STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315417	A. BUILDING _____ B. WING _____	11/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REFORMED CHURCH HOME	1990 ROUTE 18 NORTH OLD BRIDGE, NJ 08857

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS STANDARD SURVEY: 11/13/19 CENSUS: 101 SAMPLE SIZE: 25 + 10 The facility is not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for long term care facilities.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to a.) appropriately assess a [redacted] for a resident, b.) obtain and implement a physician's order for the treatment of the [redacted] in a timely manner. This deficient practice was identified for 1 of 3 residents reviewed for [redacted], Resident #239 and was evidenced by the following: On 11/4/19 at 11:00 AM, the surveyor observed Resident #239 and his/her representative in the	F 684	F684 1. Resident #239 sustained a [redacted] noted as [redacted] on the [redacted] on [redacted]. This [redacted] was later identified as a [redacted]. All [redacted] should be assessed properly and be reported to the APN/MD to ensure that the appropriate treatment is initiated at the time of the incident. In-services for all licensed nursing staff including off shift and weekend staff were initiated on 9/7/19 by the Director of Nursing on proper [redacted] assessment and MD notification for	11/29/19

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

Electronically Signed | 11/27/2019

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F 684	Continued From page 1 room. The surveyor interviewed the resident representative who stated that the resident was being discharged home that day, but that he/she had a concern that the resident had sustained an acute traumatic [redacted]) to the [redacted] on [redacted] which occurred during a transfer from a wheelchair. He/She further told the surveyor that the facility notified him/her of the incident that occurred on [redacted], but was not made aware of the severity of the [redacted]. The resident representative then showed the surveyor a picture of the traumatic [redacted] to the [redacted] on his/her personal cellphone dated 9/6/19. The surveyor reviewed the picture and the acute [redacted] appeared to be [redacted] The surveyor observed the resident's [redacted] in the presence of the resident's representative. The [redacted] area appeared to have shown signs of healing from the picture dated 9/6/19, and was now a small, jagged open [redacted] covered in 100% [redacted] The resident's skin was [redacted] The surveyor reviewed the medical record for Resident #239. A review of the Resident Face Sheet (and admission summary) reflected that the resident was admitted to the facility on [redacted] and re-admitted on [redacted] with diagnoses which included but were not limited to [redacted]	F 684	treatment orders. Further detailed mandatory in-services were given to the nursing staff on 9/23/19 and 9/27/19 by the APN on assessing skin injury and impairments and the corresponding treatments. 2. All residents who sustain a traumatic [redacted] have the potential to be affected by the deficient practice. All residents with current traumatic [redacted] were re-assessed by the Unit Managers. Treatments and proper documentation were in place for these residents. 3. The Unit Managers and Nursing Supervisors will document all traumatic injury [redacted] on the 24 hour report. In addition, an Accident/Incident Report will be completed. These reports will include the kind of injury, MD notification, and treatment orders. In-services for all of the licensed nursing staff related to this documentation policy were initiated on 9/23/19 by the Director of Nursing. 4. The Director of Nursing or designee will review the 24 hour report and all incident reports daily. Also will perform audits to ensure that a treatment is in place for each incident of [redacted], [redacted] or any other traumatic [redacted]. The audits were initiated on 11/14/19 and will continue through the entire first quarter of 2020. The results will be reported at the 2020 1st quarter QA meeting. It will be determined at this meeting if the audits will continue throughout the next Quarter based on	

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F 684	Continued From page 2 [redacted].	F 684	compliance.	

A review of the admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted] reflected that the resident had a Brief Interview for Mental Status (BIMS) score of [redacted].

A review of the resident's individualized comprehensive care plan (ICCP) dated 8/9/19 reflected a focus area for skin protection, and that on 9/2/19 the resident sustained a [redacted] on the [redacted]. documentation included that on 9/9/19 the [redacted] was [redacted], and that the center of the [redacted] was noted with [redacted] and subsequently an antibiotic was ordered. The interventions included to monitor the skin condition, use long pants, and provide a [redacted] treatment as ordered.

