STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315164	A. BUILDING _____ B. WING _____	10/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTY MANOR REHABILITATION & HCC	133 COUNTY ROAD TENAFLY, NJ 07670

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F 000	INITIAL COMMENTS Survey Date: 10/3/19 Census: 61 Sample Size: 22 + 6 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 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State	F 609		11/29/19

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

Electronically Signed | 10/25/2019

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F 609	Continued From page 1 Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of pertinent facility documents, it was determined that the facility failed to report to the New Jersey Department of Health (NJDOH) an incident in which a resident fell from an ambulance and required emergency care. The deficient practice was identified for 1 of 3 residents reviewed for accidents (Resident #20) and was evidenced by the following: On 9/26/19 at 11:04 AM, the surveyor observed Resident #20 in a wheelchair with his/her eyes closed. The surveyor was unable to interview the resident. On 9/26/19 at 9:56 AM, the surveyor interviewed the Charge Nurse/Registered Nurse (RN) who stated that Resident #20 had a fall with a major injury which occurred around [redacted] due to a mishap with the ambulance transporter. The surveyor reviewed the medical record for Resident #20. A review of the admission record revealed an original admission date of [redacted] and readmission date of [redacted] with diagnoses which included [redacted] [redacted] Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted] reflected the resident had a brief interview for mental status	F 609	1. The corrective action(s) accomplished for the resident found to be affected by the deficient practice: " Resident #20 Incident of fall out of an ambulance was reported to the NJDOH on [redacted]. The administrator also called NJ Office of Emergency Medical Services on [redacted] to report the incident. 2. The facility identified other residents having the potential to be affected by the same deficient practice: " All incidents were reviewed to determine if there were other incidents related to Mobility Assistance Vehicle Operations. No other incidents were identified. 3. The measures/systemic changes the facility will put into place to ensure that the deficient practice does not recur: " The reportable events policy will be revised to include: to report residents with major injuries resulting from a service provider. " All Department heads will be in-serviced on the policy change. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued	

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F 609	Continued From page 2 (BIMS) score of [redacted], indicating that the resident had moderately impaired cognition. On 10/1/19 at 10:51 AM, the surveyor reviewed an incident/accident report and investigative summary dated [redacted] for Resident #20 provided by the Director of Nursing (DON). The reports revealed that the transporter from an ambulance service provider "forgot that the ramp was still down" and "the resident fell out of the truck." The resident had to be sent to the hospital immediately by 911 emergency services. The investigation did not include documented evidence that the NJDOH had been notified of the incident. On 10/1/19 12:02 PM, the surveyor interviewed the DON in the presence of the survey team. The DON stated that the Licensed Nursing Home Administrator (LNHA) had additional information regarding the investigation of the incident and could not speak to whether the incident had been reported to the NJDOH. The DON added that at the time of the incident she was the Assistant Director of Nursing and the DON who had completed the summary was no longer employed at the facility. On 10/2/19 at 11:13 AM, the surveyor interviewed the LNHA in the presence of the survey team. The LNHA acknowledged that the transporter for the ambulance service provider had accidentally caused the resident to fall from the ambulance, and that the resident had to be sent to the hospital immediately by emergency services. The LNHA stated that he did not report the incident to the NJDOH because he didn't think incidents that were determined to be "purely an	F 609	effectiveness of the systemic changes: " All reportable events will be presented at the Quarterly Quality Assurance Committee meeting.	

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F 609	Continued From page 3 accident" were necessary to be reported. On 10/3/19 at 11:34 AM, the survey team met with the LNHA, DON and Regional Nurse Consultant. The LNHA acknowledged that he reviewed the incident again and agreed that the incident should have been reported. The LNHA added that he had reported the incident to the NJDOH on [redacted] after surveyor inquiry. A review of the facility policy for "Resident Abuse/Neglect" dated August 2017 reflected that the Administrator or a designee would lead the investigation of an allegation of abuse/neglect. In addition, the NJDOH and the Office of the Ombudsman would be notified immediately meaning as soon as possible but not to exceed 2 hours of an alleged violation. NJAC 8:39-9.4 (e)(3)(i)	F 609		
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	F 656		11/29/19

