STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315455	A. BUILDING ______ B. WING ______	03/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL HEALTH GATE NRSG REHAB	**1314 BRUNSWICK AVENUE TRENTON, NJ 08638**

(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 CENSUS: 118 SAMPLE: 27 A Certification Survey was Conducted to determine compliance with 42 CFR part 483, Requirement for Long Tern Care Facility. Deficiencies were cited for this survey.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen	F 550		4/9/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — Electronically Signed
TITLE
(X6) DATE 03/23/2020

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 550	Continued From page 1 or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to maintain a resident's personal privacy during care. This deficient practice was identified for Resident #87, 1 of 24 residents reviewed for dignity, and was evidenced by the following: On 02/26/20 at 10:33 AM, the surveyor conducted the initial tour of the first floor nursing unit. The surveyor noted that Resident #87's door was closed. The surveyor knocked on the resident's door and was invited by staff to enter the room. The surveyor entered the room and noted the curtains were not drawn around the resident's bed. The surveyor also noted that Resident #87 was lying in bed on his/her back, fully unclothed and completely uncovered. The surveyor observed two Certified Nursing Assistants (CNAs) inside the room at the resident's bedside proving him/her a bed bath while the resident was in full view of his/her roommate, and in full view of anyone that	F 550	F-550 1. The 2 CNAs were counseled and given a separate in-service on resident dignity. There was no negative outcome to the resident. 2. All residents have the potential to be affected when the Dignity policy is not followed. 3. An in-service was done with all CNAs by the Director of Nurses on March 5,2020 to ensure the policy and procedure on resident Rights and Dignity is followed. 4. The Director of Nurses, the Assistant Director of Nurses or Unit Managers will observe two CNAs a week providing care to ensure the appropriate technique for dignity is being followed. This will be done weekly x 2 Quarters. All findings will be reviewed at the Quality Assurance	

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F 550	Continued From page 2 entered the room. On 02/26/20 at 11:01 at AM, the surveyor interviewed CNA #1 who stated that Resident #87's body should not have been exposed. CNA #1 stated that they should have only exposed the part of the body being washed and should have drawn the curtain. On 02/26/20 at 11:05 AM, the surveyor interviewed CNA #2 who stated that she had worked at the facility for a few years and that she knew the resident's body should have been covered during care. On 02/26/20 at 12 noon, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM #1) who stated that the curtain should have been pulled and that the resident should have been covered to protect the resident's privacy. RN/UM #1 also stated that the both CNAs were previously provided with dignity training by the facility. On 03/03/20 at 2:50 PM, the surveyor discussed the above findings with the Administrator, the Director of Nursing (DON), Assistant Director of Nursing, and Regional Director. The DON stated that she could not provide an answer as to why CNA #1 and CNA #2 did not cover the resident's body during care. A review of the facility's "Residents Rights" policy, dated 09/10/19, reflected that employees shall treat all residents with kindness, respect and dignity. NJAC 4.1(a)(12)	F 550	meeting x two quarters.	
F 695	Respiratory/Tracheostomy Care and Suctioning	F 695		4/9/20

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F 695 SS=D	Continued From page 3 CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to ensure that [redacted] was administered in accordance with a physician order and the facility's policy on [redacted] administration. This deficient practice was identified for Resident #48, 1 of 2 residents reviewed for [redacted] administration, and was evidenced by the following: On 02/26/20 at 2:24 PM, during the initial tour of the facility, the surveyor observed Resident #48 lying awake in bed. The resident was wore a nasal cannula that was connected to an [redacted] with setting at [redacted]. The surveyor interviewed the resident during the observation. The resident stated that he/she did not know how many liters of [redacted] that was prescribed for him/her. As the surveyor interviewed the resident, the [redacted] alarm started to sound. A Registered Nurse (RN #1) entered the resident's room, adjusted the [redacted] and stopped the alarm. RN #1 stated to the surveyor that the resident had an order to receive [redacted]	F 695	F-695 1. Resident #48, the [redacted] was adjusted to [redacted]. Resident #48 care plan was updated to reflect [redacted]. R.N. #1 was in-serviced on the policy and procedure for [redacted] administration. 2. All residents have the potential to be affected by this deficient practice when [redacted] is incorrect. All residents receiving [redacted] were observed to ensure all [redacted] were correct. None were found to be deficient. 3. An in-service was done with all nurses by the Director of Nurses on March 5,2020to ensure the [redacted] policy and procedure is being followed. 4. The Unit Managers will observe 3 residents daily, then 3 residents weekly to ensure [redacted] is correct x two quarters. All findings will be reviewed by the Quality Assurance meeting x 2	

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F 695	Continued From page 4	F 695		

RN #1 did not acknowledge that the was running at .

