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	60A011	A. BUILDING: _____ B. WING _____	11/17/2020

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CEDAR CREST/MOUNTAINVIEW GARDENS	4 CEDAR CREST VILLAGE DRIVE POMPTON PLAINS, NJ 07444

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A 000	Initial Comments Initial Comments: Census: 68 A COVID-19 Focused Infection Control Survey was conducted by the State Agency on 11/17/2020. The facility was found not to be in compliance with the New Jersey Administrative CODE 8:36 infection control regulations standards for Licensure of Assisted Living Residences, Comprehensive Personal Care Homes and Assisted Living Programs and Centers for Disease Control an Prevention (CDC) recommended practices to prepare for COVID-19. 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 provisions of New Jersey Administrative Code Title 8, Chapter 43E, Enforcement of Licensure Regulations.	A 000		
A1185	8:36-17.2(b) Housekeeping-Sanitation-Safety-Maintenance (b) Housekeeping personnel shall be trained in cleaning procedures, including the use and care of equipment. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and Centers for Disease Control publication, the facility failed to ensure housekeeping staff followed proper cleaning procedures to prevent potential cross	A1185		

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

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A1185	Continued From page 1	A1185		

contamination of surfaces for one (HSK) of one housekeeper observed. This had the potential to affect all residents and occurred during the COVID-19 pandemic.

Findings included:

Reference: CDC, "Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings, updated 04/01/2020, read in part, "Routine cleaning and disinfection procedures (e.g., using cleaners and water to pre-clean surfaces prior to applying an EPA-registered, hospital-grade disinfectant to frequently touched surfaces or objects for appropriate contact times as indicated on the product's label) are appropriate for SARS-CoV-2 in healthcare settings, including those patient-care areas in which aerosol generating procedures are performed."

1. On 11/17/2020 at approximately 12:02 PM, a housekeeper (HSK) was continuously observed as she cleaned Rooms [redacted], [redacted], [redacted], and [redacted]. Observations of the resident room cleaning revealed the HSK started cleaning from Room [redacted] on the [redacted] floor. She donned new gloves without performing hand hygiene, she then put on a gown. The HSK was already wearing a surgical face mask before she went in the room. The resident was served a room tray and was eating at the time of the observation. The HSK retrieved a dust mop from the cleaning cart in the hallway and dust mopped the floor, starting in the bathroom, then the bedroom areas. She swept the dust and particles from the floor to the doorway, used a dustpan to pick up the debris, emptied the dustpan into the trash on her cart, and returned the dust mop to the cart. She then pulled a spray bottle labeled [product name]

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A1185	Continued From page 2	A1185		

and sprayed the contents into the toilet, the surrounding walls and flush handle. She immediately wiped the surfaces down and flushed the toilet after having washed the toilet bowl with a brush. She went back to her cart which was in the hallway to pick a feather brush, which she then used in cleaning the overhead light fixtures. She did this while the resident sat up in bed and was eating.

The HSK then retrieved a wet mop with a replaceable cleaning cover from the cart and mopped the residents' bathroom floor. She removed the cover from the mop head that she had just used to mop the bathroom floor, touching the soiled surface with her gloved hands. She returned the mop cover to her cart, got a cleaning cloth, and wiped down the bedside tables which had the residents' meal sitting on them. As she wiped down the table, she picked up and replaced the resident's meal plate, water pitcher, and a remote control.

After cleaning and mopping the rest of the residents' room, the HSK returned to the cleaning cart in the hallway while still wearing the gown and gloves that were now potentially contaminated. She moved her cart and her next stop was at Room [redacted]. While in the room, the HSK went around the resident who lived in the room.

The Unit Manager (UM) interceded in the HSK continuous usage of the same gown and gloves she had worn in the room described above. The UM verified that Room [redacted], where the HSK exited from while still wearing her gown and gloves, was in fact a transmission-based precaution room. She acknowledged the HSK was not supposed to wear the gown and gloves that had been used and were now potentially