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F 656	Continued From page 4 (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 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, and record review, it was determined that the facility failed to implement a resident's individualized care plan for the prevention of falls. This deficient practice was identified for 1 of 20 residents reviewed for care planning (Resident #160), and was evidenced by the following: On 9/26/19 at 11:11 AM, the surveyor observed Resident #160 in bed. A Licensed Practical Nurse (LPN) and a Certified Nursing Aide (CNA) were also in the room. There was a wheelchair	F 656	1. The corrective action(s) accomplished for the resident found to be affected by the deficient practice: " Resident # 160 received additional [redacted] to be placed on the wheelchair as per resident care plan. " Nursing staff were in serviced to place fall mats on both sides of the resident□s bed while resident is in bed. 2. The facility identified other residents having the potential to be affected by the same deficient practice:	

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F 656	Continued From page 5 adjacent to the resident's bed. The LPN stated to the surveyor that she had just repositioned the resident in bed. The LPN and CNA exited the room. There was no evidence of floor mats next to the resident's bed, and there was no evidence of a [redacted] positioned on the wheelchair. The surveyor attempted to interview the resident but the resident did not respond to the surveyor. On 9/27/19 at 10:24 AM, the surveyor observed Resident #160 in bed with his/her eyes closed. There was a wheelchair in the corner of the resident's room with the leg rests placed on the seat. There was no evidence of floor mats on the floor and there was no dycem on the wheelchair. On 9/30/19 at 8:52 AM, the surveyor observed the resident in bed with his/her eyes closed. There were no floor mats on the floor next to the resident's bed. The wheelchair did not have a dycem. The surveyor reviewed the medical record for Resident #160. A review of the Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility on [redacted] with diagnoses which included [redacted] A review of the significant change 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	F 656	" Review all residents with fall care plans to ensure all safety devices are available and in place as per each individual care plan. " Inservice nursing staff on resident fall care plans and ensure use of safety devices as prescribed in the individual care plans 3. The measures/systemic changes the facility will put into place to ensure that the deficient practice does not recur: " [redacted] roll will be stored on the nursing unit to provide easy access to replace dycem as needed. " The director of nursing or designee will add all ordered /care planned safety devices to Point of Care (POC) module in the electronic health record to communicate to certified nursing assistants all safety devices that are to be in place as prescribed in each resident's fall care plan and/or physician orders. " Nurses will obtain physician orders for all safety devices and will document use/placement in the treatment administration record (TAR) " The director of nursing or designee will Inservice all nursing assistants on the use of the POC module. " The director of nursing or designee will Inservice all nursing staff on the use and function of facility approved safety devices to prevent resident falls/injuries.	

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F 656	Continued From page 6 resident had a moderate to [redacted] cognitive deficit. The assessment further indicated that the resident had a history of falls in the facility. A review of the resident's individualized care plan initiated on [redacted], included that the resident was at risk for falls due to a diagnosis of [redacted], and that he/she was on [redacted] and [redacted] medications. The care plan included an intervention revised on [redacted] to apply "Floor mats when in bed, be sure to remove them from floor when not in bed to prevent tripping hazard." It further included an intervention dated [redacted] to "provide [redacted] to wheelchair." On 10/2/19 at 10:06 AM, the surveyor observed Resident #160 in bed. There were two floor mats positioned on either side of the resident's bed. The surveyor observed the wheelchair in the corner of the resident's room. There was no evidence of a [redacted] pad on the seat of the wheelchair. On 10/2/19 at 10:10 AM, the surveyor interviewed the resident's assigned CNA regarding how staff keep the resident safe from falls. The CNA stated that the floor mats were to be in place on both sides of the resident's bed at all times when he/she was in bed "for safety" if the resident tried to get out of bed and fell. She stated the floor mats were already there when she started her shift that morning. The surveyor inquired about a [redacted] pad, and the CNA stated that a [redacted] was a white or black rubber pad that was supposed to keep the resident from sliding out of the wheelchair. The CNA confirmed Resident #160 did not have one on the wheelchair, but she showed the surveyor another resident who had a	F 656	4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes: " The director of nursing or designee will conduct a weekly random audit of 15 residents of the use/placement of safety devices as prescribed by the resident□s care plan for two months and thereafter monthly for three months. " The director of nursing will report safety device audit results to the monthly fall performance improvement project meeting as well as the quarterly quality assurance meeting.	

