STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A001	A. BUILDING: _____ B. WING _____	04/18/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ATRIUM SENIOR LIVING OF PARK RIDGE	124 NOYES DRIVE PARK RIDGE, NJ 07656

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
A 000	Initial Comments Initial Comments: TYPE OF SURVEY: Focused Covid-19 Infection Prevention and Control survey CENSUS: 66 SAMPLE SIZE: 0 A Covid-19 Focused Infection Control Survey was conducted by the State Agency on (4/18/2020). 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 and Prevention (CDC) recommended practices to prepare for COVID-19.	A 000		
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 observation, interview and documentation it was determined that the facility failed to ensure the proper use of Personal Protective Equipment (PPE) of staff and cleaning	A1299		

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

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A1299	Continued From page 1	A1299		

of equipment after active use during the care of a resident. This deficient practice was evidenced by the following:

On 4/18/20 at 5:23 p.m., during a visit to the facility, the surveyor observed a Registered Nurse (RN) preparing to give medications to the residents on the unit. The surveyor observed that the RN was wearing a surgical mask, however it was loosely fitted on the face. The RN was also wearing a disposable scrub top which covered her shirt. The surveyor interviewed the RN and asked her what type of PPE was provided to her by the facility. The RN stated that, in addition to what she was wearing, the facility gave her disposable scrub pants, however, the pants did not fit, a disposable head covering, a N 95 mask and shoe coverings. The surveyor observed available on top of the medication cart hand sanitizer, which the RN used, and disposable gloves.

While the surveyor was interviewing the RN, a resident called out for help due to breathing difficulties. The RN went to the resident's door, then stood inside of the room, to assess the resident. During the assessment the resident was coughing. the RN left the resident's room and went to the medication cart, which was only a few feet away from the resident's room, and retrieved a pulse oximetry device. The surveyor observed that the RN was holding the pulse oximetry device with no gloves and so the surveyor inquired about the RN not wearing gloves. The RN donned gloves and went back to the the room to put the pulse oximetry device on the resident. The RN obtained the oxygen saturation level and stated that the resident was eating and had something in her throat, the surveyor observed that it was dinner time for the residents. After the RN finished in the room, the

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A1299	Continued From page 2	A1299		

surveyor observed her return the pulse oximetry device to the medication cart without cleaning the device. The RN stated to the surveyor that she was going to get her PPE from her locker. The surveyor observed the RN leave the floor and get on the elevator with same gloves on that she had used to care for the resident.

The surveyor reported these findings to both the Director of Quality Improvement and the Vice President of Clinical Services and both stated that the RN would be immediately re-trained on proper protocol and use of PPE as both agreed that the RN should have had the proper PPE on and should have cleaned the device after use. The facility provided documented evidence on 4/19/20 that the RN was re-trained on 4/18/20. The facility also informed the surveyor that the resident was not suspected of having Corona virus.

On 4/18/20 the facility provided the surveyor with a copy of the facility policy titled, "Corona Virus," which documented under the section headed "Adherence to Standard, Contact, and Airborne Precautions, including the use of eye protection," "Standard Precautions assume that every person is potentially infected or colonized with a pathogen that could be transmitted in the healthcare setting. All staff who enter the room of a resident with known or suspected COVID-19 should adhere to Standard, Contact, and Airborne Precautions...

Additionally, the surveyor reviewed the facility policy titled, "Cleaning, Disinfection of Equipment" which documented, "Semi-critical items-are those items that come in contact with mucous membranes or non-intact skin (examples: respiratory therapy equipment, thermometers, pulse oximeter, blood pressure cuffs, and

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A1299	Continued From page 3 basins). Semi-critical items require disinfection with disinfection solution, germicidal detergent solution, or germicidal detergent wipes...	A1299		

Atrium of Park Ridge Senior Living

Plan of Correction 5.7.2020

Tag A1299 – 8:36-18.3(a)(5) Infection Prevention and Control Services

I. Corrective actions for those found to have been affected by the deficient practice:

a. The Registered Nurse observed performing deficient practice by surveyor was immediately in-serviced by the Quality Improvement Nurse on the proper protocol and use of personal protective equipment.
b. The pulse oximetry device used during the deficient practice was properly sanitized using standard infection control practices.

II. Identification of other residents potentially affected by the deficient practice:

a. The Quality Improvement Nurse reviewed care delivery practices involving the use of equipment for treating residents utilizing blood pressure cuffs, respiratory therapy equipment, thermometers, and pulse oximetry devices. This review included an evaluation of infection control practices between staff members. No additional concerns or issues were identified.

III. Measures taken to ensure the deficient practice does not recur:

a. In-service education on the policy and procedure "Cleaning, disinfection of equipment" for all licensed nurses and caregivers was conducted by the Quality Improvement Nurse.
b. Re-training for all staff on the proper use of personal protective equipment was conducted by the Quality Improvement Nurse.
c. The agency Registered Nurse observed performing deficient practice was removed from schedule and asked not to return.
d. All agency nurses are in-serviced on Infection Control, COVID -19 and appropriate utilization of PPE upon hire.
e. Annual training on the proper use of personal protective equipment is conducted with all staff.

IV. Monitoring to ensure the deficient practice will not recur:

a. The Director of Resident Care or designee will monitor staff on a weekly basis to ensure Protective Personal Equipment is used appropriately.
b. Observations and findings will be reviewed and serve as part of our continuous quality improvement process.

Completion Date: 4/24/2020

Atrium Senior Living of Park Ridge
124 Noyes Drive - Park Ridge, NJ 07656
T. (201) 782-0442