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contaminated having been previously used in a room that had a resident on isolation. The UM educated the HSK on the spot and told her to dispose of the gown and gloves. The HSK took off the said gown and gloves, however, there was no biohazard bag in the room. The HSK walked out the room with the potentially contaminated gown and gloves. She proceeded down the hallway with the gown and gloves exposed. The hallway had staff and residents walking back and forth. The HSK's practice failed to ensure the potentially contaminated gown and gloves was bagged to minimize the potential exposure of staff and residents. Upon return to the room after disposing of the items described above, the HSK donned a new pair of gloves without performing hand hygiene and completed the cleaning the tasks in the room without changing her gloves. The HSK repeated the process of starting the room cleaning process from the bathroom, using the same gloves to complete all cleaning tasks in rooms and touching the residents' personal items with her potentially soiled gloves in Rooms [redacted] and [redacted]

By wearing a potentially contaminated gown and gloves from a transmission-based precaution room to a room that was not on transmission-based precaution, the HSK had potentially cross-contaminated the room. By failing to wear a respirator and a face covering, the HSK failed to ensure she wore the recommended PPE when she went in the room of a person under investigation (PUI). HSK had worn the same pair of gloves to clean the entire room, potentially cross contaminating the residents' rooms with her soiled gloves after handling the mop cover used on the bathroom floor. By dust-mopping the entire floor starting in the bathroom, she had potentially cross-contaminated the flooring in the residents'

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bedroom area with whatever might have been on the bathroom floor. In addition, by touching the resident's food packs, cups, books and remote control, she had potentially cross-contaminated the resident's meals with whatever contaminant that was retained on her soiled gloves. In addition, by failing to follow the manufacturer's recommended dwell time of five minutes (the time it took the chemical to be potent) for the chemical disinfectant used in the room cleaning, she failed to ensure the rooms were adequately disinfected.

On 11/17/2020 at 12:56 PM, the housekeeping supervisor (HKS) was interviewed. He said housekeeping staff were last trained on cleaning procedures approximately two months ago. He said housekeepers should clean from the clean areas to dirty areas and use different rags to clean the different living areas of residents and the entire room. He said, "Not following the proper cleaning procedures; touching residents' personal effects with used gloves and not using the cleaning products correctly can increase the spread of infections." The HKS emphasized that not following the manufacturer recommended dwell time could affect the disinfecting properties of the disinfectants. The HKS said staff were required to use full PPE when they went in isolation rooms across the facility. He said it was important for staff to follow the recommended use of PPE because of the risk of exposure, infection and re-infection of the staff and residents across the facility. He acknowledged that the disinfectant (Product name) observed with the HSK was the product the facility utilized in disinfecting across the facility. He verified the manufacturer's recommended kill time for the disinfectant was 5 minutes. He acknowledged that by spraying and immediately wiping off the disinfectant, the HSK failed to let the disinfectant sit for as long as it

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A1185	Continued From page 5 was recommended hence not ensure the disinfectant performed its disinfecting function. He said he would do more one-on-one training with the housekeepers going forward.	A1185		
A1271	8:36-18.1(a) Infection Prevention and Control Services (a) The facility shall develop and implement an infection prevention and control program. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and review of Centers for Disease Control (CDC) publication, the facility failed to implement an infection control program to prevent the spread of COVID-19 as evidenced by: 1. Failing to launder reusable gowns worn in isolation rooms before reuse as to prevent risk for possible COVID-19 transmission among staff and residents. This had the potential to affect all residents and staff; 2. Failing to ensure personal protective equipment (PPE) was readily available for staff use for residents who were persons under investigation (PUI) for COVID-19 for four of eight residents on isolation; 3. Failing to ensure transmission-based precaution signage was posted on the entrance to residents' rooms, which included the proper PPE to be used to enter the room for four of eight residents on isolation; 4. Failing to remove PPE before exiting a room of a resident on transmission-based precautions.	A1271		

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A1271	Continued From page 6 The facility identified eight residents who were persons under investigation (PUIs). This had the potential to affect all residents and occurred during the COVID-19 pandemic. Findings included: Reference: CDC publication, Strategies for Optimizing the Supply of Isolation Gowns, dated 10/09/2020, indicated; Re-use of isolation gowns. The risks to HCP [healthcare personnel] and patient safety must be carefully considered before implementing a gown reuse strategy. Disposable gowns generally should NOT be re-used, and reusable gowns should NOT be reused before laundering, because reuse poses risks for possible transmission among HCP and patients that likely outweigh any potential benefits. Similar to extended gown use, gown reuse has the potential to facilitate transmission of organisms (e.g., C. auris) among patients. However, unlike extended use, repeatedly donning and doffing a contaminated gown may increase risk for HCP self-contamination. 1. An initial tour of Evergreen #1 (a [redacted] unit) on 11/17/2020 at 8:33 AM revealed that by Room [redacted] there were three gowns hanging by the door to the room. The gowns were consistent with procedure gowns worn in an isolation room. Certified Medication Aide (CMA) #1 exited the room wearing a gown over her scrubs. On 11/17/2020 at 9:35 AM, CMA #1 was interviewed. The CMA verified Room [redacted] had two residents (Resident #1 and Resident #2) on droplet isolation precaution from being newly admitted to the facility. She acknowledged the gowns which hung on the wall by Room [redacted] were gowns worn in the isolation room. She said the facility currently reused the gowns. She	A1271		