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F 656	Continued From page 7 [redacted] pad on the chair. The CNA was not sure if Resident #160 was supposed to have one or not. At 10:20 AM, the surveyor interviewed the resident's assigned LPN who confirmed the resident had a history of falls prior to recently being admitted to [redacted] services. The LPN stated that the facility utilized bedside floor mats when the resident was in bed. The surveyor asked if the resident ever got out of bed into the wheelchair, and the LPN stated that the resident was out of bed this past [redacted] on [redacted] when she worked in order to feed the resident. The surveyor inquired if the resident was supposed to have a [redacted] pad on the wheelchair, and the LPN stated "basically all (residents) have a dycem." The surveyor asked if the [redacted] goes under or over the seat cushion and the LPN stated it was supposed to be placed on top. The surveyor and LPN observed the resident's wheelchair together and acknowledged there was no [redacted]. The LPN could not speak to why there was no [redacted] on the wheelchair. At approximately 10:23 AM, the surveyor observed a Rehab Technician deliver a [redacted] to Resident #160's room. The Rehab Technician removed an adhesive backing on the back of the [redacted] and placed a new black [redacted] on top of the resident's wheelchair cushion. The Rehab Technician could not speak to if the resident was supposed to have a [redacted] to the wheelchair prior to today. He stated that he was just told to put one onto the resident's wheelchair. On 10/3/19 at 11:41 AM, the surveyor interviewed the Director of Nursing (DON) and the Licensed Nursing Home Administrator (LNHA) in the presence of the survey team. The DON	F 656		

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F 656	Continued From page 8 acknowledged that the floor mats and the [redacted] to the wheelchair were not put in place in a timely manner in accordance with the resident's individualized plan of care. She stated she was not sure if the [redacted] had recently come off when the resident was re-admitted to the facility from the hospital on [redacted]. She confirmed that the resident was supposed to still have the floor mats while the resident was in bed, and the [redacted] to the wheelchair for when or if the resident got out of bed for any reason for the protection and prevention of falls, as indicated. She confirmed that the resident had not had any falls since his/her significant change in condition. A review of the facility's Fall Prevention Policy revised 2017 included "...measures will be implemented once a patient is identified as a fall risk." NJAC 8:39-11.2 (e) - (i); 27.1 (a)	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, and record review, it was determined that the facility failed to: a.) discontinue a physician's order for an [redacted] medication, and b.) accurately perform monthly recapitulations in accordance with professional standards of nursing practice. This deficient practice was identified for 1 of 22	F 658	1. The corrective action(s) accomplished for the resident found to be affected by the deficient practice: Resident #48-Physician order obtained to discontinue [redacted] tab by mouth every 6 hours as needed for [redacted]. " Medication error report form was	11/29/19

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F 658	Continued From page 9 residents reviewed for professional standards of nursing practice (Resident #48). 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 registered professional nurse is defined as diagnosing and treating human responses to actual and potential physical and emotional health problems, through such services as casefinding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing 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 casefinding; 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." The evidence was as follows: On 9/26/19 at 10:20 AM, the surveyor observed Resident #48 laying in bed. The surveyor attempted to interview the resident but the resident stated that he/she needed to put a robe on, then closed his/her eyes. The resident was observed to be fully dressed for the day.	F 658	completed for the transcription error. " Nurses were in serviced on protocol for proper medication order. " Nurses were in serviced on Psychotropic policy. " Nurses were in serviced on policy and procedure on Monthly Physicians Orders Recapping. 2. The facility identified other residents having the potential to be affected by the same deficient practice: " Review all residents□ orders to ensure accuracy of orders. 3. The measures/systemic changes the facility will put into place to ensure that the deficient practice does not recur: " The director of nursing or designee will in service all nurses on monthly physicians□ order recapping policy. " Monthly recaps will be co-signed by two nurses to ensure accuracy. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes: " The director of nursing or designee will conduct a monthly audit of 10 residents□ monthly physicians□ orders recapping for three months. " The findings will be documented and analyzed by the Director of Nursing to identify possible trends and will be	

