/30/20 at 09:50 AM, the surveyor reviewed the Food Storage and Retention Guide. The section titled Shelf Stable Foods indicated that condiments (salad dressing and relish) could be in dry storage for 12 months and once opened could remain in the refrigerator for 3 months when stored below or equal to 41 degrees F. NJAC 8:39-17.2 (g)
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, review of medical record and other facility documents, it was determined that the facility failed to follow facility policy to ensure that Personal Protective Equipment was utilized consistently to minimize the potential spread of infection during a.) lunch meal distribution to residents and b.) video conferencing. This Deficient practice was identified for 2 staff members and on 1 of 3 nursing units and was evidenced by the following: 1. On 09/21/20 at 9:39 AM, the surveyor interviewed the Center Executive Director (CED) who stated that a portion of B-Wing unit was utilized for residents who were newly admitted /readmitted to the facility and/or received [MEDICAL TREATMENT] who were maintained on observation status in private rooms in order to minimize the potential spread of infection of COVID-19. The CED further stated that Personal Protective Equipment (PPE) (garments or equipment worn to protect the body from infection) which included an N-95 Mask (particulate-filtering mask), face shield or goggles, gown and gloves were required in order to enter the aforementioned resident rooms. At 1:17 PM, the surveyor entered the unit through double doors on B -Wing Nursing Unit and noted signage affixed to residents' room doors which were maintained closed. The signage was a Stop Sign which cautioned: Patient-Specific Contact Plus Airborne Precautions for special respiratory circumstances please see the nurse before entering the resident's room. The instructions specified that an N-95 Respirator (a particulate-filtering face mask that filters 95% of airborne particles), gown, face shield and gloves were required to enter the room. The surveyor observed a Certified Nursing Assistant (CNA) #3 who wore a KN-95 Mask (particulate-filtering mask) and goggles as she obtained a lunch tray from the food cart located outside of the double doors. CNA #3 proceeded to deliver the meal tray without first donning (applying) a gown and gloves before she entered a resident's room even though the room had cautionary

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) signage affixed to the door, specifying that the resident was on Contact Plus Airborne Precautions. The surveyor observed CNA #3 perform hand hygiene using alcohol-based hand rub (ABHR) after she exited the resident's room. At that time the surveyor interviewed CNA #3 who stated that she worked for an outside agency. She stated that she was not sure if the portion of the unit where she distributed meals was utilized for quarantine or for isolation of residents. She also added that she did not know if she was required to wear gown and gloves for meal tray distribution or not. She further stated that she had not receive direction from nursing staff prior to her shift. Review of facility in-service training showed that CNA#3 had training on proper PPE use on the units. The signage on the doors also explained the required PPE for the resident rooms. The surveyor observed CNA #3 deliver two additional meal trays to residents' rooms wearing a KN-95 Mask and eye goggles and she did not donn a gown, face shield or gloves as the signage indicated. The CNA did perform hand hygiene after each meal tray delivery. At 1:24 PM, the surveyor interviewed the Unit Manager (UM), a Licensed Practical Nurse (LPN/UM #1) who stated that the assigned nurse was responsible to delegate required PPE use for meal pass to the CNA. The surveyor noted a cart located next to the entryway of the double door which contained the required PPE and it was accessible to all staff. At 1:25 PM, the surveyor interviewed the Registered Nurse (RN) #1 who stated that CNA #3 was instructed to donn both gown and gloves before she delivered meal trays. RN #1 then instructed CNA #3 to donn a gown and gloves before she delivered another meal tray. CNA #3 obtained another meal tray, opened the door to a resident's room and without going into the room handed the tray to another staff member with full PPE who was present inside the doorway of the resident's room. RN #1 stated that CNA #3 had been educated along with all staff by the Staff Educator numerous times that a gown and gloves were required to be worn in addition to an N-95 Mask and protective eyewear on this section of the unit within isolation rooms. Review of facility in-service training showed that CNA#3 and all other staff members had training on proper PPE use on the units. RN#1 also stated during another interview with the surveyor on 10/7/20 at 12:12 PM, that she provided oversight to CNAs to ensure they wore proper PPE. RN#1 confirmed that she had observed and reported CNA#3's non-compliance once to the Assistant Director of Nursing (ADON) prior to the 9/21/20 observation by the surveyor and that the Staff Educator who served as the Infection Preventionist (IP) provided re-inservce to CNA#3 at the time. On 9/23/20 at 11:56 AM, the surveyor interviewed the CED who stated that staff were required to wear full PPE, with gown and glove changes and to perform hand hygiene after each meal tray was delivered. He further stated that agency staff received the same training as facility staff. At 12:47 PM, the surveyor interviewed the Center Nurse Executive (CNE) who stated that staff who did not have direct resident contact, but who enter the room of a resident on Contact and Airborne Isolation for quarantine and [MEDICAL TREATMENT] unit, were required to wear a face shield, N-95 Mask, gown and gloves. On 09/29/20 at 12:04 PM, the surveyor interviewed LPN/UM #1, who stated that all CNA's were required to wear an N-95 Mask, gown, gloves, and face shield during meal tray pass. She further stated that staff were required to remove PPE and wash their hands before going to the next room. LPN/UM #1 stated that she was not aware that CNA#3 has had issues with non-compliance in wearing