STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315363	A. BUILDING _____ B. WING _____	11/22/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTCLAIR CARE CENTER	111-115 GATES AVENUE MONTCLAIR, NJ 07042

(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: 11/22/19 CENSUS: 58 SAMPLE SIZE: 15 (Plus 3 closed records) 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 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition;	F 584		11/23/19

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

Electronically Signed | 12/16/2019

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F 584	Continued From page 1 §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to maintain clean and sanitary resident rooms for 2 of 15 residents reviewed; Resident #39 and #45. This deficient practice was evidenced by the following: 1. On 11/19/19 at 8:35 AM, the surveyor observed Resident #39 in bed awake with the head of the bed elevated, and the [redacted] The resident did not respond to the surveyor [redacted] but [redacted] On that same day and time, the surveyor observed yellow hardened debris on the base of the [redacted], which was consistent with the [redacted] used for the resident's [redacted]. The surveyor observed the same hardened yellow debris on the floor beneath the pole. The surveyor found that Resident #39's	F 584	1. The floors in both rooms were cleaned on 11/20/2019. The 2 IV Poles and the wheelchair were cleaned on 11/20/2019. 2. All residents can be affected by this deficient practice. 3. All housekeeping staff were in serviced on 11/20/2019 by the housekeeping director to clean I V poles as well during routine resident room cleaning. Housekeeping also received an Inservice on 11/20/2019 by housekeeping director regarding wheelchair cleaning. On 11/22/2019 , a new QA log was created to track the wheelchair cleaning and all housekeeping personnel was in serviced. 4. Housekeeping Director will audit three resident rooms on each floor on a daily basis to ensure that floors, I V poles have	

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F 584	Continued From page 2 wheelchair was also heavily soiled. On 11/19/19 at 12:35 PM, the surveyor observed yellow hardened debris on the base of the [redacted], hardened yellow debris on the floor below the [redacted], and the wheelchair was heavily soiled. On 11/20/19 at 9:30 AM and 11:30 AM, the surveyor observed yellow hardened debris on the base of the [redacted] and hardened yellow debris on the floor below the [redacted]. The surveyor found that the resident's wheelchair was again heavily soiled. On 11/20/19 at 11:55 AM, the surveyor interviewed Housekeeper #1 assigned to Unit [redacted], who stated it was her responsibility to clean the resident's floor, table, bathroom, and to remove the garbage daily. At that same time, the surveyor, Housekeeper #1, and the Licensed Practical Nurse/Charge Nurse (LPN/CN) entered Resident #39's room. The surveyor asked Housekeeper #1 and LPN/CN, who was responsible for cleaning the base of the [redacted]. The LPN/UM replied it was Housekeeper #1's responsibility. Housekeeper #1 acknowledged that it was her responsibility but stated that she didn't notice the dirty floor or the soiled [redacted]. On 11/20/19, at 12:10 PM, the surveyor interviewed the Director of Housekeeping (DOH). The DOH informed the surveyor that it was housekeeping's responsibility to clean the residents' rooms daily, which included the floor and the base of the [redacted]. He said that it was his responsibility to make sure to	F 584	been cleaned sufficiently for the next 2 quarters. Housekeeping Director will also audit all wheelchairs after the scheduled cleaning to ensure that the wheelchairs are cleaned sufficiently for the next 2 quarters. 5. The results of both audits will be reported quarterly during the QA meeting for the next 2 quarters.	

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F 584	Continued From page 3	F 584		

check every day that the rooms were cleaned and that he should have checked it. He further stated, "I had to make her go back in and clean the [redacted] a second time. Please go and see it now." The DOH said that there was a monthly schedule for cleaning the wheelchairs and that Resident #39's wheelchair was scheduled for this Thursday. However, he would have the chair cleaned today. The DOH was unable to tell the surveyor when the resident's wheelchair was last cleaned.

2. The surveyor observed Resident #45 in bed with their eyes closed on 11/19/19 at 8:08 AM. A [redacted] Many dried, hardened tan spills were observed on the floor underneath the [redacted] from which the [redacted]. Additionally, the base of the [redacted] was covered with the same tan dried spills. The spilled material was consistent with the appearance of the [redacted].

The surveyor observed Housekeeper #2 enter Resident #45's room on 11/19/19 at 12:15 PM; He came in with a bucket and mop and proceeded to mop the resident's room. When he finished and left the room, the surveyor entered and observed that spills remained on the floor.

