STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315176	A. BUILDING _____ B. WING _____	12/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDFORD CARE CENTER	185 TUCKERTON ROAD MEDFORD, NJ 08055

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F 000	INITIAL COMMENTS Complaint #: NJ148485, NJ148806, NJ149387 Census: 130 Sample Size: 6 The facility is not in compliance with the requirements of 42 CFR Part 483, Subpart B, for Long Term Care Facilities based on this complaint survey. A COVID-19 Focused Infection Control Survey was conducted by the New Jersey Department of Health. The facility was found to be in compliance with 42 CFR §483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. Survey date: 12/11/2021 - 12/12/2021	F 000		
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 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,	F 880		2/8/22

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

Electronically Signed | 01/07/2022

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F 880	Continued From page 1	F 880		

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 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

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F 880	Continued From page 2 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: Complaint Intake #NJ148806 Based on observations, interviews, record reviews, and facility policy review, the facility failed to ensure infection control measures were followed when providing wound care to one (Resident #3) out of three sampled residents. Findings included: 1. A review of Resident [redacted]'s face sheet indicated the resident was readmitted to the facility with diagnoses that included [redacted] A review of Resident [redacted]'s quarterly Minimum Data Sheet (MDS), dated [redacted], indicated the resident's Brief Interview of Mental Status (BIMS) Score was [redacted], indicating the resident had [redacted] A review of Resident [redacted]'s interdisciplinary care plan, dated [redacted], indicated the resident's [redacted] would show signs of [redacted], and [redacted] care was to be provided as ordered. The care plan indicated aseptic technique was to be maintained during [redacted] treatments.	F 880	1. LPN #4 and the Director of Nursing were re-educated by the Corporate Director of Clinical Services on 12/12/2021 regarding Infection Control policies and procedures related to [redacted] care which included securing hair during treatments. LPN #4 and the Director of Nursing verbalized understanding of the re-education provided. There was no negative outcome to the resident. 2. Facility residents have the potential to be affected by the concern identified. 3. Facility nurses are being re-educated by the Assistant Director of Nursing regarding Infection Control policies and procedures including proper infection control procedures related to [redacted] care. Re-education will be completed by January 25, 2022. Root cause analysis was completed. Both Director of Nursing and LPN#4 were able to adequately demonstrate competency regarding wound treatment in accordance with proper infection control standards. The topline management team will view by 02/08/2022: Nursing Home Infection Preventionist Training Course Module 1 -	

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F 880	Continued From page 3 A review of Resident #[redacted]s order recapitulation, dated 1[redacted], no time, indicated [redacted] care orders were to [redacted], pat dry, apply [redacted] to [redacted], cover with [redacted] pads [redacted] pads), and wrap with [redacted] daily and as needed. During a concurrent observation and interview on 12/11/2021 at 11:25 AM, Resident [redacted] was observed sitting at the edge of the bed. The resident's right leg and foot were hanging off the edge of the bed, and the [redacted] was covered with a [redacted] dressing which appeared to be clean, dry, and intact. The resident's [redacted] was exposed and appeared [redacted] The resident stated an [redacted] was supposed to be around the [redacted] but the resident did not want it. No foul odors were noted, and the bed linen and pad appeared clean, with no visible staining. During a [redacted] care observation on 12/12/2021 at 10:09 AM, Licensed Practical Nurse (LPN) #4 and the Director of Nursing (DON) performed hand hygiene and entered Resident [redacted]'s room. LPN #4 placed a trash bag on the resident's bed and placed a drape under the resident's [redacted]. The DON's hair was up in a bun, and LPN #4 had almost waist-length braids and a half ponytail. The DON attempted to raise the resident's bed but was unable to. The DON stood at the side of the bed, and LPN #4 stood at the foot of the bed. The DON lifted the resident's leg with their hands under the [redacted] LPN #4 removed part of the dressing and dropped it in the trash bag on the bed next to the resident's [redacted]. LPN #4 leaned forward to reach the rest of the dressing	F 880	Infection Prevention and Control Program and Module 5- Outbreaks. The frontline staff will view by 02/08/2022: CDC COVID-19 Prevention Messages for Front Line Long Term Care Staff - Sparkling Surfaces and Keep COVID Out! All staff will view by 02/08/2022: Nursing Home Infection Preventionist Training Course Module 11B - Environmental Cleaning and Disinfection, Module 6A - Principles of Standard Precautions and Module 6B - Principles of Transmission Based Precautions. 4. The [redacted] Care Treatment Policy was modified on December 12, 2021 to specifically address infection control procedures relating to nurses properly securing hair/items prior to rendering [redacted] care. The Assistant Director of Nursing will conduct [redacted] care observations 2 x per week for the next twelve weeks to verify infection control procedures are properly adhered to during [redacted] care/treatments. Areas of concern will be addressed. Results of these audits will be reviewed at the monthly Quality Assurance and Performance Improvement meetings for the next three months with follow up provided as needed.	