A review of the facility's Incident/Accident Report (I/AR) dated 9/2/19 completed by the Registered Nurse (RN) who worked the 7:00 AM - 3:00 PM shift on 9/2/19 documented that the resident obtained a [redacted] to the [redacted] which was [redacted]. The I/AR reflected that that the injury occurred while the resident was at physical therapy when two therapists were transferring the resident from his/her wheelchair. The I/AR further reflected that the RN had to apply pressure to the [redacted] for five minutes for the [redacted] and then applied a padded foam dressing to the [redacted] area. The I/AR reflected that the resident representative

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was notified of the injury, and a message was left with the resident's physician answering service. The I/AR did not include evidence of a physician's order to treat the [redacted].

A review of the September 2019 Physician Order Sheet (POS) did not reflect evidence of a physician's order for the [redacted] to the lower extremity on 9/2/19 and 9/3/19. It wasn't until 9/4/19 that a [redacted] treatment was ordered by the physician. The initial order dated 9/4/19 specified to cleanse the [redacted] with normal saline, pat it dry, cover with a petroleum dressing, gauze, and wrap with kling wrap once daily.

A review of the September 2019 Treatment Administration Record did not reflect a physician's order or evidence of accountability that a treatment was performed on the resident's traumatic [redacted] on 9/2/19 and 9/3/19.

A review of the resident's progress notes dated 9/6/19 reflected the Nurse Practitioner (NP) assessed the [redacted] for the first time, four days after the [redacted] occurred.

A review of the facility's Educational Conference (EC) dated 9/7/19 reflected that the RN who worked on 9/2/19 during the 7:00 AM - 3:00 PM shift was verbally counseled regarding the incident. The EC included, "You should perform accurate assessment of the injury, call another nurse or supervisor to help out when in doubt. Call MD [Medical Doctor] for appropriate treatment, may need to send the resident to the hospital for [redacted] management immediately following incident. Make sure there is a treatment in place for any kind of [redacted]." The RN signed that she read and understood the EC.

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F 684	Continued From page 4	F 684		

A review of a second EC dated 9/23/19 reflected that a second RN who worked on 9/3/19 on the 7:00 AM - 3:00 PM shift was counseled for applying an inappropriate wound treatment when there was no active physician's order. The EC included, "As you stated you just removed the dressing and reapply[ied] the dressing without looking into the treatment order and not doing any treatment. You mentioned to the Unit Manager that it did not look like a [redacted], looking more like a [redacted] but nothing further was done like referral to APN [Advanced Practitioner Nurse] /MD. [redacted] was left without treatment order on 9/3/19 ..."

The 7:00 AM - 3:00 PM RN who worked on 9/3/19 indicated in a hand-written statement that she notified her Registered Nurse/Unit Manager (RN/UM) because she felt the [redacted] did not look like a [redacted] and appeared to look more like a [redacted].

The hand-written statement further indicated that on 9/9/19 when the RN assessed the traumatic [redacted], after not working the weekend, noticed a change in the [redacted] appearance and condition. The '[redacted] was reddened somewhat [redacted] had formed on the outer edges." The RN proceeded to notify the physician and obtained a physician's order for the [redacted] medication, [redacted] twice a day for seven days.

A review of the resident's initial [redacted] consultation assessment dated 9/10/19 completed by the [redacted] care NP reflected that the resident was seen for the evaluation and management for a laceration to the [redacted]

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[redacted]. The documentation reflected that the resident had a [redacted] that consisted of 40 percent [redacted] and 60 percent [redacted] areas. The documentation in the assessment further reflected that the resident was receiving an antibiotic treatment for an infected [redacted]

On 11/8/19 at 10:09 AM, the surveyor interviewed the resident's Certified Nursing Aide (CNA) who stated that the resident was alert with forgetfulness and able to make his/her needs known. The CNA stated that she remembered the resident had something on his/her [redacted] only because she recalled seeing a bandage on it.