The surveyor observed Housekeeper #3 enter the resident's room on 11/20/19 at 11:26 AM; She came in with a bucket and mop and mopped the room. When she finished, the surveyor observed that the spills remained, as noted previously. The surveyor interviewed Housekeeper #3. She stated she was aware of the stains and proceeded to scrub the spill by hand with a cloth. The stain remained.

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F 584	Continued From page 4 The surveyor observed the Regional Housekeeping Supervisor and Housekeeper #3 in Resident #45's room on 11/20/19 at 11:45 AM. The supervisor instructed Housekeeper #3 to scrub the spills manually. The surveyor entered the room and discussed the above concerns and that the stains persisted after two housekeepers mopped on two consecutive days. He replied that the substance on the floor was very sticky and hard to clean up. The surveyor reviewed the facility's Daily Procedure For Cleaning Resident Rooms dated 11/20/19 which reflected: Procedure # 3: Clean vertical surfaces, using appropriate cleansers and equipment. Example: light switches, over-bed tables and legs, IV poles and lamps and procedure & 7: Damp mop floors-be sure to follow proper procedures & be sure to utilize "wet floor" signs. On 11/21/19 at 11:30 AM, the surveyor met with the Administrator and DON and discussed the above observations and concerns. On 11/22/19 at 12:00 PM, no further information was provided by the facility. NJAC 8:39-31.4(a) (f)	F 584		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the	F 625		11/23/19

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F 625	Continued From page 5 nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to notify the resident in writing of the facility's bed hold policy at the time of the resident's transfer out of the facility. This deficient practice was identified for 1 of 3 residents (Resident #63) reviewed for closed records and was evidenced by the following: The surveyor reviewed Resident #63's closed record on 11/20/19 at 11:16 AM. The resident was admitted to the facility on [redacted] and transferred to the hospital and admitted for [redacted]	F 625	This plan of correction constitutes the facility□s written allegation of compliance for the deficiency cited. This plan of correction has been prepared in order to meet the requirements of the state and federal law. It is the facility□s policy to ensure that a notice of the facility□s bed-hold policy be provided in writing to the resident or resident□s representative, prior to the resident transferring to a hospital or going on therapeutic leave.	

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F 625	Continued From page 6 The surveyor interviewed the Social Worker (SW) on 11/20/19 at 12:06 PM. The SW explained that residents are notified of the bed hold policy during admission via their admission packet. She stated that she had explained verbally about the bed hold policy at the time of transfer to the hospital, but reiterated that nothing was given in writing. The SW provided the bed hold policy on 11/20/19 at 12:23 PM. The Administration Policy and Procedure Manual - Admission, effective 10/2016, last reviewed 10/2019, indicated "each resident who is transferred to a hospital . . . the nursing facility must provide the resident and the resident representative the duration on the bed hold policy in writing." NJAC 8:39-4.1(a)31; 5.1;5.3	F 625	Corrective action: 1. Facility□s Bed-Hold Policy has been reviewed and updated. Identify other potential residents: The facility has determined that all residents have the potential to be affected. Systemic Changes: The Bed Hold Policy will be distributed in writing to each resident representative or resident being transferred to the hospital or going on therapeutic leave with 48 hours of that resident leaving the facility. Monitoring: 1. Social worker will monitor Bed Hold Policy distribution via electronic documentation on a daily basis for 3 months. 2. The Bed Hold Policy will be included on social worker□s monthly audits. 3. Outcome and results of the audit will be discussed during quarterly QAPI meetings.	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to	F 658	This plan of correction constitutes the facility's written allegation of compliance	12/13/19

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F 658	Continued From page 7 follow a physician's order for the administration of a [redacted] for 1 of 1 resident reviewed, Resident #39. This deficient practice was evidenced by the following: Reference: New Jersey Statues, Annotated Title 45, Chapter 11 Nursing Board, The Nurse Practice Act for the State of New Jersey states; "The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as case finding, health teaching, health counseling, and provision of care supportive to or restorative of life and well being, and executing a medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist." Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: The practice of nursing as a licensed practical nurse is defined as performing tasks and responsibilities within the framework of case finding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." On 11/19/19 at 8:35 AM, the surveyor observed [redacted] The label on the [redacted] documented the [redacted] and documented that	F 658	for the deficiency cited. This plan of correction has been prepared in order to meet the requirements of the state and federal law. It is the facility policy to ensure that resident who is fed by [redacted] will receive the correct amount of [redacted] ordered by the physician. Corrective action: On 11/19/2019 resident # 39 [redacted] was correctly set-up by supervisor with th [redacted] On the same day, DON and supervisor conducted an audit of all [redacted] to ensure accurate digital setting to facilitate the delivery of the [redacted] prescribed by the physician. Other [redacted] were found to be properly set-up. DON and dietitian evaluated resident # 39 for significant weight changes. Identify other potential residents: All residents who are [redacted] have the potential to be affected by failure to provide the accurate [redacted] prescribed by the physician. Systemic Changes: On 11/20/2019 ADON initiated in-service to all nurses on how to accurately check rate and volume every shift and how to properly set-up [redacted] if discrepancy exist. Monitoring: Daily audits by daytime supervisors have been initiated to validate accurate amount of [redacted] delivered as prescribed by the primary physician. The audit will be conducted for a period of	