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A1271	Continued From page 7	A1271		

verified the used gowns were exposed. Due to the wandering behavior exhibited by residents who lived on the [redacted] unit, the CMA acknowledged there was the potential for the residents on the unit to cross-contaminate themselves by the exposed gowns. The gowns were not being laundered after each use, but were saved to reuse again.

A review of the facility's PPE inventory indicated the facility had sufficient gowns.

During an interview on 11/17/2020 at 2:13 PM, the Administrator stated he wasn't aware that used gowns should not be stored outside the room.

2. An initial tour of [redacted] #1 ([redacted] on 11/17/2020 at 8:33 AM revealed that by Room #[redacted], there were three gowns hanging by the door to the room. There was no isolation cart next to the room with full PPE supplies, including gowns, gloves, mask, and eye protection.

On 11/17/2020 at 9:35 AM, Certified Medication Aide (CMA) #1 was interviewed. The CMA verified Room [redacted] had two residents (Resident #1 and Resident #2) on droplet isolation precautions from being newly admitted to the facility. She acknowledged the gowns which hung on the wall by Room [redacted] were reusable isolation gowns, which had already been used for the residents on transmission-based precautions. She verified there was no isolation cart with PPE available outside of the room, with a clean gown, gloves, masks, or eye protection.

3. An initial tour of [redacted] #1 ([redacted] unit) on 11/17/2020 at 8:33 AM revealed that Room #[redacted], a room identified by the facility as a PUI room, had no signage posted identifying the

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A1271	Continued From page 8 residents were on transmission-based precautions, or what PPE was required to enter the room. On 11/17/2020 at 9:35 AM, Certified Medication Aide (CMA) #1 was interviewed. The CMA verified Room [redacted] had two residents (Resident #1 and Resident #2) on droplet isolation precautions from being newly admitted to the facility. She verified there was no door sign to alert staff that they were going in a room on transmission-based precautions and what PPE was needed before entering the room. Reference: CDC publication, Using Personal Protective Equipment (PPE), dated 08/19/2020, indicated; How to Take Off (Doff) PPE Gear 1. Remove gloves. 2. Remove gown...Dispose in trash receptacle. 3. Healthcare personnel may now exit patient room. 4. An initial tour of [redacted] #1 (a [redacted] unit) on 11/17/2020 at 8:33 AM revealed that by Room [redacted], there were three gowns hanging by the door to the room. Certified Medication Aide (CMA) #1 exited the room wearing a gown over her scrubs. The CMA did not discard the contaminated PPE prior to exiting the residents' room. On 11/17/2020 at 9:35 AM, Certified Medication Aide (CMA) #1 was interviewed. The CMA verified Room [redacted] had two residents (Resident #1 and Resident #2) on droplet isolation precautions from being newly admitted to the facility. She acknowledged the gowns which hung on the wall by Room [redacted] were gowns worn in the isolation room. She said the facility currently reused the gowns.	A1271		

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A1271	Continued From page 9 On 11/17/2020 at 2:13 PM, the Infection Control Preventionist (ICP) was interviewed. The ICP said residents and staff were trained on the use of PPE. The ICP said potential breaches of infection control could result from staff's failure to follow proper infection control practices taught to them. She said the breaches in infection control practice whether it was proper use of PPE when going in and out of an isolation room, not having an isolation cart outside transmission based precaution rooms and caring for residents who were not on isolation had risk of spreading infection quickly within the facility.	A1271		
A1275	8:36-18.2(a)(1) Infection Prevention and Control Services (a) The facility shall develop, implement, and review, at least annually, written policies and procedures regarding infection prevention and control. Written policies and procedures shall be consistent with the following Centers for Disease Control publications and OSHA standards, incorporated herein by reference, as amended and supplemented: 1. Guidelines for Hand Hygiene in Health Care Settings, MMWR/51 (RR-16), October 25, 2002; This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and Centers for Disease Control (CDC) publication, the facility failed to ensure staff were fit tested for N95 masks currently in use by the facility. The facility	A1275		

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A1275	Continued From page 10	A1275		

identified eight residents were persons under investigation (PUI) for COVID-19 and were on transmission-based precautions. This had the potential to affect all residents, and occurred during the COVID-19 pandemic.

