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	315226	A. BUILDING ______ B. WING ______	10/09/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HUNTERDON CARE CENTER	**1 LEISURE COURT FLEMINGTON, NJ 08822**

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F 000	INITIAL COMMENTS CENSUS: 139 SAMPLE SIZE: 30 + 27 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the	F 656		11/9/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 10/23/2020

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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resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review and review of pertinent facility documentation, it was determined that the facility failed to develop a comprehensive care plan for a resident with dementia and on [redacted] medications. This deficient practice was identified for 1 of 30 residents (Resident #135) reviewed for comprehensive care plans.

On 10/1/2020 at 11:12 AM, the surveyor observed Resident #135 reclined in a [redacted] in the hallway near the nursing station. The resident was wearing a surgical mask. The surveyor observed the resident repeatedly stating, "cover me" even after a staff member covered the resident with blankets.

The surveyor reviewed the medical record for Resident #135.

A review of the Admission Record face sheet (an admission summary) reflected that the resident had been admitted to the facility with diagnoses which included but were not limited to;

F 656

Corrective action for resident #135:
-A care plan was put in place for resident #135's cognitive deficits and behavioral symptoms, as well as for use of [redacted] medication.

Identification of other residents who could be affected by the deficient practice:
-Residents with [redacted] medications care plans were reviewed. No other residents were identified.

Measures or systemic changes to ensure that the deficiencies will not recur:
-Unit Managers were educated by the Director of Nursing on the need to review the baseline care plans for new admissions to assure that the care plan addresses cognitive or behavioral issues, as well as [redacted] use since the electronic health record does not trigger these items.
-Unit Managers and MDS will review

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F 656	Continued From page 2 A review of the admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated reflected that the resident had a brief interview for mental status (BIMS) score of indicating a cognitive impairment. The assessment further reflected that under Diagnoses the resident had The assessment also reflected that under that the resident had received an medication for three of the last seven days and that were received on a routine basis only. The MDS further revealed that the "Care Areas" of " and Drug Use" triggered as an area that required a decision for a new care plan, care plan revision, or continuation of a current care plan. A review of the physician's Order Review History Report for October 2020 included a physician's order (PO) dated for the medication milligrams at bedtime for and a PO dated for an medication mg every six hours as needed for . A review of the individualized comprehensive care plan initiated as early as for Resident #135 did not include a care plan with goals or interventions for or the medication use. On 10/6/2020 at 11:32 AM, the surveyor interviewed the resident's assigned Licensed	F 656	newly identified residents with behavioral symptoms and medications, care triggered areas to ensure there was a care plan developed. -The MDS Coordinators were educated by the Director of Nursing on the need to assure that when a care area is triggered as an area that requires a decision for a new care plan, care plan revision, or continuation of a current care plan, that such decision must be followed up by appropriate follow up with the plan of care. -Director of Nursing, or designee, will conduct a random audit weekly for 4 weeks, and monthly for 3 months of a new resident admission to evaluate that necessary care plans were initiated. -Director of Nursing, or designee, will conduct a random audit weekly for 4 weeks, and monthly for 3 months of an MDS to assure that Care Areas triggered are appropriately followed up with care plans. Monitoring the continued effectiveness of the systemic change: -Director of Nursing, or designee, will conduct random audits for trigger areas and completion of care plans for residents with behavioral symptoms, and medication use weekly X 4 and monthly X3. Results will be reported at the Quality Assurance Committee meeting for at least 2 consecutive quarters to assure compliance.	

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Practical Nurse (LPN). The LPN acknowledged that there was no care plan for [redacted] and the use of [redacted] medications. She stated that Resident #135 should have a care plan for both. The LPN then stated that on admission, the nurse usually generated the care plans, and that the Unit Manager (UM) would update the care plan as needed.

On 10/6/20 at 11:56 AM , the surveyor interviewed the UM regarding her involvement in the care planning process, but the UM was unable to directly speak to her involvement in the comprehensive care plans stating that it was because the length of stay for the residents on her unit were approximately two weeks.