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F 658	Continued From page 10 A review of the resident's medical record reflected the following: A review of the Admission Record face sheet (an admission summary) reflected that the resident was re-admitted to the facility on [redacted] and had diagnoses which included [redacted] A review of the most recent significant change 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 a [redacted] impaired cognition. A review of the July 2019 Physician's Order sheet reflected a physician's order (PO) dated [redacted] for an [redacted] medication, [redacted] (mg) to be administered every six hours as needed for [redacted]. There was no evidence of a stop date for the [redacted] A review of a follow-up Physician's Orders dated [redacted] reflected a new telephone Physician Order to add a stop date for the [redacted] to be administered as needed for 14 days. There was no evidence within the Physician Order sheets that reflected the order dated [redacted] had been discontinued when the new order had been clarified on [redacted] A review of the September 2019 Medication Administration Record (MAR) reflected the PO originally dated [redacted]. The date on the order was crossed out to reflect [redacted] when an anxiety diagnosis was added. The order on the	F 658	presented to the Pharmacy and Therapeutics committee as well as at the quarterly quality assurance meeting.	

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F 658	Continued From page 11	F 658		

MAR had no discontinued date and just specified to "see below." Further review of the September MAR reflected a PO dated [redacted] for [redacted] that was limited to 14 days, as needed.

A review of the October 2019 Physician's Order Form provided by the Pharmacy Provider, continued to reflect the order dated [redacted] for the [redacted] mg, administer one tablet by mouth every six hours as needed for [redacted]. Next to the order was a handwritten check mark, in addition to a check mark next to all the other physician orders on the form.

A review of the October 2019 MAR reflected the active corresponding PO for [redacted] dated [redacted] without the stop date. The order had a check mark next to it. The MAR reflected that the resident had not received [redacted] for October at the time of surveyor review.

On 10/2/19 at 11:48 AM, the surveyor and the Charge Nurse/Registered Nurse (RN) reviewed the PO's and the MAR's. The RN stated that the resident had not needed the [redacted] lately and that staff were able to control his/her [redacted] with non-pharmacological interventions. The RN added that she believed that since the resident already had a PO for [redacted], the PO dated [redacted] was possibly a duplicate order. She indicated that she would clarify regarding the surveyor's inquiry.

On 10/3/19 at 11:49 AM, the surveyor interviewed the Director of Nursing (DON) and Licensed Nursing Home Administrator (LNHA) in the presence of the survey team. The DON stated that the original PO dated [redacted] should have been discontinued when the Attending Physician

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F 658	Continued From page 12 added a stop date to the as needed [redacted] medication. She added that the nurses should have picked this up during monthly recapitulations (Recaps), a process in which nurses review for the accuracy of physician orders and their corresponding MAR's. The LNHA added that Recaps are done by all nurses on all shifts. The DON confirmed that the nurses put a check mark on the POS and the MAR's to reflected that the Recaps had been completed, but the DON confirmed that the [redacted] order should have been picked up as a discrepancy and clarified during the Recap process, in accordance with professional standards of practice. The surveyor reviewed the facility's Monthly Recaps policy dated as revised 2019. The policy included that Physician's orders will be reviewed on a monthly basis for accuracy, compliance with state/federal requirements and will accurately reflect the physician and facility directed care. A review of the facility's Psychotropic policy dated revised 6/2019 included that as needed orders for psychotropic drugs are limited to fourteen days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication, and documents that rationale in the medical record. NJAC 8:39-11.2 (b); 29.2 (d)	F 658		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an	F 880		11/29/19

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F 880	Continued From page 13	F 880		

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 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

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F 880	Continued From page 14 (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, record review, and review of other pertinent facility documents, it was determined that the facility failed to: a) implement and account for the necessary transmission based precautions to prevent the spread of infection during an identified upper respiratory infection outbreak, b.) ensure adequate and convenient placement of personal protective equipment supplies and receptacles for the disposal of used materials, c.) conduct a timely and accurate tracking of facility-acquired infections, and d.) report the [redacted] outbreak in a timely manner to the local county department of health. This deficient practice was	F 880	1.The corrective action(s) accomplished for the resident found to be affected by the deficient practice: Resident #21: Isolation signs and a PPE storage bin was placed by Room [redacted] Resident # 23: Isolation sign and PPE bin in the hallway outside resident #23 was mistakenly placed. Resident #23 and roommate did not have any symptoms or active infection. Isolation sign and resident PPE bin was removed. CNA was in serviced to consult line listing or ask nurse	