Findings included:

Reference: CDC publication, titled, "Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic," last updated 11/04/2020, indicated, "Respirator use must be in the context of a complete respiratory protection program in accordance with OSHA Respiratory Protection standard (29 CFR 1910.134). HCP [healthcare personnel] should be medically cleared and fit tested if using respirators with tight-fitting facepieces (e.g., a NIOSH-approved N95 respirator) and trained in the proper use of respirators, safe removal and disposal, and medical contraindications to respirator use.""To work properly, FFRs must be worn throughout the period of exposure and be specially fitted for each person who wears one. This is called "fit testing" and is usually done in a workplace where respirators are used."

1. An initial tour of [redacted] #1 ([redacted] unit) on 11/17/2020 at 8:33 AM revealed Certified Medication Aide #1 exiting Room [redacted]. The aide was wearing a N95 mask, with a surgical mask over the respirator.

On 11/17/2020 at 9:35 AM, CMA #1 was interviewed. The CMA verified Room [redacted] had two residents (Resident #1 and Resident #2) on droplet isolation precaution from being newly admitted to the facility. The CMA enumerated the required personal protective equipment (PPE)

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needed to be worn going in an isolation room as a gown, gloves, N95 mask and goggles. The CMA said the facility issued an N95 respirator once every five days. She said the N95s were turned in at the end of the week and were reprocessed. She said she was not fit tested for the N95 she was wearing. She said, "We were fit tested for the N95 mask in March 2020, but this was not this mask." It had since been replaced.

On 11/17/2020 at 10:04 AM, a physical therapist (PT) was in Room [redacted] the room was a transmission-based precaution room as described. She was wearing a N95 respirator with a surgical mask over the respirator when she arrived at the room.

On 11/17/2020 at 10:35 AM, the PT was interviewed. She said the facility fit tested staff for the N95 respirator at the very beginning of COVID-19 (referring to COVID-19 onset in March 2020). She clarified that although she was fit tested for the N95 respirator in the past, she did not get fit tested for the current model of N95 she was wearing. She said, "I just wanted a N95 respirator to be comfortable with going in the residents' rooms and the facility provided it."

On 11/17/2020 at 2:13 PM, the Infection Control Preventionist (ICP) was interviewed. The ICP said staff were trained on the use of PPE. The ICP said potential breaches of infection control could result from staff's failure to follow proper infection control practices taught to them. She said the breaches in infection control practice whether it was proper use of PPE when going in and out of an isolation room or not wearing N95 mask or not replacing surgical mask between going in and out of isolation rooms and caring for residents who were not on isolation had risk of spreading infection quickly within the facility.

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A1299	8:36-18.3(a)(5) Infection Prevention and Control Services (a) Written policies and procedures shall be established and implemented regarding infection prevention and control, including, but not limited to, policies and procedures for the following: 5. Techniques to be used during each resident contact, including handwashing before and after caring for a resident; This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review, Centers for Disease Control (CDC) publication, and New Jersey Department of Health (NJDOH) issued Executive Directive, the facility failed to implement an infection control program to prevent the spread of COVID-19 as evidenced by: 1. Failing to ensure housekeeping and nursing staff adhered to transmission-based precautions for two of three units. The facility identified eight residents that were persons under investigation (PUIs); 2. Failing to ensure staff performed hand hygiene and changed gloves appropriately; 3. Failing to offer hand hygiene to residents before mealtime for two of three units. This had the potential to affect all residents, and occurred during the COVID-19 pandemic. Findings included: Reference: NJDOH publication, Considerations for Cohorting COVID-19 Patients in Post-Acute Care Facilities, dated 10/22/2020, indicated the	A1299		

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following; Full Transmission-Based Precautions and all recommended COVID-19 PPE should be used for all patients/residents who are: New and re-admissions. The publication indicated COVID-19 recommended PPE included; N95 respirator or higher [or facemask if unavailable], eye protection, gloves, and isolation gown.