On 10/6/2020 at 12:32 PM, the surveyor interviewed the MDS Coordinator who stated that on admission the care plan was initiated by the admitting nurse, then it gets updated by the UM. She stated that she would initiate and update the care plans after the comprehensive admission MDS assessment was completed. The MDS Coordinator was unable to provide documented evidence that a care plan for [redacted] or [redacted] medication use was initiated. The MDS Coordinator then stated that she was not sure why the resident did not have the care plans, and that Resident #135 should have had the care plans especially because he/she was on [redacted] medications.

On 10/9/2020 at 9:50 AM, the surveyor reviewed the facility policy titled, "Care Plan Meeting Communication" with an updated date of June 2017, which included under Procedure:

"Upon admission and throughout the course of a

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F 656	Continued From page 4 resident's stay, staff will establish each Resident's needs, strengths, goal, personal/cultural preferences, and wishes for treatment that will then be put into plans of care; care plan meetings are one method by which: A. These areas can be established B. Resident's and/or their Representatives can communicate their input, including but limited to, requests for revisions. -These meetings may be held during the first few days after admission and then quarterly, annually..." On 10/9/2020 at 9:57 AM, the surveyor interviewed the Director of Nursing (DON) in presence of the survey team acknowledged that while the staff were monitoring behaviors for the resident and addressing the resident's needs related to his/her cognitive status, she confirmed that Resident #135 did not have an individualized care plan developed for his/her [redacted] care or the use of the [redacted] medication. NJAC 8:39-11.2(d)	F 656		
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, record review, and review of pertinent facility documentation, it was determined that the facility failed to communicate and document the physician's	F 658	Corrective action for resident #146: The physician agreed with the recommendation for [redacted] and the order was written.	11/9/20

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response to [redacted] Consultant recommendations in accordance with professional standards of nursing practice. This deficient practice was identified for 1 of 3 residents reviewed with [redacted] (Resident #146).

The evidence was as follows:

Reference: New Jersey Statues, Annotated Title 45, Chapter. 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 with in 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 9/30/2020 at 11:15 AM, the surveyor observed Resident #146 lying in bed on an air mattress with a pillow positioned under his/her right side. The surveyor attempted to interview

F 658

Identification of other residents who could be affected by the deficient practice:
Audit was completed on residents who are evaluated by the [redacted] care company to ensure recommendations were communicated to the physician. None were identified.

Measures or systemic changes to ensure that the deficiencies will not recur:
-A nurse will review the recommendations of the [redacted] care company's consult with the attending physician, and shall document the discussion in the medical record, and then write any order changes given by the physician.
-A protocol outlining the procedure regarding wound care company's recommendations was developed.
-Licensed Nurses were educated by the Director of Nursing on the protocol regarding wound care consultant's recommendations.
-The Unit Managers will review all recommendations from the wound care company's documentation in the medical record weekly to ensure the physician notification and discussion was recorded in the progress notes and corresponding orders.
-The ADON was re-educated by the Director of Nursing on the need to wait for the direction of the physician/nurse practitioner before an order is written as per the Nurse Practice Act.

Measures or systemic changes to ensure that the deficiencies will not recur:

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F 658	Continued From page 6 the resident regarding the condition of his/her skin, but the resident was unsure if he/she had any [redacted]. On 9/30/2020, the surveyor reviewed the medical record for Resident #146. A review of the Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility with diagnoses which included but were not limited to [redacted]. A review of the quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted] reflected that the resident had a brief interview for mental status (BIMS) score of [redacted], indicating the resident had an intact cognition with some forgetfulness. It further included that the resident had [redacted] that was being treated with medicinal ointments. On 10/5/2020 at 1:20 PM, the surveyor reviewed the resident's electronic health record which included a [redacted] Consultant/Nurse Practitioner ([redacted] NP) Patient Visit Record dated [redacted] which indicated that the resident had one [redacted]. The recommendations included to discontinue a treatment of [redacted] ointment and instead apply [redacted] properties) to the [redacted] daily and prn (as needed). A review of the electronic Progress Notes (ePN) dated 9/28/20 or thereafter, did not reflect	F 658	-Director of Nursing, or designee, will review a random wound care company's consultation and check for documentation that the recommendations were communicated to the attending physician and that orders were written as appropriate weekly for 4 weeks, and then monthly for 3 months, to assure that there is documentation of discussion with the attending physician about recommendations, and that appropriate orders were written. -Director of Nursing, or designee, will report on the results of the audits and any corrective actions taken, at the Quality Assurance Committee meeting for at least 2 consecutive quarters.	

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F 658	Continued From page 7 documented evidence that the [redacted] NP recommendation was communicated to the Attending Physician (AP) or that the Attending Physician did not approve of the recommendation. On 10/6/2020 at 9:31 AM, during surveyor interview, the Assistant Director of Nursing (ADON) stated that he usually accompanied the [redacted] NP during [redacted] rounds which occurred weekly on Mondays and that if the recommendation was a usual or customary treatment, he would put the recommended order directly into the resident's electronic health record. He further stated that if the treatment recommendation was atypical, he would consult the Attending Physician first before he put the recommended order into the resident's electronic health record. The ADON then stated that he was not working on [redacted] and had not yet followed up on any orders that were recommended by the [redacted] NP on that date, but that the [redacted] NP was here yesterday ([redacted] and recommended that the treatment be changed to a crushed [redacted]. The ADON stated that when he was off on [redacted] the UM of [redacted] assisted with [redacted] rounds. On 10/6/2020 at 9:47 AM, during surveyor interview, the Unit Manager (UM) confirmed that he went on [redacted] rounds on [redacted]0 for the facility and that the process for [redacted] rounds usually involved observing the [redacted] with the [redacted] NP. He stated that when the [redacted] NP made recommendations the WC/NP will communicate those recommendations to the ADON and it was the ADON's responsibility to notify the AP. The UM stated that if the ADON was not available	F 658		

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F 658	Continued From page 8 that it will be the responsibility of the Unit Manager of the resident's assigned unit. The UM then stated that on [redacted] that the ADON and the resident's assigned Unit Manager were not available, so he recalled on [redacted] that he gave the [redacted] NP's recommendation to the resident's assigned LPN (LPN #1) that day. On 10/6/2020 at 9:58 AM, the surveyor interviewed LPN #1, who stated that she was not working on [redacted] and that she was not aware of a recommendation from the [redacted] NP. She further stated that the [redacted] treatment order for Resident #146 had changed in the electronic health record today [redacted] to the [redacted]. The surveyor then reviewed the [redacted] /NP Patient Visit Record dated 1[redacted] which indicated that the [redacted] NP recommendation was to discontinue the [redacted] and to apply [redacted] milligrams (mg) [redacted] [redacted] twice daily and as needed (prn). A review of the ePN from [redacted] reflected there was no documented evidence that the [redacted] NP recommendation for the [redacted] [redacted] tablet was communicated with the AP. On 10/6/2020 at 12:55 PM, the surveyor reviewed the electronic Treatment Administration Record (eTAR) for October 2020 which indicated an order dated [redacted] for the [redacted] Tablet [redacted] mg ([redacted]; apply to the [redacted] [redacted] topically every day and evening shift for [redacted] care and cleanse [redacted] solution. On 10/7/2020 the surveyor reviewed the eTAR	F 658		

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for October 2020 which indicated an order for [redacted] mg ([redacted] treatment was performed on [redacted] on the day shift and then the order was marked as discontinued after the first dose.

A review of the ePN for 1[redacted] did not reflect documented evidence as to who discontinued the order for the [redacted]l or why it was discontinued.