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F 880	Continued From page 15 identified for 9 of 10 residents reviewed for infections (Resident #23, #24, #25, #37, #48, #49, #53, and #160), and was evidenced by the following: On 9/26/19 at 9:43 AM, the first day of the survey, the Licensed Nursing Home Administrator (LNHA) informed the survey team that the facility currently had an [redacted] infection outbreak that had been reported to the local county department of health on [redacted]. The LNHA added that the last recorded new onset of infection had been [redacted] and that the surveyors should wear personal protective equipment (PPE) including a mask when in resident rooms. The LNHA stated that the nurses on the units could further answer to what PPE specifics were required for each resident on the unit. He stated that the Director of Nursing (DON) was the designated Infection Preventionist at the time, but that they were working on getting two other staff members involved in that role. On 9/26/19 at 9:50 AM, the surveyor observed stop signs outside of the following rooms with no garbage cans or laundry bins within proximity of the entrance/exit of each rooms: room [redacted], room [redacted], room [redacted], room [redacted] room [redacted], room [redacted] room [redacted], room [redacted], room [redacted], room [redacted], room [redacted], and room [redacted] On 9/26/19 at 9:56 AM, the surveyor interviewed the Registered Nurse/Charge Nurse (RN/CN) who stated that there were stop signs outside of the some of the resident rooms. These signs indicated that one or more of the residents in that room had symptoms of an [redacted] infection and the staff had to take special transmission-based precautions before entering	F 880	which resident is sick and if PPE is required. Resident # 24 PPE bin was placed outside resident #24 room. A trash can was placed near the entry/exit door of resident. Staff members were in serviced on wearing PPE before entering a resident's room who had signs and symptoms of a [redacted] infection. Staff members were in serviced on wearing PPE when ambulating residents who had signs and symptoms of a [redacted] infection. Resident # 37 Nurses were in serviced on proper disposal of PPE using a trash can by entry/exit door. Nurses were in serviced to perform hand hygiene between residents, before resident contact, after contact with contaminated surfaces and after removing gloves. Resident # 48 Resident #48 was not on the line listing. Resident #48 roommate had symptoms of [redacted] infection. Resident #48 was being monitored by staff members for signs and symptoms of [redacted] infection. Resident # 49 CNA was in serviced on wearing PPE in resident's room who have symptoms of [redacted] infection. CNA in serviced on hand hygiene after removing gloves and after contact with contaminated garbage bags. Resident # 53: CNA was in serviced on	

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F 880	Continued From page 16 the room. The RN/CN stated the precautions were [redacted]" precautions ([redacted]. The surveyor asked the RN/CN what [redacted] precautions included. The RN/CN stated that the [redacted] precautions depended on the type of care the staff were going to give to the designated resident. The RN/CN stated that if the CNA was going to perform physical care for the resident, the CNA would be required to apply a gown, gloves, and mask. The surveyor asked the RN/CN what type of special precaution the surveyor should take before entering the resident's room. The RN/CN stated that a mask was the only PPE required prior to entering the resident's room. The RN/CN further stated that all the residents that were showing signs and symptoms of having a[redacted] infection such as [redacted] were required to stay in their rooms. The RN/CN further told the surveyor that the symptoms of the [redacted] outbreak on the [redacted] had started a few weeks ago and Resident #24 was currently symptomatic with a [redacted]. The surveyor team observed the following: 1. On 9/26/19 at 10:46 AM, the surveyor was standing outside of the private room of Resident #24. The surveyor heard the resident produce a moist, productive [redacted]. The surveyor observed a stop sign outside of the resident's door which indicated to stop and please check in at the nurse's station before entering. The surveyor did not observe any personal protective equipment (PPE) outside of the resident's room. The surveyor walked approximately twenty feet down the hallway to a plastic bin which contained the	F 880	wearing PPE in resident's room who have symptoms of [redacted] infection. CNA was in serviced on performing hand hygiene after removing gloves and after contact with contaminated surfaces. Garbage can was placed near resident #53 entry/exit door Resident # 160 PPE bin was placed outside Resident #160 bedroom. Nursing staff were in serviced on wearing PPE inside a resident's room who have signs and symptoms of [redacted] infection. Nurse was in serviced on the use /meaning of stop sign. Physician order obtained for transmission -based precaution. Care plan for URI initiated. Multi resident use of medical devices (room [redacted] Thermometer)- Staff were re-in serviced on sanitizing all medical devices used for multiple residents before initial use and between each use. Room [redacted] and [redacted]- a PPE bin was placed by each room. 2.The facility identified other residents having the potential to be affected by the same deficient practice: PPE Bins - Additional PPE bins were ordered/purchased on 9/19/2019, 9/30/19, a total of 12 bins were placed in the hallways outside isolation rooms for ready access to PPE by facility staff. On 10/30/2019 an additional 24 PPE storage bins were purchased to ensure PPE storage bins may be placed by each room	