Reference: CDC publication, Considerations for Preventing Spread of COVID-19 in Assisted Living Facilities, dated 05/29/2020, indicated the following; Encourage residents to wear a cloth face covering (if tolerated) whenever they are around others, including when they leave their rooms and when they leave the facility (e.g., residents receiving hemodialysis).

Reference: CDC publication, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, dated 11/04/2020, indicated the following; Patients may remove their cloth mask when in their rooms but should put it back on when around others (e.g., when visitors enter their room) or leaving their room.

1. On 11/17/2020 at approximately 12:02 PM, a housekeeper (HSK) was continuously observed as she cleaned Rooms [redacted], #[redacted], #[redacted] and #[redacted]. Observations of the resident room cleaning revealed the HSK started cleaning from Room #[redacted] on the [redacted] floor. She donned new gloves, and then put on a gown. She was wearing a surgical mask, but no eye protection. The resident in the room was not wearing a facial covering while the housekeeper cleaned the room, and the housekeeper was within 6 feet of the resident. After cleaning and mopping the resident's room, the HSK returned to the cleaning cart in the hallway while still wearing the gown

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and gloves that were now potentially contaminated. She moved her cart and her next stop was at Room [redacted].

The Unit Manager (UM) interceded in the HSK continuous usage of the same gown and gloves she had worn in the room described above. The UM verified that Room [redacted] where the HSK exited from, while still wearing her gown and gloves, was in fact a transmission-based precaution room. She acknowledged the HSK was not supposed to wear the gown and gloves that had been used and were now potentially contaminated having been previously used in a room that had a resident on isolation.

By failing to wear a respirator and a face covering, the HSK failed to ensure she wore the recommended PPE when she went in the room of a person under investigation (PUI). By failing to advise residents to wear a face covering when she went in their rooms, the HSK failed to ensure she was not cross-contaminating the resident and vice versa when she stood in close proximity that was less than six feet away from the residents in the course of cleaning their rooms.

By wearing a potentially contaminated gown and gloves from a transmission-based precaution room to a room that was not on transmission-based precaution, the HSK had potentially cross-contaminated the room.

On 11/17/2020 between 12:00 PM and 12:45 PM, observations were conducted during in-room tray delivery of the noon meal on the [redacted] #2 Unit located on the [redacted] floor. Certified Medication Aide (CMA) #2 and CMA #3 served meals to residents on the unit. CMA #3 delivered a tray in Room [redacted] which was a room with a resident on transmission-based precaution. She

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failed to wear full PPE when going in the room. Specifically, the CMA was only wearing a surgical mask. She failed to ensure she wore a gown, donned gloves and eye protection. CMA #2 also repeated the practice in Room [redacted], which also had a resident on transmission-based precaution. CMA #2 and CMA #3 served 10 other residents on the unit. They failed to replace the surgical face mask they had worn going into transmission-based precaution rooms as described above. The residents were not encouraged to wear a facial covering when staff entered their room. The identified failures and breaches in infection control practices identified above failed to ensure residents ate their meal under sanitary condition and direct care staff did not cross-contaminate the residents by failing to advise the resident to protect their faces when staff went in their rooms, and when staff failed to use the appropriate PPE when they went in rooms which had residents on transmission-based precaution.

Reference: The Centers for Disease Control and Prevention (CDC) Hand Hygiene Guidance, updated 1/30/2020, read in part, "Healthcare personnel should use an alcohol-based hand rub or wash their hands with soap and water for the following clinical indications: Before moving from work on a soiled body site to a clean body site on the same patient, After touching a patient or the patient's immediate environment. After contact with blood, body fluids, or contaminated surfaces and immediately after glove removal."

2. On 11/17/2020 at approximately 12:02 PM, a housekeeper (HSK) was continuously observed as she cleaned Rooms [redacted], [redacted] and [redacted]. Observations of the resident room cleaning revealed the HSK started cleaning from Room #[redacted] on the [redacted] floor. She donned

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new gloves without performing hand hygiene, she then put on a gown. The HSK dust mopped the floor, then cleaned the toilet. She went back to her housekeeping cart which was in the hallway to pick a feather brush to dust. She did not change her gloves or perform hand hygiene after cleaning the toilet. She proceeded to wipe down the surfaces in the resident's room. After cleaning and mopping the rest of the resident's room, the HSK returned to the cleaning cart in the hallway while still wearing the gloves that were now potentially contaminated. She moved her cart and her next stop was at Room #XXX3.