The surveyor reviewed Resident #48's Admission Record (an admission summary) which indicated that the resident was readmitted to the facility with diagnoses that included:

A Physician's Order Form (POF) revealed an order dated , for The POF also included an order dated , to check the resident's) every shift and to maintain the resident's at or above.

The Annual Minimum Data Set (MDS), an assessment too revealed that the resident had a Brief Interview for Mental Status (BIMS) score of which indicated that the resident was cognitively impaired. The MDS also indicated that the resident was totally dependent on two persons for bed mobility and transfers from the bed to the wheelchair, and totally dependent on one person for personal hygiene and received therapy.

The Interdisciplinary Care Plan revealed that the resident was on . There was no documentation on the care plan to indicate that the resident had any behaviors related to self-removal of his/her

On 03/02/20 at 10:09 AM, the surveyor observed Resident #48 seated in a recliner chair inside the

Provider's plan of correction (continued): quarters.

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resident's room. The resident wore a [redacted] [redacted] that connected to an [redacted] [redacted] with [redacted] running at [redacted]

On 03/02/20 at 10:51 AM, the surveyor interviewed RN #1 who inspected Resident #48's [redacted] in the presence of the surveyor. RN #1 adjusted the [redacted] to [redacted]. She confirmed that the [redacted] [redacted] was set incorrectly instead of the [redacted] as prescribed. She further stated that the [redacted] flow meter was set at [redacted] at 9:00 AM, and that it might have accidentally gotten bumped off rate during transfer from the bed to the chair.

On 03/03/20 at 10:26 AM, the surveyor observed Resident #48 seated in the recliner chair inside the resident's room. The surveyor observed that the resident was not wearing the [redacted]. When interviewed, the resident stated that he/she did not have his/her [redacted] on and that he/she was supposed to be wearing [redacted]. The surveyor noted that the resident's [redacted] and [redacted] [redacted] was on the floor next to the right side of the resident's recliner chair. The [redacted] was attached to the [redacted] and was set at [redacted].

On 03/03/20 at 10:36 AM, the surveyor interviewed RN #1 who stated that Resident #48 was supposed to have his/her [redacted] on. RN #1 further stated that she last observed Resident #48 wearing the [redacted] at 9:00 AM. At that time, the Registered Nurse Unit Manager (RN/UM #2) entered the resident's room and stated that the resident must have removed the [redacted]. RN/UM #2 checked the resident's [redacted] (a [redacted] [redacted]. The [redacted]

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F 695	Continued From page 6 reading measured [redacted] and fluctuated up to [redacted] which was lower than what the physician ordered. On 03/03/20 at 10:40 AM, a Certified Nursing Assistant (CNA #3) entered Resident #48's room. CNA #3 stated that she got the resident up from the bed to the recliner chair at 10:18 AM. She further stated that the resident complained that he/she wanted the [redacted] adjusted. CNA #3 stated that the resident removed the [redacted] and that she instructed the resident to put the [redacted] back on. CNA #3 stated that she did not know if the resident put the [redacted] back on and that she did not report the incident to RN #1. A review of the facility's [redacted] Administration" policy, dated 12/12/19, revealed the purpose of the procedure was to provide guidelines for safe [redacted] administration. The policy included to adjust the [redacted] device so that it was comfortable for the resident and the proper [redacted] of [redacted] was being administered. The policy also indicated to observe the resident upon setup and periodically thereafter to be sure [redacted] was being tolerated and to notify the supervisor if the resident refuses the procedure. NJAC 8:39-11.2(b); 27.1(a)	F 695		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly	F 812		4/9/20

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F 812

Continued From page 7

from local producers, subject to applicable State and local laws or regulations.
(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.
(iii) This provision does not preclude residents from consuming foods not procured by the facility.

§483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review, it was determined that the facility failed to ensure that a.) kitchen equipment was maintained in a safe and sanitary condition b.) 6 of 6 kitchen staff observed performed proper hand hygiene prior to food handling, and c.) 2 of 2 kitchen staff with facial hair wore a beard restraint during food preparation in the kitchen.

This deficient practice was identified in the facility's kitchen and was evidenced by the following:

On 02/26/20 from 9:35 AM to 10:00 AM, the surveyor toured the facility's kitchen in the presence of the Food Service Director (FSD) and observed the following:

There were three clear colored food storage bins with white lids stored underneath a stainless-steel counter. All three containers were heavily stained and discolored.