appropriate PPE. No other saff reported concerns regarding CNA #3's use of appropriate PPE. At 1:35 PM, the surveyor interviewed the Infection Preventionist (IP) who stated that when staff distributed meal trays to residents who were in a Contact/Airborne Precautions room, they were required to wear a gown, gloves, face shield and N-95 mask. She stated that everyone was expected to perform hand hygiene each time they removed their PPE. She further stated that the potential risk of contamination from room to room was possible if required PPE was not worn. On 09/23/20 at 12:32 PM, the CNE provided the surveyor with an In-Service Sign-in Sheet dated 05/06/20, with the Topic: Meal Tray Pass during COVID-19 which revealed that CNA #3 received education. The in-service specified that: Nurse aide (s) and nurses will be assigned to deliver trays to suspected, presumed, or confirmed positive COVID-19 patients. The Nurse aide and nurses passing trays to these patient rooms will wear a gown, gloves, N95 respirator, and a face shield when passing the meal trays. Further review of the facility documentation reflected that the facility removed CNA #3 from the schedule for 9/22/20 and also submitted a formal letter of termination of employment to CNA#'s outside agency on 9/24/20. During interview with the facility IP on 10/7/20 at 10:18 AM, the IP stated that she also conducted oversight on staff compliance with wearing appropriate PPE. The IP provided a document titled: Covid-19 walking/virtual Rounds for Infection control. The rounding document showed daily walking rounds of units and one episode when a staff member was re-educated by the IP regarding the use of proper PPE during the month of September. 2. A review of the Admission Record revealed that Resident #53 was admitted to the facility with [DIAGNOSES REDACTED]. Review of the quarterly MDS dated [DATE], revealed that the resident was rarely understood and was severely cognitively impaired. The MDS specified that the resident required total dependence of two persons for transfers and that the resident had a [MEDICAL CONDITION] and required both oxygen therapy, suctioning of [MEDICAL CONDITION] [MEDICAL TREATMENT] treatments. Review of Resident #53's Care Plan revealed an entry that was revised on 09/04/2020, which indicated that the resident had the potential for infection/COVID 19 and was at risk for infection. The care plan indicated that the resident was at High Risk due to frequent medically necessary care outside facility ([MEDICAL TREATMENT]) and that Resident#53 was on Contact Plus Airborne Precautions. On 09/22/20 at 1:15 PM, the surveyor approached the room of Resident #53 and saw a signage affixed to the outside of the door which indicated that the resident was on Contact Plus Airborne Precautions and all who entered the room must donn an N-95 Respirator, gown, face shield, and gloves prior to entry. The surveyor entered the room and observed the Social Services Director (SSD) seated in a chair at the bedside in the resident's room. The SSD wore a KN-95 Mask and goggles but did not wear a face shield, gown or gloves. When interviewed, she stated that she was there to conduct a video conference between the resident and a family member. The surveyor observed a tablet computer which was set up in a freezer bag on the resident's over bed table. At 1:19 PM, the surveyor interviewed the SSD who stated that a mask, goggles and gown were required to enter the resident's room but she could not find a gown. She stated that while she did not wear gloves during the video conference in the resident's room, she wore mask, goggles and performed hand hygiene. During another interview with the SSD on 10/7/20 at 11:32 AM, she stated she did receive education education about PPE use and that Resident #53 was not newly readmitted to the facility and as such, she looked at the resident differently with regard to wearing face shield. The SSD stated that she did not see any other resident after Resident#53. The SSD also stated that she was re-inserviced by the IP following the above incident. On 09/23/20 at 10:21 AM, the surveyor interviewed the Infection Preventionist (IP) who stated that Resident #53 was on [MEDICAL TREATMENT] and required Contact Plus Airborne Precautions per protocol. She further stated that when the SSD entered the resident's room she was supposed to donn a gown, gloves, face shield and N-95 mask to conduct the video conference in an isolation room to prevent contamination. On 09/23/20 at 12:47 PM, the surveyor interviewed the CNE who stated that whoever entered isolation rooms and rooms of residents on [MEDICAL TREATMENT] were required to wear a face shield, N-95 mask, gown and gloves and hand hygiene was required to prevent the spread of infection regardless of having direct contact with the resident or not. Review of Resident #53's Lab Results Report dated 09/30/20 at 12:42 PM, revealed that the resident's sputum culture was positive for Acinetobacter Baumannii (multi drug resistant organism) and Pseudomonas Aeruginosa. Review of Practitioner Note dated 09/28/20 at 4:24 PM, revealed that Resident #53 had confirmed sputum culture for Acinetobacter Baumannii (multi drug resistant organism) and Pseudomonas Aeruginosa. The CNE provided the surveyor with an in-Service Sign-in Sheet dated 05/08/20, which indicated that the SSD received training on: Guidance on expanded use of K-N95 Masks, New Precaution Signs, Hand Hygiene and Safe Practices and PPE for Health Care Personnel per Centers for Disease Control Guidance which contained a copy of the Extended Contact and Airborne Precautions and all requirements for PPE usage within resident rooms. The surveyor reviewed the facility policy, IC301 Contact Precautions (Revision Date 06/15/19) revealed the following: In addition to Standard Precautions, Contact Precautions will be used for diseases transmitted by direct or indirect contact with the patient or the patient's environment. to reduce the risk of transmission of epidemiologically important microorganisms by direct or indirect contact and that staff must use barrier precautions when entering the room, including to wear a gown and gloves. NJAC 8:39-19.4