On 10/7/2020 at 12:45 PM, during surveyor interview, the [redacted] NP stated that Resident #146 had [redacted] ([redacted] She stated that on [redacted] she recommended [redacted] for the [redacted] and then on [redacted] this week the [redacted] showed increased [redacted], so she recommended a [redacted] tablet to the [redacted]. The [redacted] NP indicated that if a treatment was not working for 2 to 4 weeks she will recommend switching to another treatment. The [redacted] NP stated that she was not aware that the recommendation for the [redacted] was not followed on [redacted] but stated that the Attending Physician reserves the right to either order the recommended treatment or to withhold it. The [redacted] NP further stated that the resident did not like to turn or move in bed about in bed.

On 10/8/2020 at 8:44 AM, during surveyor interview, Resident #146's AP stated that the nurses will notify her that the [redacted] NP recommended a treatment, and if she approved it, she would order it. The AP stated that she was aware of the recommendation for the [redacted] [redacted] but that she was not in agreement with it because the resident was already on a [redacted] and that the resident still had [redacted] The AP further

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F 658	Continued From page 10 stated that she saw the resident on [redacted] later in the afternoon likely after the [redacted] consultant was here because the [redacted] "looked good" on [redacted]. The surveyor then asked the AP if she had ordered [redacted] mg [redacted] be applied to the [redacted]. The AP then stated that she was not aware of a recommendation or order for [redacted] in accordance with the [redacted] Consultant's recommendation, but confirmed that the resident needed the [redacted], and she ordered it on [redacted] after her visit with the resident. The AP stated that the resident appeared to be having a recent unavoidable medical decline. On 10/8/2020 at 12:05 PM, during surveyor interview, the ADON admitted that he placed the [redacted] NP recommended order for [redacted] mg twice a day to the [redacted] in the electronic health record and then proceeded to call the AP but that he never got in touch with the AP. He then stated that when he did not receive a return phone call, he then discontinued the order in the electronic health record, and replaced it with the previous [redacted] treatment orders. He confirmed that the resident received [redacted] and that the AP wanted the [redacted] upon her visit to see the resident on [redacted]. He acknowledged there should have been documented evidence in the ePN regarding the matter. On 10/9/2020 at 9:50 AM, the surveyor reviewed the undated facility policy titled, "2.0 Physician Interim Order Process" which read under Procedure "5. For Treatment: Verbal orders may only be received by licensed nurses, certified respiratory therapists, nurse practitioners, physician's assistants (from their supervising physician only),	F 658		

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F 658	Continued From page 11 physical therapist, occupational therapists, speech therapists, and dieticians, per state regulations." On 10/9/2020 at 9:58 AM, during surveyor interview in the presence of the survey team, the Director of Nursing (DON) stated that any recommendations from the [redacted] NP should be verified with and ordered by the AP before it is placed in the computer by the nurse. The DON further stated that the facility did not have a policy regarding [redacted] Consultant's recommendations. The facility could not provide any documented evidence that the facility communicated the [redacted] NP recommendations to the AP for the [redacted] and [redacted] visits. The DON acknowledged that while there was no documentation of the physician's response on [redacted] regarding the physician not approving the [redacted] recommendation, the resident received the [redacted] treatment in accordance with the order that the physician wanted. She confirmed that on [redacted] the documentation should have been clearer of the physician and nurse's communication before starting the [redacted] NJAC 8:39-29.2 (d)	F 658		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals	F 761		11/9/20