There was a stainless steel four-tiered drying

F 812

F-812

1. The storage bins in question were replaced. The rest of the kitchen was inspected for other storage bins that were stained or discolored to ensure that there were no other storage bins to be replaced. There were no others found.
The 4 large wet stainless steel pans were immediately re-washed and properly air dried. On the third shelf the 2 large stainless steel pans that were wet were immediately re-washed and properly air dried. The rest of the racks were carefully inspected to ensure that the other utensils and pans were being properly air dried.
The pan of rice found in the walk-in freezer/refrigerator was immediately discarded. The rest of the freezer/walk-in refrigerator was inspected to ensure that all food was properly labeled and dated with use by dates.
FSW #3 and Cook #1 were immediately instructed to put on beard nets and to

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F 812	Continued From page 8 rack inside the dish room. On the second shelf of the rack, there were four large stainless-steel pans wet and nesting with visible water residue. On the third shelf of the rack, there were two large stainless-steel pans that were wet and nesting with visible water residue. Inside the walk-in freezer, there was a half size stainless pan with rice dated 02/25/20 with no use by date. During a follow-up visit to the kitchen on 03/02/20 from 11:16 AM to 12:20 PM, in the presence of the facility's owner (owner), Administrator and FSD, the surveyor observed the following: A Food Service Worker (FSW #3) entered the kitchen and was not wearing a beard restraint. FSW #3 began to prepare residents' meal trays. FSW #3 placed cups, utensils and beverages on the trays. Cook #1 was observed preparing Italian bread and pasta. Cook #1 was observed with facial hair and was not wearing a beard protector. The surveyor observed Cook #1, Cook #2, FSW #1, FSW #2, FSW #3, and FSW #4 as they washed their hands at the handwashing sink inside the kitchen. The cooks and FSW wet their hands, applied soap and immediately placed their hands underneath the flow of water. None of the Cooks and FSW above scrubbed their hands away from the flow of water before their hands were rinsed. They all removed a paper towel from the paper towel dispenser and dried their hands. After drying their hands, they all	F 812	cover their facial hair. Cooks # 1 and # 2 as well as FSW 1,2,3,4 were immediately instructed to re-wash their hands properly according to the Hand Washing policy. The rest of the food service workers were observed washing their hands properly as well. 2. These deficient practices have the potential to affect the residents and staff of the facility due to the fact that the lack of infection control and proper sanitation can bring on food borne illnesses. 3. The Food Service Director as well as the Administrator on March 5,2020 in-serviced all Dietary employees on the policy and procedure for proper sanitation practices in the kitchen on a quarterly basis. The Food Service Director and the Administrator will inspect the kitchen on a daily basis for discolored bins and utensils that have to be replaced. The Food Service Director and the Administrator will inspect pots, pans and utensils to ensure they are properly air dried. All Dietary employees will be continually in-serviced on the proper labeling and dating of refrigerated/freezer food items. The Infection Control Preventionist will continue to in-service and observe the dietary employees for proper hand washing technique. 4. The Administrator and the Food service director will ensure the above deficiencies will not reoccur by inspecting/monitoring the cited items above daily x 60 days then every other	

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F 812	Continued From page 9 used the same paper towel to turn off the faucet. The owner and FSD, who were with the surveyor at the time, stated that the kitchen staff needed more education on handwashing. On 03/02/20 at 2:06 PM, the surveyor interviewed FSW #3 and Cook #1. FSW #3 acknowledged she washed her hands underneath the flow of water instead of scrubbing her hands away from the flow of water. Cook #1 stated that he had been the facility's cook for [redacted]. Cook #1 stated that he was nervous and washed his hands underneath the flow of water. On 03/02/20 at 2:08 PM, the surveyor interviewed Cook #2. Cook #2 stated that he did not recall washing his hands underneath the flow of water. On 03/02/20 at 2:18 PM, during interview, FSW #2 stated that she knew how to wash her hands and that she was supposed to scrub her hands away from the flow of water before she rinsed under the flow of water. A review of the facility's "Handwashing" policy and procedure, dated 08/13/19, revealed that handwashing was performed to prevent the spread of bacteria before, during and after preparing food, before meals. The procedure included the following: Turn water on at the sink; Wet hands and wrist thoroughly; Apply skin cleanser or soap to hands; Lather all surfaces of fingers and hand, including above the wrist producing friction for at least 20 seconds; Rinse all surfaces of hands and wrist without contaminating hands; Use a clean, dry paper towel to dry all surfaces of hands, wrist and fingers without contaminating hands; Use a clean	F 812	day x 30 days, then the Administrator will continue to check weekly ongoing. All findings will be reviewed at the Quality Assurance meeting x 2 quarters.	

