STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315468	A. BUILDING _____ B. WING _____	05/20/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CARE ONE AT MORRIS	100 MAZDABROOK ROAD PARSIPPANY TROY HILL, NJ 07054

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	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review and review of other facility documentation, it was determined that the facility failed to ensure that staff follow proper infection control protocol for PPE (personal protective equipment) use for a resident on contact isolation for [MEDICAL CONDITION] ([MEDICAL CONDITION], a bacterium that can cause symptoms ranging from diarrhea to life-threatening inflammation of the colon that can be transmitted person-to-person.) This deficient practice was identified for Resident #1, 1 of 2 residents with [MEDICAL CONDITION] on 1 of 4 nursing units (200 unit non-COVID) reviewed for transmission-based precautions in a facility experiencing a COVID-19 outbreak and was evidenced by the following: During a tour of the 1st hall of the 200 unit (non-COVID), on 05/20/2020 at 10 AM, the surveyor observed Resident #1's room door with signage that indicated to Stop See Nurse. The surveyor also observed there was a metal metal isolation bin hanging on the door. The metal isolation bin contained one box of gloves and no other PPE. On 05/20/2020 at 10:21 AM, the surveyor observed a Certified Nursing Assistant (CNA #1) walking out of Resident #1's room wearing a yellow PPE gown, hair protector, mask, and gloves. CNA #1 was carrying a clear plastic bag that contained unidentifiable items. The surveyor observed the staff member walk across the hall to the bathing suite room, grasped the door handle to open the closed door and entered the room as the door closed behind her. One minute later, the surveyor observed CNA #1 leave the bathing suite room and begin to walk up the hall wearing a yellow PPE gown, hair protector, mask but no gloves. During an interview with the surveyor on 05/20/2020 at 10:23 AM, CNA #1 stated she only worked on the non-COVID units. CNA #1 stated she had been in-serviced on the signs and symptoms of COVID-19, PPE and handwashing. CNA #1 stated she did not know what type of isolation Resident #1 was on and that the process was for her to get that information on report from the nurse when she came on duty in the morning. CNA #1 stated all the resident rooms were being treated as isolation rooms now and nothing would be done differently entering or exiting the resident rooms. CNA #1 further stated she had been in and out of Resident #1's room at least twice today with the same PPE. In the presence of the surveyor, CNA #1 asked the nurse in the hallway what type of isolation Resident #1 was on and was told [MEDICAL CONDITION]. CNA #1 stated she should have gotten another gown to wear in the isolation room, but there were not any in the isolation bin on Resident #1's door. On 05/20/2020 at 10:30 AM, the DON entered the 1st hall of the 200 unit (non-COVID) and approached the surveyor and CNA #1. In the presence of the DON, the surveyor observed Resident #1's room. The DON confirmed that there only gloves were in the isolation bin hanging from the resident's room. The DON stated there should have been gowns available for the staff in the isolation bins. The DON stated that the isolation bins were restocked by the central supply staff member who was currently out sick. The DON stated that staff should have alerted housekeeping to restock the PPE in the isolation bin. The DON stated that the CNAs get report when they start their shift and would have been made aware of the isolation rooms and how to treat the isolation residents. The DON stated that CNA #1 should have doffed (removed) her PPE when exiting Resident #1's and that CNA #1 had been in-serviced on the use of PPE and isolation. During an interview with the surveyor on 05/20/2020 at 10:37 AM, CNA #2 stated she cared for the resident in the room located next to Resident #1 on the 200 unit, who was also on isolation for [MEDICAL CONDITION]. CNA #2 stated she was made aware during morning report that the resident she was assigned to had [MEDICAL CONDITION] and that the process was to remove the PPE gown when exiting the isolation room and to wash their hands. CNA #2 stated this was done to prevent the spread of infection. During an interview with the surveyor on 05/20/2020 at 10:44 AM, the 200 unit (non-COVID) Licensed Practical Nurse Unit Manager (LPN/UM), stated the process was for the CNAs to get report from the nurses when they come on shift. The LPN/UM stated that the CNAs also use the computer/kiosk (Kardex - a medical information system) to document. She added that the computer alerts staff to things like isolation rooms so the CNAs would be very aware. During an interview with the surveyor on 05/20/2020 at 10:49 AM, the Registered Nurse (RN) on the 200 unit (non-COVID) stated when CNA #1 came on shift that morning she gave CNA #1 report that Resident #1 had [MEDICAL CONDITION]. The surveyor observed that the RN was wearing a mask and gown and the RN stated there was enough PPE available in the building. The RN stated and that she should have kept an eye on the PPE in the isolation bin because it was nursing's job to monitor when the PPE in the isolation bin needed to be restocked. During an interview with the surveyor on 05/20/2020 at 11:18 AM, the RN Infection Control (RN/IC) nurse stated that the entire staff was educated and had in-services that included PPE, COVID-19 and screening the residents and staff. The RN/IC nurse stated that a resident with [MEDICAL CONDITION] would be on contact precautions which required a new gown and gloves to enter the room and removal of the gown and gloves before leaving the room to prevent the spread of infections. Review of Resident #1's Admission Record revealed the resident was readmitted to the facility in May 2020 with [DIAGNOSES REDACTED]. Review of Resident #1's Care Plan (CP) revealed an entry dated 05/14/2020, which indicated, Infection of G.I. (gastrointestinal) tract (C Diff) with an intervention to maintain isolation precautions as indicated (contact). Review of the Physician/Practitioner Progress Note, dated 05/14/2020, revealed Resident #1 had [MEDICAL CONDITION] upon readmission. Review of CNA #1's Kardex for Resident #1, dated 05/20/20, revealed isolation contact precautions. Review of CNA #1's education revealed the following: Infection Control and Prevention course, dated 11/29/2019; Handwashing: Infection Control, dated 09/23/2019; Competency validation for PPE - Donning and Doffing and identifying the appropriate PPE for standard precautions and transmission based precautions, which indicated CNA #1 met the competency requirements, dated 03/20; Donning PPE; Handwashing; Isolation precautions and types of isolation with an objective of knowing the PPE required for use, dated 04/03/2020. Review of the facility, [MEDICAL CONDITION] policy, dated 03/19, revealed residents with diarrhea as suspect CDI ([MEDICAL CONDITION]) are placed on contact precautions. Review of the facility, COVID-19 Preparedness and Response Manual, (not dated) contained the Special Droplet/Contact Precautions instructions which revealed, clean hands when entering and leaving the room, wear mask, wear eye protection, gown, and glove at the door. On 05/21/2020 at 11:03 AM, the surveyor conducted a telephone interview with the DON. The DON stated the way staff was made aware of a resident requiring isolation precautions was by the isolation sign and when given report. NJAC 8:39-19.4(a)(2); 27.1(a)

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.