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F 658	Continued From page 8 the [redacted]. On 11/19/19 at 12:35 PM, the surveyor again observed [redacted]. The same label was on the bag containing the [redacted]. The surveyor reviewed the November 2019 Physician's Order Form which reflected an order dated 11/4/19 to discontinue [redacted] and start [redacted]. Review of the admission record reflected Resident #39 was admitted to the facility on [redacted] and readmitted on [redacted] with diagnoses which included [redacted]. The surveyor reviewed the Quarterly Minimum Data Set (MDS), an assessment tool dated [redacted], which reflected Resident #39 had [redacted]. The QMDS revealed the resident's weight was [redacted]. The surveyor reviewed the Significant Change MDS dated [redacted], which showed the resident's weight was [redacted]. The resident was on a physician-prescribed weight-gain regimen and gained [redacted]. The surveyor reviewed the Care Plan for [redacted] related to [redacted] due to [redacted] with interventions that included to provide [redacted] as ordered: [redacted] On 11/20/19 at 9:30 AM, the surveyor interviewed	F 658	three months to ensure compliance. Daytime supervisor will report any discrepancies to DON for further recommendation if needed. Supervisors will continue to report to the dietician significant weight loss/gain during monthly weight committee meeting. Audits will be provided to the quality assurance committee on a quarterly basis. Outcome and results of the audit will be discussed during QAPI meeting	

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the Licensed Practical Nurse/Charge Nurse (LPN/CN) who acknowledged that the [redacted] The LPN/CN told the surveyor that she had documented the reading at the start of the shift and the end of the shift, and documented that the [redacted] for 11/19/19 for the 7:00 AM - 3:00 PM shift was [redacted]. She stated she must have overlooked the [redacted]. The surveyor asked the LPN/CN when she noticed the [redacted]. The LPN/CN replied that the Assistant Director Of Nursing (ADON) brought it to her attention "yesterday" around 1:30 PM.

On 11/20/19 at 9:45 AM, the surveyor interviewed the ADON who stated that around 1:30 PM, during her rounds, she noticed Resident #39's [redacted]. At that time, the ADON [redacted] and brought her findings to the attention of the LPN/CN.

The surveyor reviewed the facility's [redacted] Policy revised June 2019 which indicated the following procedures:

"1. To provide [redacted] for maintenance of life by a [redacted]
5. Make sure both the [redacted] and [redacted] are labeled correctly with patient's name, room number, and [redacted].
6. Set up [redacted] according to prescribed [redacted].
Charting:
1. Type of [redacted].
Special Notation: 1. Physician will order type and

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F 658	Continued From page 10 [redacted]." On 11/21/19 at 11:30 AM, the surveyor met with the Administrator and DON and discussed the above observations and concerns. On 11/22/19 at 12:00 PM, no further information was provided by the facility.	F 658		
F 880 SS=E	NJAC 8:39-27.1 (a) 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, 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	F 880		12/13/19

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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 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