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F 812	Continued From page 10 paper towel to turn off the faucet without contaminating hands. A review of the facility's "Hair Net" policy, dated 09/18/19, revealed that it was the policy of the facility that no employee should enter the kitchen before they cover their head hair and/or facial hair. NJAC 8:39 17.2(g)	F 812		
F 814 SS=D	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, it was determined that the facility failed to maintain the trash compactor area in a sanitary manner. This deficient practice was identified for 1 of 1 trash compactor area inspected and was evidenced by the following: On 02/26/20 at 10:10 AM, in the presence of the Food Service Director (FSD), the surveyor observed the facility's outside trash compactor area. The trash compactor did not have a lid and the gate was open. The FSD and surveyor observed three large green bags of trash and assorted cardboard boxes inside the trash compactor. The contents inside the trash compactor had not been compacted. On 03/03/20 at 11:45 AM, in the presence of the facility's owner, the Administrator, and FSD, the surveyor observed the outside facility trash	F 814	F-814 1. The Trash Compactor in question was immediately secured. A wire mesh was installed on the door to keep employees safe and to deter rodents from entering the compactor. The Dietary employees, the Maintenance Director, and the Housekeeping Director were immediately in-serviced by the Administrator on March 5,2020 to make sure to compact the trash immediately after throwing it into the compactor. The Dietary employees were also in-serviced by the Administrator on march 5,2020 to make sure that the crushing mechanism of the compactor remains closed so that no one can fall in and rodents do not have access to the trash. In addition all Dietary employees were in-serviced by the Administrator on March 5,2020 and instructed to make sure that they close the gate and latch it	4/9/20

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F 814	Continued From page 11 compactor area. The trash compactor did not have a lid and the gate was open. When interviewed, the owner stated that the trash compactor did not have a lid and that a lid, and agreed that the compactor should have a lid to prevent infestation of pests. During an interview on 03/03/20 at 3:40 PM, the owner stated that the facility did not have a trash compactor policy and that it was the kitchen staffs' responsibility to compact the trash. On 03/04/20 at 10:49 AM, following surveyor inquiry on 03/03/20 at 3:40 PM, the owner provided the surveyor with a "Trash Compactor" policy and procedure dated 03/20/20. The policy reflected that the trash compactor area shall be kept clean and safe. The housekeeping staff shall clean and monitor the trash compactor and the area surrounding it on a daily basis. After the trash was deposited in the compactor, the crushing mechanism shall be left in a closed position to restrict entry by wildlife and prevent anyone from falling into the compactor. The safety and cleanliness of the compactor shall be monitored by housekeeping, the Dietary Manager and the Administrator. NJAC 8:39-17.2(g)	F 814	after each use. The compactor company was contacted and came out and repaired the safety button on the gate that disengages the motor when the gate is open. 2. This deficient practice has the potential to affect all residents and employees. The deterrence of rodents prevents them from infiltrating the facility. The employees can be severely injured should the compactor not function properly and by leaving the gate open with the mechanism not closed leaving the danger of someone falling in and sustaining injury. 3. The compactor will be monitored by the Dietary Director, Housekeeping Director and Maintenance Director on a daily basis to ensure that the compactor policy and procedure policy are being followed. An in-service was done by the Administrator on March 5,2020 with all the Dietary employees, all Housekeeping employees, and all Maintenance employees quarterly as to the policy and procedure of the compactor. 4. The Administrator will monitor the Dietary employees daily x 60 days,then weekly x 30 days to ensure that they are following the policy and procedure of the compactor. All findings will be reviewed at the Quality Assurance meeting x 2 quarters.	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control	F 880		4/9/20

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F 880	Continued From page 12 The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and 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,	F 880		

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F 880	Continued From page 13 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 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 a.) follow the appropriate infection control protocol for hand hygiene on 02/28/20 and on 03/02/20 during meal service on the [redacted] nursing unit, and b.) follow appropriate infection control procedures regarding donning Personal Protective Equipment (PPE) while caring for a resident on contact isolation precautions and cleaning/disinfecting equipment used on a resident in a contact isolation room.	F 880	F-880 1. CNA #1 and CNA #2 were given written counseling on the Proper Handling of Food. CNA #1 and CNA #2 were separately in-serviced by the Director of Nurses on MArch 5,2020 on food handling, PPE, Infection Control and cleaning equipment after use. The [redacted] of resident #79 (AWD)was separately in-serviced on the proper donning of Personal Protective	