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F 761	Continued From page 12 §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. 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 an expired [redacted] medication [redacted] was removed from the active inventory stored in the medication cart from April 2020 to October 2020. This deficient practice was identified for 1 of 4 medication carts [redacted] Unit) that were inspected and was evidenced by the following: On 10/7/20 at 10:54 AM, the surveyor inspected the Spruce Unit medication cart with the Registered Nurse (RN) in the presence of another surveyor. The top drawer contained four (4) tubes of [redacted] The surveyor observed that 3 of 4 available [redacted] in the medication cart had an expiration date of 4/2020.	F 761	Identification of residents with potential to be affected by deficient practice: The facility immediately removed the [redacted] from the one unit identified. All residents could potentially be affected by deficient practice. Measures or systemic changes to ensure that the deficiencies will not recur: -All medication carts were audited for expired meds and none were found in any other carts. -Licensed nurses were re-educated by the Director of Nursing on the importance of checking all items in the medication cart, including [redacted], for expiration dates on an ongoing basis, regardless of the inability of the Pharmacist Consultant to perform his monthly inspections due to Covid-19. -Nurse will check the medication carts	

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At that time, the surveyor interviewed the RN in the presence of another surveyor. The RN stated that that the [redacted] were over-the-counter (OTC) stock medication stored in the medication cart available for use when needed. The RN added that the nurses were responsible for checking the medication cart for expired medications. The RN further stated that she should have removed the expired medications from active inventory before the medication expired. The RN then took the three (3) expired tubes and stated that she would discard the medication.

On 10/8/20 at 9:40 AM, the surveyor interviewed the Consultant Pharmacist (CP) via the telephone who stated that he would normally do a unit inspection every month to make sure there were no expired medications in active inventory but has not been in the facility since March 2020 due to the Corona virus (COVID-19) restrictions. The CP added that from April 2020 to present the nurses were responsible for removing expired medications from active inventory.

On 10/8/20 at 12:04 PM, the survey team met with the Licensed Nursing Home Administrator (LNHA), Director of Nursing (DON), Assisted Director of Nursing (ADON) and Regional Nurse Consultant. The DON acknowledged that the CP had not been completing unit inspections due to COVID-19 restrictions. The DON added that the nurses were responsible for removing any expired medications from active medication inventory.

A review of the undated facility policy for "Medication Storage" provided by the LNHA reflected that expired medications will be

F 761

daily to identify and remove any expired items.
-Upon orientation, and periodically thereafter, nurses will be inserviced on the importance of monitoring expiration dates.

Monitoring the continued effectiveness of the systemic change:
-Assistant Director of Nursing, or designee, will do random audits to validate expired medications were removed from inventory weekly X 4, and monthly X 3 months.
-The Pharmacist Consultant, upon return, will resume his monthly inspections. Pharmacist Consultant will include in his monthly report any identification of expired items. In the absence of the Pharmacist Consultant, the Director of Nursing/designee will conduct the audit. Results of the audits will be reviewed by the Director of Nursing and Administrator.
-The results of the monthly inspections and follow up actions taken will be presented at the Quality Assurance Committee meeting for at least 2 consecutive quarters to assure that education and oversight has been effective.

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F 761	Continued From page 14 removed from the medication storage areas and disposed of in accordance with facility policy. NJAC 8:39- 29.4 (c)(h)	F 761		
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, 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	F 880		11/9/20

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F 880	Continued From page 15 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 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 ensure: a.) a [redacted] was cleansed upon direct contact with linens and b.) hand hygiene	F 880	Corrective action taken for resident #146: -The nurse performing the treatment was re-educated on the need to monitor to	

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was performed between glove changes during the [redacted] treatment observation. This deficient practice was identified for 1 of 3 residents reviewed for [redacted] (Resident #146).

The evidence was as followed:

On 9/30/2020 at 11:15 AM, the surveyor observed Resident #146 lying in bed on an air mattress. The resident had a pillow positioned under his/her right side. The surveyor attempted to interview the resident at that time, but the resident was unsure if he/she had any [redacted].