HSK had worn the same pair of gloves to clean the entire room and did not perform hand hygiene, potentially cross contaminating the resident's room with her soiled gloves after cleaning the toilet and mopping the floor.

The Unit Manager (UM) interceded in the HSK continuous usage of the same gown and gloves she had worn in the room described above. The UM verified that Room [redacted] where the HSK exited from while still wearing her gown and gloves was in fact a transmission-based precaution room. She acknowledged the HSK was not supposed to wear the gown and gloves that had been used and were now potentially contaminated having been previously used in a room that had a resident on isolation. The UM educated the HSK on the spot and told her to dispose of the gown and gloves. Upon return to the room after disposing of the items described above, the HSK donned a new pair of gloves without sanitizing her hands and completed the cleaning the tasks in the room without changing her gloves. The HSK repeated the process of starting the room cleaning process from the bathroom, using the same gloves to complete all cleaning tasks in rooms and touching the

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residents' personal items with her potentially soiled gloves in Rooms [redacted] and [redacted].

On 11/17/2020 at 12:56 PM, the housekeeping supervisor (HKS) was interviewed. He said, "Not following the proper cleaning procedures; touching residents' personal effects with used gloves...can increase the spread of infections."

On 11/17/2020 between 12:00 PM and 12:45 PM, observations were conducted during in room tray delivery of the noon meal on the [redacted] #2 Unit located on the [redacted] floor. Certified Medication Aide (CMA) #2 and CMA #3 served meals to residents on the unit. Both CMAs did not perform hand hygiene prior to delivering the meal trays in the residents' rooms. CMA #2 and CMA #3 served 10 other residents on the unit without performing hand hygiene in between going in the residents' rooms. The identified failures and breaches in infection control practices identified above failed to ensure residents ate their meal under sanitary condition.

3. On 11/17/2020 between 12:00 PM and 12:45 PM, observations were conducted during in room tray delivery of the noon meal on the [redacted] #2 Unit located on the [redacted] floor. Certified Medication Aide (CMA) #2 and CMA #3 served meals to residents on the unit. They did not offer and/or encourage hand hygiene when they delivered the noon meal to the residents.

On 11/17/2020 at 2:13 PM, the Infection Control Preventionist (ICP) was interviewed. The ICP said residents and staff were trained on social distancing, frequent handwashing, cough etiquette, use of PPE, adherence to County and State Health Department directives. The ICP said potential breaches of infection control could result from staff's failure to follow proper infection

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A1299	Continued From page 18 control practices taught to them. She said, the breaches in infection control practice whether it is hand washing, donning of gloves, proper use of PPE when going in and out of an isolation room, not advising resident to cover their faces when staff went in their rooms, not wearing N95 mask or not replacing surgical mask between going in and out of isolation rooms and caring for residents who were not on isolation had risk of spreading infection quickly within the facility.	A1299		
A1303	8:36-18.3(a)(7)(i-iv) Infection Prevention and Control Services (a) Written policies and procedures shall be established and implemented regarding infection prevention and control, including, but not limited to, policies and procedures for the following: 7. Sterilization, disinfection, and cleaning practices and techniques used in the facility, including, but not limited to, the following: i. Care of utensils, instruments, solutions, dressings, articles, and surfaces; ii. Selection, storage, use, and disposition of disposable and nondisposable resident care items. Disposable items shall not be reused; iii. Methods to ensure that sterilized materials are packaged, labeled, processed, transported, and stored to maintain sterility and to permit identification of expiration dates; and iv. Care of urinary catheters, intravenous catheters, respiratory therapy equipment, and other devices and equipment that	A1303		