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This deficient practice was identified for 4 of 4 staff members observed, and for Resident #79, 1 of 1 resident reviewed for transmission-based precautions and was evidenced by the following:

1. On 02/28/20 from 12:06 PM to 12:36 PM, the surveyor observed three staff members, Licensed Practical Nurse (LPN #1), Certified Nursing Assistants (CNA #1) and CNA #2, as they served lunch to residents in the rooms on the [redacted]. The surveyor observed the following:

LPN #1 stood beside the lunch truck outside the residents' rooms and inspected the trays before handing them to the CNAs. At 12:06 AM, CNA #2 took a tray to a resident in room [redacted] Without wearing gloves or performing hand hygiene, CNA #2 removed a slice of bread from the lunch tray and then buttered the bread for the resident. CNA #2 did not offer hand hygiene to the resident and did not perform hand hygiene before returning to the food truck.

While the surveyor was still in room [redacted] with CNA #2, CNA #1 entered the room with a tray for the roommate. Without wearing gloves or performing hand hygiene, CNA #1 retrieved a slice of bread from the plastic wrapping, held the bread in her bare hands, buttered the bread, set it on the resident's tray, and then left the room. CNA #1 did not offer hand hygiene to the resident and did not perform hand hygiene before returning to the food truck.

At 12:10 PM, both LPN #1 and CNA #2 wheeled the food truck to the front of room [redacted]. After LPN #1 inspected the trays, CNA #2 retrieved a tray from the lunch truck and took the tray to the

F 880

Equipment.

2. All residents have the potential to be affected by this deficient practice when Infection Control Policy and Procedure are not followed as well as the proper procedure for handling food.

3. All nurses and CNAs were in-serviced by the Director of Nurses on March 5,2020 on the proper handling of food, PPE equipment, Infection control and the cleaning of equipment after use.

4. The Director of Nurses, Assistant Director of Nurses and Unit Managers will observe three CNAs daily then three CNAs twice a week, then three CNAs weekly x 60 days to ensure the proper handling of food, donning of PPE, infection control and cleaning of equipment. All findings will be reported at the Quality Assurance meeting x 3 quarters.

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resident in room [redacted] Without wearing gloves or performing hand hygiene, CNA #2 set up the tray for the resident, which included, using her bare hands to hold a slice of bread while she buttered the bread. CNA #2 did not offer hand hygiene to the resident and did not perform hand hygiene prior to returning to the food truck.

At 12:11 PM, CNA #2 took a lunch tray to room [redacted] Without performing hand hygiene, CNA #2 set up the food for the resident, which included, cutting up the food, and opening and inserting a straw into the resident's milk without performing hand hygiene. CNA #2 did not offer hand hygiene to the resident and did not perform hand hygiene before returning to the food truck.

At 12:12 PM, CNA #2 and LPN #1 wheeled the food truck to room [redacted] CNA #2 took a tray into room [redacted]. Without performing hand hygiene, CNA #2 set up the food for the resident, which included, cutting up the food, and opening and inserting a straw into the resident's milk without performing hand hygiene. CNA #2 did not offer hand hygiene to the resident and did not perform hand hygiene before returning to the food truck.

At 12:16 PM, CNA #2 wheeled the lunch truck to room [redacted]. She took a tray into room [redacted] Without wearing gloves or performing hand hygiene, CNA #2 removed the slice of bread from the plastic wrapping, and placed it in her bare hand as she buttered the bread. As CNA #2 was setting up the resident's tray, she accidentally spilled the resident's coffee onto the lunch tray. CNA #2 removed a paper towel from the dispenser and dried off the coffee spill. She then finished setting up the resident's tray. CNA #2 did not offer hand hygiene to the resident and

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F 880	Continued From page 16 did not perform hand hygiene before returning to the food truck. At 12:18 PM, LPN #1 and CNA #2 proceeded to the front of room [redacted] with the food truck. CNA #2 delivered a tray to the resident in room [redacted]. Without performing hand hygiene, CNA #2 set up the tray. CNA #2 did not offer hand hygiene to the resident and did not perform hand hygiene before returning to the food truck. At 12:20 PM, CNA #2 took a lunch tray to the roommate in room [redacted]. Without performing hand hygiene, CNA #2 set up the food for the resident. CNA #2 did not offer hand hygiene to the resident and did not perform hand hygiene before returning to the food truck. At 12:23 PM, CNA #2 delivered a tray to a resident in room [redacted] CNA #2 moved a wheelchair out of the way, moved the bedside table closer to the bed, and then set the food tray on the table. CNA #2 did not offer hand hygiene to the resident and did not perform hand hygiene before returning to the food truck. At 12:25 PM, CNA #2 took a lunch tray to a resident in room [redacted] Without wearing gloves or performing hand hygiene, CNA #2 cut up the resident's food, picked up the resident's bread with her bare hands and buttered the bread. CNA #2 did not offer hand hygiene to the resident and did not perform hand hygiene before returning to the food truck. At 12:29 PM, CNA #2 took a lunch tray to a resident in room [redacted]. CNA #2 set the tray on the resident's table and stated to the surveyor that she would return to feed the resident later.	F 880		