On 10/5/2020 at 10:20 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) who stated that Resident #146 had a [redacted] [redacted] to the [redacted] [redacted] At that time, the LPN stated to two surveyors that she was going to perform Resident #146's [redacted] treatment with the assistance of a Certified Nursing Aide (CNA). The two surveyors observed the LPN prepare for the [redacted] treatment. The surveyors observed the LPN perform hand hygiene and don (put on) a pair of gloves. While the CNA assisted in positioning the resident off their [redacted], the LPN cleansed the [redacted] with a 4x4 moistened gauze. The surveyors observed the LPN remove the gloves and she donned another pair of gloves without performing hand hygiene. She then cleansed the wound and around the [redacted] two more times, removing and replacing her gloves each time without performing hand hygiene between the glove changes.

The surveyors then observed the LPN tell the CNA to allow the resident to lay onto his/her [redacted], without dressing the [redacted].

F 880

assure that the resident remains off their [redacted] while doing hand hygiene, and to keep hand sanitizer in reach for use when removing gloves.
-Therapy evaluated a positioning device to assist in keeping the resident positioned on resident's side for the duration of the treatment, and a [redacted] was provided.

Identification of other residents who could be affected by the deficient practice:
-Director of Nursing conducted treatment observations to audit hand hygiene and prevention of contamination. No other residents were identified.

Measures or systemic changes to ensure that the deficiencies will not recur:
-Licensed nurses were re-educated by Director of Nursing on treatment administration with emphasis on hand hygiene and keeping hand sanitizer within easy reach during procedure, in order that closer monitoring of positioning during dressing change can assure that [redacted] does not make contact with linens.
-Infection Preventionist nurse, or designee, will conduct [redacted] observations regarding positioning of residents during treatments and hand hygiene upon removal of gloves weekly X 4 and then monthly for 3 months to check for compliance.

Monitoring the continued effectiveness of the systemic change:
-The Infection Preventionist nurse, or designee, will report the results of the

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F 880	Continued From page 17 The CNA then assisted the resident to lay flat on his/her [redacted] causing the [redacted] to come into direct contact with the bed linens. When the LPN returned from performing hand hygiene, she donned a pair of gloves and told the CNA to reposition the resident off his/her [redacted] so she could continue with the [redacted] treatment. The LPN did not cleanse the [redacted] [redacted] again after it came into direct contact with the bed linens, and prior to placing the treatment onto the [redacted] The surveyors observed the LPN a skin protectant around the [redacted] and she changed her gloves without performing hand hygiene. On 10/5/2020 at 1:09 PM during surveyor interview, the LPN stated that she should perform hand hygiene every time she changes her gloves but that she was "nervous." The LPN further stated that she did not realize that the resident's [redacted] had touched the bed sheets, but that if she knew she would have cleaned the wound bed again. On 10/9/2020 at 9:00 AM, the surveyor reviewed the undated facility policy titled, "Treatment Administration Procedure" which included under Procedure: "4. Wash hands (at least 20 seconds) if visibly soiled, or use alcohol gel and apply clean gloves. 5. Prepare resident (get help to hold resident over or lif[redacted]). 8. Use alcohol gel and apply new clean gloves. 10. Apply clean gloves, and using pre-wetted gauze cleanse [redacted] outward and discard gauze. Repeat as necessary until clean. 11. Remove gloves and wash hands (at least 20 seconds) or use alcohol gel. Put on clean gloves. 17. Assistant to return resident to comfortable	F 880	Treatment Observation and any corrective actions taken at the Quality Assurance Committee for 2 consecutive quarters.	

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F 880	Continued From page 18 position." On 10/9/2020 at 9:58 AM, the surveyor interviewed the Director of Nursing (DON) in the presence of the survey team. The DON stated that if the nurse realized that the [redacted] became contaminated that the the [redacted] should be cleansed again before continuing with the treatment. The DON added that the nurse was not aware that the resident's wound had come into direct contact with the bed sheets. The DON further stated that hand hygiene should be performed every time gloves are removed with either alcohol-based hand rub (ABHR) or soap and water at the sink. She stated that the nurse should have accessed a bottle of ABHR that are available on the carts and put it directly on the table to use during the [redacted] treatment. NJAC 8:39-19.4(a)	F 880		