On 11/12/19 at 9:26 AM, the surveyor interviewed the RN who worked the 7:00 AM - 3:00 PM shift RN on 9/3/19 who stated she was the regular nurse assigned to care for the resident. The RN stated that the resident was admitted to the facility with a [redacted]. The RN further stated that the resident sustained a [redacted] to his/her [redacted] while staying at the facility. The surveyor asked the RN what was the difference between a [redacted] and a [redacted]. The RN described the resident's laceration as having more depth and was irregular in shape. The RN stated she told the RN/UM to "take a look" at the [redacted]. The RN stated that the next day when she came into work on 9/4/19 there was a treatment order in place for the [redacted]. The RN/UM stated that if an incident occurred it was the nurses responsibility to fill out an incident report, notify the family, the physician, and implement an appropriate treatment order for the

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injury. The RN further stated that the resident required [redacted] treatment soon after the injury occurred, and the [redacted] was healing" upon discharge from the facility.

On 11/12/19 at 9:39 AM, the surveyor attempted to conduct a phone interview with the RN who worked on 9/2/19 when the traumatic [redacted] occurred. The RN did not respond to the voicemail.

On 11/12/19 at 9:42 AM, the surveyor interviewed the RN/UM who stated that the resident was alert with forgetfulness. The RN/UM stated that the resident sustained a traumatic [redacted] to their [redacted] which occurred accidentally during a surface to surface transfer by two therapy staff members. The RN/UM stated that he thought the resident's [redacted] had encountered the wheelchair causing the [redacted]. The RN/UM stated, "after the fact the [redacted] was not a simple [redacted] as initially thought, and a [redacted] would be a better word for it." The RN/UM stated that when an incident occurred, the nurse working was responsible for assessing the resident and providing first aid care. Then the nurse should notify the physician, obtain an order and notify the family. The RN/UM was unsure if the 7:00 AM - 3:00 PM shift RN working on 9/2/19 had obtained a physician's order. The RN/UM stated that the nurse would document if the physician was notified on the incident report and the medical record, and it was necessary for the nurse to describe the injury to the resident's physician so a medically appropriate treatment could be put in place.

On 11/12/19 at 11:29 AM, the surveyor interviewed the Director of Nursing (DON) who

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F 684	Continued From page 7	F 684		

stated that when an incident occurred specific to the resident's skin the nurse would initiate an incident report and investigate the cause so the facility could implement a preventative measure to prevent another incident from taking place. The DON further stated that if a treatment needed to be put in place related to a skin injury, the facility would call the resident's physician and receive a physician's order for the appropriate treatment.

On 11/13/19 at 9:54 AM, the surveyor interviewed the NP in the presence of the Licensed Nursing Home Administrator (LNHA) and DON, and the survey team. The NP stated that she worked full time at the facility and was very involved in the resident's case. She stated that the resident was very compromised and had multiple co-morbidities. The NP acknowledged that a treatment to the [redacted] was not implemented in a timely manner. The NP further stated that upon discharge home, the [redacted] had "healed" and "it was completed closed" and a little cocoa-butter would take care of the discoloration. She added that she had talked to the family representative about the that already. (This did not correspond with the surveyor's observation on 11/4/19 and with the RN interview on 11/12/19 at 9:26 AM that the '[redacted] was healing", and the resident's discharge instructions).

A review of the facility's [redacted] Tracking Policy and Procedure dated 6/2019 indicated, "2. If the resident has a [redacted]), the nurse will notify the physician and obtain treatments orders and notify the family.