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At 12:30 PM, CNA #2 took a lunch tray to the roommate in room [redacted] Without wearing gloves or performing hand hygiene, CNA #2 removed a slice of bread from the tray, held it in her bare hand, and buttered the bread. She then removed the straw wrapper and placed the straw into the mild container. CNA #2 did not offer hand hygiene to the resident and did not perform hand hygiene before returning to the food truck.

At 12:32 PM, CNA #2 took a lunch tray to a resident in room [redacted] Without wearing gloves or performing hand hygiene, CNA #2 removed a slice of bread from the tray, held it in her bare hand, and buttered the bread. CNA #2 did not offer hand hygiene to the resident and did not perform hand hygiene before returning to the food truck.

At 12:34 PM, CNA #2 took a lunch tray to a resident in room room [redacted] Without wearing gloves or performing hand hygiene, CNA #2 removed a slice of bread from the tray, held it in her bare hand, and buttered the bread. CNA #2 did not offer hand hygiene to the resident and did not perform hand hygiene before returning to the food truck.

At 12:36 PM, CNA #2 took a lunch tray to the roommate in room [redacted]. CNA #2 moved a resident's wheelchair out of the way, set the tray on the table, and then cut up the resident's food. CNA #2 did not offer hand hygiene to the resident and did not perform hand hygiene after touching the wheelchair and before returning to the food truck.

The surveyor could not interview the residents

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due to their [redacted] status.

When CNA #2 finished passing out the trays, she returned to room [redacted] Without performing hand hygiene, she sat in a chair near the resident. She was about to start feeding the resident when the resident requested that CNA #2 scratch his/her back. CNA #2 got up, donned gloves, scratched the resident's back, removed the gloves, and then washed her hands.

On 03/02/20 from 12:20 to 12:30 PM, the surveyor observed CNA #2 and LPN #1 as they distributed meals to residents who ate in their rooms on the [redacted]. The surveyor observed the following:

CNA #2 removed a lunch tray from the food truck and delivered it to a resident in room [redacted] CNA #2 set the tray on the resident's overbed table, moved the resident's wheelchair out of the way, and then set up the resident's tray. With her bare hands, she removed the straw wrapper and placed the straw into the milk container. CNA #2 did not offer hand hygiene to the resident and did not perform hand hygiene after touching the wheelchair and before returning to the food truck.

CNA #2 delivered a tray to a resident in room [redacted]. CNA #2 moved a walker out of the way, she then set up the resident's lunch tray. Using her bare hands, she unwrapped a straw and inserted it into the milk container. CNA #2 did not offer hand hygiene to the resident and did not perform hand hygiene after touching the walker and before returning to the food truck.

CNA #2 delivered a tray to a resident in room [redacted] CNA #2 picked up a towel that was on the

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resident's bed and placed the towel to the side. She then cleared the resident's table and placed the tray on the table. CNA #2 did not offer hand hygiene to the resident and did not perform hand hygiene before returning to the food truck.

CNA #2 delivered a tray to a resident to room [redacted] CNA #2 set up the tray, which included unwrapping a straw and inserting it into a milk container. CNA #2 did not offer hand hygiene to the resident and did not perform hand hygiene after leaving the resident's room.

The surveyor could not interview any of the residents due to their [redacted] status.

On 03/02/20 at 12:30 PM, the surveyor interviewed CNA #2. She stated that her practice was to wash her hands after all trays had been served to the residents. CNA #2 stated that it would take too long if she had to stop and perform hand hygiene between residents. When asked about touching residents' bread and straw with her bare hands, she stated that they were told not to wear gloves when they served meals to residents. CNA #2 stated that she only performed hand hygiene if she touched something soiled such as "urinal." When asked about cleaning residents' hands before meal service, CNA #2 stated that she had seen hand sanitizing wipes in the facility but that she did not usually offer the wipes to residents. When asked if her practice was based on facility protocol, CNA #2 stated that it was partly facility protocol and partly her own practice.