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F 880	Continued From page 12 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 appropriate handwashing practices during the dining observation for 1 of 1 Certified Nursing Assistant's (CNA) observed during the dining observation; b) ensure that the facility consistently and accurately completed the Surveillance Report documentation according to Infection Control Policy (IPCP) standards, facility policies and procedures; c) ensure that appropriate infection control procedures were followed by maintaining a clean environment for 1 of 15 residents reviewed (Resident #60); and, d) ensure food service workers (FSW) consistently used hair restraints during meal preparation for 2 of 3 FSWs observed. This deficient practice was evidenced by the following: 1. On 11/19/19 at noon, during the lunch meal observation in the main dining room, the surveyor observed that CNA #3 removed a pair of gloves from her uniform pocket and donned (put on) the gloves. The CNA then wiped Resident #5 and # 53's hands with a towelette. The CNA then put on a new pair of gloves without performing hand hygiene in between direct contact with the residents. At that same time, the surveyor interviewed CNA #3 who stated she should have performed hand hygiene after removing gloves and in between direct contact with residents. She further stated, " Oh, I forgot to wash my hands because I was so nervous."	F 880	This plan of correction constitutes the facility□s written allegation of compliance for the deficiency cited. This plan of correction has been prepared in order to meet the requirements of the state and federal law. It is the facility□s policy to maintain an infection prevention and control program to provide safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable disease and infections. Corrective action: 1. On 11/21/2019, the said CNA#3 was immediately re-educated/ in serviced on proper hand hygiene 2. The Infection Control Nursing Unit Report (ICNUR) from January 2019 through October 2019 was reviewed and corrected by DON and Infection Preventionist for both floors. DON initiated and revised the quality assurance /infection control surveillance report. 3. On 11/21/2019, the soiled diaper on the floor containing feces was immediately removed by the CNA and properly disposed in the soiled utility closet. On 11/21/2019, housekeeping immediately cleaned the toilet seat and surrounding areas. On the same day, CNA #2 was re-educated and in service	

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	315363	A. BUILDING _____ B. WING _____	11/22/2019

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F 880	Continued From page 13 On 11/20/19 at 12:07 PM, the surveyor interviewed the Registered Nurse Supervisor (RNS) who informed the surveyor that she was also the Infection Control Nurse. The RNS stated that she had started in the facility [redacted] ago. She further stated that hand hygiene should be done in between resident contact, during [redacted] dressing, before and after toilet use and every time staff had to change gloves. She said that towelettes should not be used as a substitute for hand hygiene. In addition, she indicated that the staff should not use gloves that were taken from the uniform pocket. On 11/21/19 at 11:37 AM, the survey team met with the Administrator and Director of Nursing (DON) and discussed the above observations and concerns. 2. A review of the Infection Control Nursing Unit Reports (ICNUR) from January 2019 through October 2019, showed that there were blanks and incomplete information about the type of infection and categorization of infection either in-house or the community. There were discrepancies from ICNUR that did not match with provided reports from the monthly Pharmacy Therapeutic Type Report and the laboratory reports. Further review of the ICNUR and Surveillance Reports provided by the DON, showed that it did not include documented evidence that the data collected each month was analyzed to include plans and interventions. On 11/20/19 at 10:49 AM, the DON informed the survey team that currently she was overseeing	F 880	regarding the importance of maintaining a clean and sanitary enviroment. 4. On 11/19/2019, the 3 FSW□s adjusted the nets and completely covered their hair immediately. Systemic Changes: 1. Hand washing policy and procedure was reviewed (Hand Hygiene Guidelines) by DON and Administrator. On 11/21/2019, all staff was in-serviced by Infection preventionist regarding proper hand washing/hygiene and proper usage of personal protective equipment (PPE). 2. Infection Control policy and procedure was reviewed by DON and Administrator. On 11/21/2019, Infection preventionist in-service all nursing staff how to utilize accurately and consistently the quality assurance/infection control surveillance report. 3. On 11/21/2019, the Infection preventionist educated/ in service all staff on proper disposal soiled materials in appropriate receptacles and maintaining a clean and sanitary environment. 4. On 11/20/2019 and 11/21/2019, the FSD in-service all dietary staff regarding uniform and personal hygiene. Monitoring:	

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F 880	Continued From page 14 the Infection Control of the facility which included the gathering of data and reporting because the Infection Control Nurse who is the RNS was new to the facility. On that same day at 11:00 AM, the DON stated that she would get back to the surveyor regarding the Surveillance reports which included the line listing for infection and use of antibiotics according to the facility policy. On 11/21/19 at 11:37 AM, the survey team met with the Administrator and the DON, and were made aware of the concerns. The DON stated that the team discussed the Surveillance Reports and ICNUR "verbally" but did not document plans and interventions with regards to data collection each month and in comparison with every quarter. On 11/22/19 at 8:30 AM, the DON in the presence of the surveyors acknowledged that the ICNUR was incomplete. She stated that there were some discrepancies in the ICNUR and what was reported monthly by the Pharmacy and Laboratory, which were needed in completing the reports. On that same day and time, the DON stated that "moving forward" the verbal plan and interventions for the analysis of the Surveillance reports will be documented in order to determine if the plan or interventions were effective. She further stated "that's what I intended to do" to make sure the reports must be complete, supporting documents with the use of antibiotics will be collected and documented according to the Surveillance policy and procedure.	F 880	1. Infection Preventionist will audit hand washing and proper usage of PPE on all staff on a monthly basis for 3 months. Outcome and results of audit will be discussed during quarterly QAPI meeting. 2. Infection Preventionist will monitor quality assurance /infection control surveillance report for accuracy weekly for 3 months. Outcome and results of audit will be discussed during quarterly QAPI meeting. 3. Supervisor/ Nurse on the floor will monitor all staff on proper disposal of soiled materials and linens daily during morning and evening rounds for 3 months. Housekeeping Director will audit three resident rooms on each floor daily to ensure that floors and toilet have been cleaned sufficiently for the next 2 quarters. Outcome and results of audit will be discussed during quarterly QAPI meeting. 4. The FSD will continue to enforce and monitor employee compliance to uniform and personal hygiene daily inspection for 30 days and report findings to the Administrator. Following the 30-day checks, the FSD will do weekly inspections and report findings to the Quality assurance committee and Administrator quarterly	