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F 880	Continued From page 17 PPE materials of gowns, gloves, and a mask. This bin was the closest bin in proximity to the resident's room for obtaining PPE before entering the resident's room. There was no trash can and/or laundry bin near the exit doorway of the room. The surveyor applied the PPE and entered the resident's room. Resident #24 was observed lying in bed. The resident stated that he/she had a cough for a long time now. The surveyor entered the resident's bathroom and observed an open-top small sized trash can with a clear plastic liner. The can was empty of trash. The surveyor further observed a green trash can in the back of the resident's room which did not contain a plastic liner. The surveyor removed the PPE and discarded it in the trash can in the bathroom and performed hand hygiene. The PPE filled the trash can. As the surveyor was exiting the room, a Certified Nursing Aide (CNA) entered the resident's room and walked over to the resident's bed. The CNA was not wearing a gown, gloves, and/or a surgical protective mask upon entering the resident's room to provide care. On 9/26/19 at 11:53 AM, the surveyor observed a Physical Therapist (PT) walking Resident #24 down the hallway using an assistive device. The PT was not wearing any PPE and the resident was not wearing a mask. The Restorative Certified Nursing Aide (R/CNA) was walking behind the resident with a wheelchair. The R/CNA was wearing gloves only. On 9/26/19 at 12:01 PM, the surveyor observed the R/CNA exit Resident #24's room, take off a pair of gloves and throw them in a trash can that was newly placed by the resident's bedroom door.	F 880	in the event of a facility wide infection outbreak. Trash Can Placement Rooms [redacted] - All trash cans were moved back to be closer to the door when staff and visitors remove and discard PPE. Hand Hygiene and PPE use- All facility staff were in-serviced on proper hand hygiene On 9/27/2019 additional signs indicating use of Mask, gloves and gown were implemented to remind staff and visitors to use all PPE for resident currently on isolation. Physicians' order obtained for Transmission -based precaution for all residents having signs and symptoms of upper respiratory infection. Care plan for [redacted] infection updated for each resident included in the line listing. Care plan updated for each resident who are at risk of [redacted] infection. 3.The measures/systemic changes the facility will put into place to ensure that the deficient practice does not recur: Implement a new infection treatment/tracking report form and in-service all nurses on the use of the new form. Implement new Infection tracking and trending report. That will include: resident name, room#, unit, admit date, physician, primary Dx, date symptoms began, symptoms, symptoms present on admission, risk factors, date infection IDd, Location of infection, pathogen diagnostic	