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A1303	Continued From page 19 provide a portal of entry for pathogenic microorganisms; This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review, the facility failed to ensure shared equipment was disinfected appropriately between residents' use for three of three units. This deficient practice occurred during the COVID-19 pandemic and had the potential to affect all residents. Findings included: Reference: Occupational Safety and Health Administration (OSHA): Title 29 Part 1910.1030. Bloodborne pathogens, included the following: "Standard Precautions: equipment or items in the patient environment likely to have been contaminated with infectious body fluids must be handled in a manner to prevent transmission of infectious agents (e.g., wear gloves for direct contact, properly clean and disinfect or sterilize reusable equipment before use on another patient)." 1. An initial tour of the facility on 11/17/2020 at 8:33 AM revealed Certified Medication Aide (CMA) #1 exited Room [redacted]. In her hand, she held onto a mounted vital sign machine. When the CMA exited the room, she turned to her immediate right and walked down the hallway with gloves still on her hands. She doffed the gloves in a trash can which sat at the end of the hallway. She did not perform hand hygiene after she doffed the gloves. The CMA then went back	A1303		

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to the vital sign equipment which she had placed by the room referenced above. She took the equipment with her and went on into Room [redacted] While at the door, the CMA knocked and announced that she was there to care for the resident. She went in the room, recorded the resident's vital signs and exited the room. The CMA proceeded into Room [redacted] where she repeated the sequence described above. Although a clear spray bottle labelled (product name) disinfectant sat in a basket-like compartment on the mounted vital sign machine. An observation revealed the CMA did not use the content in the bottle on the vital sign machine when she exited Room [redacted] and in between use in Rooms [redacted] and [redacted].

On 11/17/2020 at 9:35 AM, the CMA was interviewed. She acknowledged she did not disinfect the shared vital sign equipment between residents' use. She said, "I do see the (product name) disinfectant in the vital sign machine compartment, I do not know what they poured in it, so I do not use it."

2. On 11/17/2020 at 10:04 AM, a physical therapist (PT) was in Room [redacted], the room was a transmission-based precaution room as described above. PT arrived at the room entrance with a wheelable travel bag. She sat the bag by the room entrance and reached for a pair of gloves from a side zipped compartment on the bag. The gloves were not in a box. The PT donned the gloves without first performing hand hygiene. She removed a gown which hung from the wall and put it on. The PT then went in the resident's room with her bag and closed the door behind her.

On 11/17/2020 at 10:35 AM, the PT was interviewed. She said the facility met frequently to

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A1303	Continued From page 21 in-service about precautionary measures to curb the transmission of COVID-19. She verified she did not disinfect the bag when she took them in residents' rooms across the facility. She said, "I never thought to disinfect the bag because I thought the disinfectant would penetrate the box." She acknowledged that by failing to ensure she disinfected the bag in between going in rooms with residents on transmission-based precaution and those that were not, she was potentially cross contaminating the residents with whatever contaminant she picked when she went in the individual residents' rooms. She said she would get guidance from the administrative staff going forward.	A1303		
A1333	8:36-18.4(k) Infection Prevention and Control Services (k) Equipment and supplies used for sterilization, disinfection, and decontamination purposes shall be maintained according to manufacturers' specifications. This REQUIREMENT is not met as evidenced by: Based on observation and interviews, the facility failed to ensure disinfectants were used as directed by the manufacturer. Specifically, the housekeeping staff failed to adhere to disinfectant dwell times for one of one housekeeper observed. By failing to follow the manufacturer's recommended dwell time, surfaces were not adequately disinfected. This deficient practice had the potential to affect all residents and occurred during the COVID-19 pandemic. Findings included:	A1333		

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A1333	Continued From page 22 1. On 11/17/2020 at approximately 12:02 PM, a housekeeper (HSK) was continuously observed as she cleaned Rooms [redacted], [redacted] and [redacted]. Observations of the resident room cleaning revealed the HSK started cleaning from Room [redacted] on the [redacted] floor. She pulled a spray bottle labeled [product name] and sprayed the contents into the toilet, the surrounding walls and flush handle. She immediately wiped the surfaces down and flushed the toilet after having washed the toilet bowl with a brush. On 11/17/2020 at 12:56 PM, the housekeeping supervisor (HKS) was interviewed. He said housekeeping staff were last trained on cleaning procedures approximately two months ago. The HKS emphasized that not following the manufacturer recommended dwell time could affect the disinfecting properties of the disinfectants. He acknowledged that the disinfectant (product name) observed with the HSK was the product the facility utilized in disinfecting across the facility. He verified the manufacturer's recommended kill time for the disinfectant was 5 minutes. He acknowledged that by spraying and immediately wiping off the disinfectant, the HSK failed to let the disinfectant sit for as long as it was recommended and the surface was not adequately disinfected. He said he would do more one-on-one training with the housekeepers going forward.	A1333		