A review of the facility's Incident Reporting Policy and Procedure dated 6/2019 included, "It is the policy of Reformed Church Home that all

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F 684	Continued From page 8 incidents are properly reported, recorded and analyzed for casual factors and trends. Corrective and/or preventative measures will be implemented as indicated. The Incident Reporting Policy and Procedure further indicated, "1. Incidents will immediately be reported to the nurse, supervisor and/or unit manager, as well as the attending physician. Depending upon the severity of the incident, the Director of Nursing, and/or the Administrator is to be contacted." A review of an Inservice Education (IE) dated 9/7/19 reflected that the nurses working at the facility were educated on the difference between a [redacted] and a [redacted]. The documentation provided to the nurses in the in-service indicated that a [redacted] consisted of three types of classifications. The IE indicated, "Type 1 [redacted] are linear have a flap with no loss of skin. If the [redacted] has a flap, it should always be repositioned to cover the [redacted] base. Type 2 [redacted] have partial loss of skin, and the flap doesn't cover the [redacted] base when repositioned. Type 2 [redacted] have total loss of flap." The IE further indicated, "A [redacted] is a deep cut or tearing of your skin. Accidents with knives, tools, and machinery are frequent causes of [redacted]. In the case of deep [redacted], bleeding can be rapid and extensive." NJAC 8:38-27.1(a)	F 684		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and	F 880		11/27/19

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comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the

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F 880	Continued From page 10 circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to appropriately implement transmission-based precautions in accordance with nationally accepted guidelines to prevent the spread of infectious disease. This deficient practice was identified for 1 of 1 residents reviewed for transmission-based infections (Resident #78), and was evidenced by the following: On 11/4/19 at 10:30 AM, the surveyor observed a "Stop See Nurse" sign and a bin containing personal protection equipment (PPE), including disposable gowns, gloves, and masks used to prevent transmission of an infection. The bin was located outside Resident #78's room. The	F 880	1. Resident #78 was placed on contact isolation from [redacted] until [redacted] for a [redacted]. The resident did not remain in the room as per the current CDC Guidelines to prevent the spread of infectious disease. The facility staff was not able to correct the deficient practice for this resident, as the resident was removed from contact precautions after a [redacted] had been obtained on [redacted]. 2. Resident #78 was not affected by this deficient practice. There was a potential for other residents to be affected.	

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F 880	Continued From page 11 resident was not in his/her room. The surveyor observed a Housekeeper wearing only gloves inside the bathroom emptying the resident's garbage. The Housekeeper placed the garbage bag into his housekeeping cart at the door. The Housekeeper then donned a mask and a gown from the PPE bin. The Housekeeper informed the surveyor that this was an isolation room, so he needed to wear gloves, a mask, and a gown when inside the room. The Housekeeper continued that he was about to clean the bathroom so wearing PPE was necessary to clean the bathroom, but that it was not necessary to wear the PPE when emptying the garbage. The Housekeeper proceeded into the bathroom and placed his blue plastic caddy which contained chemical cleaning solutions directly onto the resident's bathroom floor. At 11:19 AM, the surveyor observed Resident #78 sitting in his/her wheelchair by the stored medication and treatment carts outside of the activity room. The resident refused to be interviewed by the surveyor. At 11:30 AM, the surveyor observed Certified Nursing Aide (CNA) #1 wearing only gloves inside Resident #78's room and the CNA #1 was adjusting the resident's floor mats. The resident was not observed in the room. CNA #2, who wore only a mask and gloves assisted CNA #1 in the resident's bedroom, and then closed the door behind her. The surveyor then observed CNA #2 open the door and dispose the resident's garbage inside the communal garbage bin in the hallway. CNA #2 then used her same gloved hands to open the PPE bin and remove a new garbage bag, she then closed the resident's door.	F 880	To prevent recurrence of this deficient practice: a. The MDRO and Contact Isolation Policies were revised to comply with the CDC guidelines on 11/14/19. Residents who are placed on Contact Precautions will now remain in their room until treatment is completed; the resident is asymptomatic; and it is determined by the Infection Preventionist/designee and the attending MD/APN that they no longer present a risk of transmission. In-services were initiated by the Director of Nursing on 11/14/19 to inform the entire nursing and medical staff about the policy revisions. b. The Infection Preventionist/designee will perform weekly audits for all residents placed on Contact Precautions to ensure that the policy is being followed. These findings will analyzed and presented at the quarterly QA meetings. 1. A housekeeper did not follow the proper procedure for donning PPE, cleaning an isolation room and removing garbage from that room. 2. No residents were affected by this deficient practice although other residents could have been affected. 3. On 11/12/18 the housekeeper was re-educated by the Environmental Services Operations Manager on the proper procedure for donning PPE,	