On 03/02/20 at 12:40 PM, the surveyor interviewed LPN #1. When asked about the facility's protocol for infection control during meal

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F 880	Continued From page 20 service, LPN#1 stated that she had not had infection control training related to meal service since she was hired in [redacted]. LPN #1 stated that staff were not supposed to touch the residents' food with their bare hands and that she knew this from her previous experience. LPN #1 also stated that staff was supposed to wash their hands if they touched the residents' furniture or other items in the residents' rooms, before continuing to serve the meal trays. When asked about hand hygiene for residents, LPN #1 stated that she was not provided with hand sanitizer for residents. On 03/03/20 at 02:28 PM, the surveyor informed the facility of the above findings. During an interview with facility administration on 03/04/20 at 10:53 AM, the Director of Nursing (DON) stated that the facility did not have a separate policy regarding infection control during meal service. Both the DON and Regional Director stated that the facility provided general infection control to all staff members. The DON stated that staff should know not to touch residents' food with their bare hands and should provide hand hygiene to residents as part of general infection control. Review of the facility's undated "Handwashing" policy revealed that there were no protocols to address handwashing for food handling during dining meal service. The surveyor reviewed an infection control in-service, dated [redacted], which revealed that LPN #1 received general infection control education. The surveyor noted the infection	F 880		

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F 880	Continued From page 21 control in-service did not address dining meal service. The list of in-service attendees did not include CNA #1 or CNA #2. 2. On 02/26/20 at 10:26 AM, while standing at the resident's room doorway, the surveyor observed Resident #79 seated in his/her wheelchair. The surveyor noted that Resident #79 had a [redacted] The surveyor observed that there was a white and black colored sign posted outside the resident's room door. The sign indicated that visitors were to report to the nurse prior to entering the room. The surveyor observed a clear, plastic, two-drawer container outside the resident's room, which contained PPE (items such as gloves, gowns, and face masks designed to protect individuals from exposure to or contact with infectious agents). At this time, a facility staff member who was later identified as an "Admission's Department Worker (ADW)" entered the room without applying any PPE. The ADW, with her bare hands, repositioned the resident in his/her wheelchair and adjusted the resident's blanket that was covering the resident's [redacted] The ADW then exited the room without performing hand hygiene. Review of the "Admission Record" revealed that Resident #79 was admitted to the facility with diagnoses that included, [redacted]	F 880		

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Review of an initial Minimum Data Set (MDS), an assessment tool dated [redacted], revealed that Resident #79 had a Brief Interview for Mental Status (BIMS) of [redacted] which indicated the resident was cognitively [redacted] The MDS also showed that the resident required extensive assistance from staff for all activities of daily living.

Review of Resident #79's isolation care plan (CP), dated [redacted], reflected that the resident was on [redacted] precautions for [redacted] [redacted] is transmitted through direct and indirect contact with an infected person and the person's environment. The CP interventions included to maintain contact isolation precautions. The CP also reflected to place a stop sign to instruct family/visitors/caregivers to see the nurse prior to entering the room.

Review of a Physician's Order Sheets (POS) from [redacted] through [redacted], did not reflect a physician's order for [redacted] precautions for CRE.

Review of the [redacted] Report," dated [redacted] at 12:19 PM, revealed that Resident #79 tested positive for [redacted]

On 02/26/20 at 11:30 AM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM #1). When RN/UM #1 was questioned as to the type of PPE needed in order to enter the resident's room. RN/UM#1 stated that no PPE was required to enter the room. RN/UM stated that the infection was in the resident's

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[redacted] and that the [redacted] was contained in a [redacted] collection bag.

On 02/27/20 at 9:44 AM, the surveyor donned (put on) a gown and gloves and knocked on the resident's door. The resident shook his/her head in an up and downward motion giving the surveyor permission to enter the room. When interviewed, Resident #79 stated that he/she had a [redacted] and was on [redacted] precautions.

On 03/02/20 at 9:31 AM, the surveyor observed two Certified Nursing Assistants (CNAs) standing inside the resident's room. CNA #1 was not wearing any PPE. CNA #2 was wearing a gown and gloves. The CNAs were using a mechanical lift to transfer Resident #79 from the bed into the wheelchair. When they finished transferring the resident, CNA #1 wheeled the mechanical lift out of the resident's room and down the hallway where it was then stored in a corner. The surveyor noted that CNA #1 continued to walk down the hallway to a nurse. CNA #1 did not sanitize the mechanical lift after using it for Resident #79.