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A review of the facility policy on Infection Control and Procedure Manual Infection Surveillance provided by the DON with a review date of 11/2019, showed that "The infection Control Coordinator serves as the leader of surveillance activities, maintains documentation of incidents, findings and any corrective actions made by the facility and reports surveillance findings to the facility's Quality Assessment and Assurance Committee, and public health authorities when required," and "Monthly time periods will be monitored for trends and data to be used in the surveillance activities may include but are not limited to 24-hour shift reports, lab reports, antibiograms obtained from lab, antibiotic use reports from pharmacy, skills validations for hand hygiene, PPE, and rounding observation data."

A review of the facility policy on Infection Control and Procedure Manual Hand Hygiene provided by the DON with a review date of 11/2019, showed that "Staff involved in direct resident contact will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents and visitors," and "The use of antimicrobial-impregnated wipes (i.e. towelettes) are not a substitute for using an alcohol-based hand rub or antimicrobial soap and the use of gloves does not replace hand washing; wash and after removing gloves."

3. On 11/20/19 at 8:47 AM, during the medication observation pass, the surveyor observed the Licensed Practical Nurse (LPN) perform hand hygiene in Resident #60's bathroom. At that time, the surveyor and LPN #1 observed a soiled diaper on the floor containing feces. The surveyor and LPN #1 also observed dried feces all over the toilet seat.

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On that same date and time, the surveyor interviewed CNA #1 who was routinely assigned to care for Resident #60. CNA #1 stated that CNA #2 provided care for Resident #60 "this" morning.

On 11/20/19 at 9:10 AM, the surveyor interviewed CNA #2 who stated that she changed the resident earlier "this" morning and left the diaper on the bathroom floor. She went to get a plastic bag but forgot about it. The surveyor asked CNA #2 why she didn't clean the toilet seat. CNA #2 replied, "that must have been from yesterday." The surveyor asked CNA #2 if she thought she should have cleaned it even if it was from yesterday. CNA #2 did not respond.

The surveyor reviewed Resident #60's admission record which reflected Resident #60 was admitted to the facility on [redacted] with diagnoses which included [redacted]

The surveyor reviewed the Admission Minimum Data Set (MDS), an assessment tool dated [redacted], which indicated Resident #60 was [redacted], required extensive assistance with bed mobility, transfers and toileting, and was incontinent of urine and occasionally incontinent of bowel.

On 11/21/19 at 11:30 AM, the surveyor met with the Administrator and Director of Nursing and discussed the above observations and concerns.

On 11/22/19 at 9:15 AM, the surveyor reviewed the Facility's Policy titled, "Caring for the incontinent resident" dated 6/2019 which reflected under Procedure #16 to remove soiled linen and

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F 880	Continued From page 17 diaper, put in a plastic bag and dispose properly. On 11/22/19 at 12:00 PM, no further information was provided by the facility. 4. The surveyor observed 3 FSWs prepare breakfast on 11/19/19 at 7:48 AM in the kitchen. Two of the FSWs did not have their hair completely covered by the hair nets they wore. The surveyor brought it to the attention of the FSWs. The 3 FSW's left the area and adjusted the nets to completely restrain their hair. The Food Service Director (FSD) provided the surveyor with the Personal Hygiene Policy, dated 1/1/17, on 11//22/19 at 12 PM. The policy indicated, "cover all hair and facial hair with restraint." The FSD stated she educated all food service staff to "always cover all head with a hair restraint." NJAC 8:39-19.3 (a) NJAC 8:39-19.4 (a) (1)	F 880		