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	315417	A. BUILDING _____ B. WING _____	11/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REFORMED CHURCH HOME	1990 ROUTE 18 NORTH OLD BRIDGE, NJ 08857

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 12 At 11:47 AM, the surveyor observed Resident #78 in the dining room eating lunch. The resident refused to speak with the surveyor. The surveyor reviewed the medical record for Resident #78. A review of the Resident Face Sheet (an admission record) reflected that the resident was admitted to the facility on [redacted] with diagnoses which included [redacted]. A review of the most recent significant change Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted] reflected that the resident had a brief interview for mental status (BIMS) score of [redacted] It further included that the resident was frequently incontinent (loss of functional control) of the bladder. A review of the laboratory report for a collected [redacted] indicated that the resident had a [redacted] and that contact precautions (transmission-based precautions with the use of gowns and gloves) were indicated. A further review of the report indicated that the Advance Practicing Nurse (APN) wrote directly on the report with the date of 11/1/19 to implement "contact precautions" and [redacted] treatment for seven days.	F 880	keeping cleaning supplies from being contaminated, and removing garbage from Contact Isolation Rooms. 4. In-services were initiated on 11/14/19 by the Environmental Services Operations Manager for the remaining housekeeping staff, including off shifts and weekend employees on proper procedure for cleaning Contact Isolation rooms. The Director of Nursing initiated in-services for the nursing, housekeeping, and maintenance employees on 11/14/19 on wearing proper PPE in Contact Isolation Rooms and how to dispose of them properly. Both the Environmental Services Operations Manager and the Director of Nursing or their designees, will perform weekly audits and record observations of their staff entering, cleaning, and exiting Contact Isolation rooms. These findings will be analyzed and reported at the quarterly QA meetings. 1. The [redacted] results for resident #78 on [redacted] indicated that it was [redacted]. The APN documented on the lab report to start Contact Isolation Precautions. The sign to see the nurse and the PPE equipment was placed outside the resident□s door on [redacted] The physician□s order for Contact Precautions for [redacted] was entered on [redacted] 2. Resident #78 was not affected by this deficient practice although residents can	

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F 880	Continued From page 13 A review of the November 2019 electronic Medication Administration Record included a physician's order dated three days later on [redacted]. A review of the resident's individualized, comprehensive care plan (ICCP) included a focus area dated effective [redacted] with interventions that included to maintain contact isolation. On 11/7/19 at 8:19 AM, the surveyor observed CNA #2 open the resident's door from the inside with a mask on and removed a gown from the PPE box outside the door, then closed the resident's door from the inside. At 8:46 AM, the CNA left the resident's room wheeling Resident #78 to the dining room. The CNA wore a mask, but no gloves or gown. The CNA then proceeded to multiple areas of the unit including the nurse's station, hallway and activity room wearing the same mask. The CNA then grabbed a new mask from the cabinet by the nurse's station, and brought the mask to the activity room, where she changed masks. The used mask was disposed of in the garbage in the activity room. At 12:23 PM, the surveyor observed Resident #78 sitting in his/her wheelchair by the nurse's station. The surveyor observed CNA #2 wheel the resident to his/her room wearing no gloves or gown. On 11/8/19 at 8:21 AM and 11:08 AM the surveyor observed the resident outside of his/her room in common areas including but not limited to the nurse's station, activity room, hallways, and dining room, in which other residents were within the vicinity of Resident #78.	F 880	potentially be affected by this deficient practice. 3. The Director of Nursing initiated in-services on 11/14/19 with the nursing staff on the Contact Isolation Policy, highlighting the importance of entering the physician□s order in the EMR immediately after receiving the lab results and order from the MD or APN. 4. The Director of Nursing/designee will perform weekly audits on all Contact Isolation residents□ orders to ensure that they are entered in a timely manner. The results will be reported at the quarterly QA meetings. 1. CNA#1 and CNA#2 were observed to be noncompliant with applying and disposing of PPE when entering and exiting resident#78□s Contact Isolation Room. 2. Resident #78 was not affected by this deficient practice although other residents could have been affected. 3. On 11/14/19 the Director of Nursing re-educated with return demonstration both CNA#1 and CNA#2 on the proper procedure for applying and disposing of PPE. CNA#2 was further educated due to the fact that she wears a mask during flu season. She was told that when she enters a contact isolation room, she must apply a new mask when entering, dispose of it when leaving and reapply a new mask before going out into the hallway.	