When interviewed on 03/02/20 at 10:00 AM, CNA #2 stated that it was the facility's policy to wear PPE if she was providing direct care to the resident. CNA #2 stated that she was only helping CNA #1 to transfer Resident #79 from the bed to the chair. At that time, the surveyor interviewed CNA #1 who stated that she stored the mechanical lift without sanitizing it and that she should have cleaned the lift after using it on a resident on [redacted].

On 03/02/20 at 12:30 PM, the surveyor observed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315455	A. BUILDING ______ B. WING ______	03/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL HEALTH GATE NRSG REHAB	**1314 BRUNSWICK AVENUE TRENTON, NJ 08638**

(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 24 Licensed Practical Nurse (LPN #1) standing inside Resident #79's room administering medication. LPN #1 was not wearing any PPE. When interviewed, LPN #1 stated that it was the facility's policy to only wear PPE when providing personal care to the resident. LPN #1 stated that the infection was in the resident's [redacted] and because the resident had an [redacted] [redacted] bag, there was no risk of transmission. During an interview with the Director of Nursing (DON) on 03/03/20 at 9:18 AM, the DON stated that it was the facility's policy for staff to wear PPE if they were providing direct care or in contact with a resident's bodily fluids. During an interview on 03/03/20 at 10:55 AM, the ADW stated that Resident #79 was [redacted] [redacted] The ADW stated that she received [redacted] precaution training and should have worn PPE. Review of the facility's Contact Isolation policy, dated 09/18/19, showed that the facility used contact precautions in addition to standard precautions for residents known or suspected to have serious illnesses easily transmitted by direct resident contact or by contact with items in the resident's environment. The policy included that dedicated care equipment should be considered for the resident and if use of common equipment or items was unavoidable, the items should be adequately cleaned and/or disinfected before use on another resident. NJAC 8:39-19.4 (a)	F 880		

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	476002	A. BUILDING: ______ B. WING ______	03/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL HEALTH GATE NRSG REHAB	1314 BRUNSWICK AVENUE TRENTON, NJ 08638

(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) COMPLETE DATE
S 000	Initial Comments THE FACILITY WAS NOT IN COMPLIANCE WITH THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE, CHAPTER 8:39, STANDARDS FOR LICENSURE OF LONG TERM CARE FACILITIES. THE FACILITY MUST SUBMIT A PLAN OF CORRECTION, INCLUDING A COMPLETION DATE, FOR EACH DEFICIENCY AND ENSURE THAT THE PLAN IS IMPLEMENTED. FAILURE TO CORRECT DEFICIENCIES MAY RESULT IN ENFORCEMENT ACTION IN ACCORDANCE WITH THE PROVISIONS OF THE NEW JERSEY ADMINISTRATIVE CODE, TITLE 8, CHAPTER 43E, ENFORCEMENT OF LICENSURE REGULATIONS.	S 000		
S1440	8:39-19.6(d) Mandatory Infection Control and Sanitation (d) Equipment requiring water drainage, such as ice machines and water fountains, shall be properly drained to a sanitary connection. This REQUIREMENT is not met as evidenced by: Based on observations on 02/28/20 in the presence of facility management, it was determined that the facility failed to provide 1 of 3 ice machines with a drain to a sanitary connection. This deficient practice was evidenced by the following: At 12:10 PM, in the [redacted] pantry marked [redacted] (Clean Utility Room), the surveyor observed that the ice machine was being drained directly into the open hand sink on the counter and not into a sanitary connection as required.	S1440	F- 1440 1. The ice machine in the [redacted] pantry marked [redacted] (Clean Utility Room) was immediately taken out of use. A call was placed to Mr. Rooter for repair. The ice machine was fixed to meet regulations of sanitation and a new drain was installed. 2. All residents have the potential to be affected when the ice machine is not draining into a sanitary connection as required.	4/9/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 03/23/20

New Jersey Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	476002	A. BUILDING: ____ B. WING ____	03/04/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROYAL HEALTH GATE NRSG REHAB	**1314 BRUNSWICK AVENUE** **TRENTON, NJ 08638**

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S1440	Continued From page 1 During an interview at the time of the observation, the Maintenance Director and the Regional Plant Operations Director both stated that they were unaware that the ice machine drain had to be connected to a sanitary connection. The Administrator was notified of the deficiency at the Life Safety Code exit conference on 02/28/20. 8:39-19.6(d)	S1440	3. An in-service was done by Administrator on March 5,2020 with the Maintenace Director and the Plant Operations Manager in regards to the regulation of Mandatory Infection Control and Sanitation (Long Term Care State) 4. The Administrator will monitor daily x 4 weeks the ice machine in question and ensure proper drainage is being maintained. All findings will be reported at the Quality Assurance meeting x 2 quarters.	