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on the resident's f[redacted]t (resident was trying to [redacted]wer [redacted]). LPN #4's hair was touching the dirty dressing in the bag and the resident's [redacted]. Gauze was dried onto the resident's [redacted] of the [redacted]. At 10:20 AM, the resident complained of [redacted] and requested [redacted]. LPN #4 went to get [redacted] The DON complained of a sore back and lowered the resident's [redacted] on the drape. At 10:31 AM, LPN #4 returned and administered [redacted] The resident instructed the DON and LPN #4 to keep going. LPN #4 performed hand hygiene, donned gloves, and wet gauze with [redacted]. The DON held the resident's [redacted] again under the [redacted] and [redacted] of the [redacted] LPN #4 squirted [redacted] on the dressings dried to the [redacted] and removed the dressings. LPN #4 placed the dirty dressings in the trash bag. LPN #4 reached over (hair touching dirty dressings) and placed wet 4x4 gauze on three sections of the resident's [redacted], on the [redacted] [redacted], then on the [redacted] LPN #4 wiped the [redacted] then placed the wet gauze in the trash, wiped a small section of the [redacted] with gauze and placed the gauze in the trash. LPN #4 then took the wet gauze on top of the [redacted] and wiped the top section of the [redacted] and used the same gauze to wipe the inner aspect of the [redacted], the outer part of the resident's [redacted] and then the [redacted]. LPN #4 then placed the gauze in the trash. LPN #4 then removed long Q-tip-like applicators and squeezed [redacted] on them and applied the gel to the top part of the [redacted]. LPN #4 then reached for [redacted] pads and placed one on top of the resident's [redacted], two on the [redacted], and a 4x4 gauze on the [redacted] covered with an [redacted] pad the DON held in placed. LPN #4 then wrapped the [redacted] with white gauze dressing, reaching over the foot of the bed to reach the [redacted] with their braids touching the trash bag, drape, and

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environment. LPN #4 then reached for the [redacted] and had difficulty opening the wrapping. The DON was complaining of a sore back and talking to the resident as the resident lowered their [redacted] onto the dirty drape. The DON lifted the [redacted] and LPN #4 wrapped from the [redacted] t up the [redacted], with braids touching the trash bag, drape, and environment. LPN #4 then removed the drape and trash bag, performed hand hygiene, and documented [redacted] care.

During an interview on 12/12/2021 at 11:05 AM, LPN #4 stated hair should be tied back to avoid it touching dirty dressings and especially [redacted]. LPN #4 stated if hair touched [redacted], then the potential for cross contamination and spread of infection was huge. LPN #4 forgot to tie their hair back. LPN #4 stated that because care was provided to other residents on the unit, they could transmit whatever infection was on the [redacted] to other residents and could take infection home to their family (newborn). LPN #4 stated gauze used to clean one [redacted] site should not be used on another [redacted] site and was not quite sure why the same gauze was used. LPN #4 stated infection located on one [redacted] site could then be transferred to the other [redacted] site. LPN #4 forgot to remove the dirty drape and ensure clean dressing did not touch the dirty drape and stated, "Whatever infection was on that drape, is now on the dressing." LPN #4 stated the clean dressing was placed on the bed and the resident lay on the blanket and infection can be easily spread.

During an interview on 12/12/2021 at 11:58 AM, The DON stated, "Yeah, I saw that," when asked about LPN #4's hair touching the trash, drape, [redacted] and environment. The DON stated the expectation was that hair did not contact

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anything. The DON stated it was important not to have hair touch anything for infection control and to prevent cross contamination. The DON stated LPN #4 provided care to other residents and could spread infection. The DON stated each wound site should have been cleaned with a separate gauze to prevent cross contamination.

A review of the facility's policy, titled, "Infection Prevention and Control Program Policy," dated 10/2021, indicated, "Important facets of infection prevention include: ... (7) following established general and disease-specific guidelines such as those of the Centers for Disease Control (CDC)."

A review of the facility's policy, titled, "[redacted] Prevention and Management Policy," dated 10/2021, indicated the purpose of the policy was "To ensure that residents receive appropriate interventions to prevent new [redacted] from forming and promote healing of [redacted] The policy indicated, "The licensed nurse is responsible to implement treatments based on the [redacted] Treatment Protocols unless otherwise ordered by the attending physician. Treatments require a physicians order."

New Jersey Administrative Code § 8:39-19.4(a)1-6