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F 880	Continued From page 14 On 11/12/19 at 9:00 AM, CNA #2 stated that Resident #78 at times voiced he/she needed to use the bathroom, but the resident was incontinent of bladder. The resident had PPE outside his/her room for an infection, and upon entry to the room, gown and gloves were to be donned. The CNA stated that she wore a mask because she had not received the influenza vaccine. The CNA continued that the PPE was disposed of inside the red garbage cans in the bathroom. The garbage was then disposed of separately then the rest of the building's garbage. The CNA added that the resident was allowed out of his/her room while on contact precautions. At 9:22 AM, the resident's Licensed Practical Nurse (LPN) informed the surveyor that the resident needed total assistance with care needs. The resident was on contact precautions for [redacted], which meant before entering his/her room, gown, gloves, and mask were to be donned to prevent the spread of infection. The LPN stated that it was ok that the resident was out of the room because the precautions were only utilized when in direct contact with the resident. At 10:37 AM, the Registered Nurse/Unit Manager (RN/UM) informed the surveyor that the resident was on contact precautions for [redacted] which meant prior to entering the resident's room, gloves, mask, and gown were to be donned. Prior to leaving the room, the PPE was disposed of in the garbage in the bathroom. The RN/UM stated that the resident was allowed out of his/her room since the urine was contained inside his/her incontinent brief.	F 880	4. The Director of Nursing initiated in-services on 11/14/19 for the entire nursing, housekeeping and maintenance employees on the policy and procedures for PPE in Contact Isolation rooms including the procedure for wearing masks during flu season. The Director of Nursing/designee will perform random weekly audits and observe staff entering and exiting the isolation rooms to ensure compliance and report the findings at the quarterly QA meetings.	

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F 880	Continued From page 15	F 880		

At 10:49 AM, the Housekeeping Supervisor informed the surveyor that if there was PPE outside a resident's room, the housekeeper asked the nurse what he/she needed to wear prior to entering the room. Residents that were on contact precautions had separate garbage and linen receptacles in their bathrooms for disposal. Garbage disposal went directly from the resident's room to the outside garbage collector, and the linen went directly to the laundry room to be washed separately. The Housekeeping Supervisor added that for all rooms, chemicals were brought off the cart as needed, and the blue plastic caddies should not leave the cart or be placed on the floor.

At 11:07 AM, the Director of Nursing (DON), informed the surveyor that she was the Infection Preventionist. The DON stated that contact precautions involved donning gloves and gowns when performing tasks that involved secretions. The DON specified for contact precautions for [redacted], staff wore gowns and gloves when entering the resident's room. The resident was allowed outside of his/her room since the [redacted] was contained inside the incontinence brief. The DON acknowledged that the resident was frequently incontinent of [redacted].

At 1:27 PM, the DON, in the presence of the Licensed Nursing Home Administrator (LNHA), Assistant Administrator, and survey team, stated that the facility used the Center for Disease Control (CDC) as the national guidelines for contact precautions. The DON added that the CNA who left Resident #78's room wearing a mask, wore the mask because she had not received the influenza vaccine. The DON then acknowledged that the CNA should not have worn

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F 880	Continued From page 16	F 880		

PPE from a contact precaution room outside that room.

On 11/13/19 at 10:09 AM, the DON, in the presence of the LNHA, Assistant Administrator, APN, and survey team stated that per the facility's policy, the resident was allowed out of his/her room if on contact precautions. The DON provided information from the CDC dated 2007 for Guidelines to Isolation Precautions. The DON stated that she had nothing more recent from the CDC to provide the survey team.

At this time, the APN stated that the resident was incontinent, but he/she was toileted frequently. The APN also stated that since the resident was dressed, no one would be in contact with the [redacted] so he/she could come out of the room.

The Assistant Administrator stated that the point of contact precautions was that staff wore PPE when care was rendered.

The LNHA stated that the thought process was that the [redacted] was contained in the resident's incontinence brief, so it was okay for the resident to partake in communal dining and activities as usual.

The surveyor reviewed the facility's Policy and Procedure Contact Isolation Precautions dated revised June 2019, which included all residents requiring isolation precautions [redacted] will be on contact isolation precautions according to CDC guidelines.

The surveyor reviewed the CDC guidelines for Implementation of Personal Protective Equipment in Nursing Homes to Prevent Spread of Novel or

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F 880	Continued From page 17 Targeted Multidrug-resistant Organisms (MDROs) updated July 26, 2019 which included contact precautions were intended to prevent transmission of infectious agents, like MDROs (example [redacted]), that are spread by direct or indirect contact with the resident or the resident's environment. The guidelines also included that contact precautions required the use of gown and gloves on every entry into a resident's room. Residents on contact precautions should be restricted to their rooms except for medically necessary care and restricted from participation in group activities. NJ 8:39-19.4	F 880		

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	030709	A. BUILDING: _____ B. WING _____	11/13/2019

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H 000	Initials Comments The facility is not in compliance with N.J.A.C. Title 8 Chapter 43E- General Licensure Procedures and Standards Applicable To All Licensed Facilities.	H 000		
H3470	8:43E-10.11(c)(2) Other Rprtng Rqrmnts Unrltd to Pt Sfty Act Examples of reportable events in the nature of physical plant and operational interruptions, include, but are not limited to, the following: Loss or significant reduction of water, electrical power, or any other essential utilities necessary to the operation of the facility. This REQUIREMENT is not met as evidenced by: Based on documentation review on 11/4/19 and electronic correspondence on 11/7/19 in the presence of facility management, it was determined that the facility failed to report electrical power outage to the New Jersey Department of Health (NJDOH) in accordance with reportable events protocols. This deficient practice was evidenced by the following: On 11/4/19, a review of the facility's emergency generator log for the previous 12 months revealed that the facility lost primary power to the facility on two (2) occasions. These power outages were documented for 5/22/19 for 0.2 hours (12 minutes), and 7/22/19 for 0.7 hours (42 minutes).	H3470	H3470 1. There were no residents immediately affected by this deficient practice. 2. Residents can be potentially affected by this practice. 3. To prevent recurrence of this deficiency, the job description for the maintenance employee was revised to reflect that they are responsible for checking and reporting utility system interruptions to the Director of Environmental Services/designee immediately. The Director of Environmental Services initiated in-services on 11/14/19 with the entire maintenance staff, including weekend and off shift employees, on reporting any	11/27/19

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

Electronically Signed | 11/27/19

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H3470	Continued From page 1 On 11/7/19, the facility's Licensed Nursing Home Administrator (LNHA) confirmed, via electronic communication, that these outages were not reported to the NJDOH at the time.	H3470	physical plant and operational interruptions, to him or his designee immediately. The Director of Environmental Services/designee will notify the Assistant Administrator/Administrator of the outage so that the outage can be immediately reported on the Department of Health website. 4. To monitor compliance, the Director of Environmental Services/designee will perform daily audits to ensure that any outages are reported. These findings will be documented in the life safety binder and reported at the quarterly QA meetings.	