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F 880	Continued From page 18 The surveyor then observed the R/CNA walk over to a multi-use rolling walker that the resident had just used and touch the rolling walker with her hands without performing hand hygiene. There was no cleaning/disinfecting of the walker after it's use by Resident #24. On 9/26/19 at 12:02 PM, the surveyor interviewed the R/CNA of Resident #24 who stated that the stop sign outside of the resident's door indicated that the resident had an infection and the staff was required to wear a mask and gloves inside of the resident's room. The R/CNA further stated that when exiting the resident's room, the staff was supposed to perform hand hygiene using soap and water or an alcohol-based hand gel. On 9/26/19 at 12:32 PM, the surveyor interviewed the CNA who was observed entering the room of Resident #24 without wearing PPE. The CNA stated that staff were required to apply a gown, gloves, and a mask before entering a resident's room who had a signs and symptoms of a [redacted] infection in order to prevent the spread of infection. She did not speak to why she wasn't wearing the PPE during the surveyor's observation. 2. On 9/26/19 at 11:01 AM, the surveyor observed a CNA apply a mask outside of the private room of Resident #53. The CNA was not wearing gloves or a gown before entering the resident's room to assist the resident with handling items in the bathroom. The surveyor observed the resident in the bathroom brushing his/her teeth. The resident exited the bathroom with the CNA behind her and the surveyor observed the resident produce a [redacted] into a terry cloth	F 880	test ordered, lab results. The director of nursing will report all new infections daily at the morning meeting. In-service all nurses on identification and reporting of suspected infection outbreak. Revise Emergency Management manual to include additional transmission control measures (i.e. Trash can placement, hand hygiene, PPE use and storage bins, physician order, update care plan, etc.) 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes: The Director of Nursing or designee will conduct a weekly random competency evaluation of 10 staff members on hand hygiene and/or PPE use for three months. The Director of Nursing will document and report the audit results at the monthly infection control committee meeting as well as the quarterly quality assurance meeting.	

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F 880	Continued From page 19 towel. The surveyor observed the CNA apply one glove to their right hand only and the left hand was holding a clear plastic bag. The CNA took the used towel with the gloved hand and disposed of it into the trash bag. Upon exiting the resident's room the surveyor observed that the CNA had not performed hand hygiene and then proceeded to walk to the storage room on the unit to place the towel into a large laundry receptacle. Without washing her hands she opened the door to the storage room and obtained a new box of gloves. The CNA then performed hand hygiene. There was no trash can for used/soiled PPE and/or laundry disposal in the vicinity of the resident's entry/exit of the room. On 9/26/19 at 11:02 AM, the surveyor interviewed the CNA who was assisting Resident #53 in the bathroom who stated that staff just had to wear a mask when caring for a resident who had a [redacted] infection. The CNA further stated that if the surveyor had any further questions to ask a nurse. 3. On 9/26/19 at 12:11 PM, the surveyor observed a stop sign outside of the shared room of Resident #23 which indicated to stop and please check in at the nurse's station before entering. The surveyor further observed a PPE bin in the hallway outside of the resident's bedroom. The surveyor observed a CNA apply a mask in the hallway outside of the resident's room and then a pair of gloves inside of the resident's room. The CNA then applied a plastic bracelet to the wrist of Resident #23 who was seated in their wheel chair.	F 880		

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F 880	Continued From page 20 On 9/26/19 at 12:14 PM, the surveyor interviewed the CNA who applied the bracelet to Resident #23's wrist. The CNA stated that the stop signs were outside of the doors because the staff had to stop and ask the nurse what type of precaution were required for that resident. The CNA further stated that before entering Resident #23's room she had to apply a mask and gloves. The CNA stated that a gown was only indicated if the resident was [redacted] a lot because that meant the resident was on [redacted] precautions. On 9/26/19 at 12:20 PM, the surveyor observed a CNA making the bed of Resident #23. The CNA was not wearing a gown, gloves, and/or a mask. The surveyor observed another staff member standing in the resident's room wearing gloves and a mask. The staff member was not wearing a gown. On 9/26/19 at 12:32 PM, the surveyor interviewed the CNA who was observed making Resident #23's bed without wearing PPE. The CNA stated that the stop signs outside of the resident's room indicated that the resident had an infection and the staff had to apply a gown, gloves, and a mask before going into the room to prevent the spread of infection. The surveyor asked the CNA which resident in the room had an infection. The CNA stated that she didn't know. The CNA further stated that she should have asked the nurse what resident was sick before entering the resident's room. The CNA admitted that she wasn't wearing PPE when in the resident's room and stated, "Oh, you seen that." 4. On 9/26/19 at 11:11 AM, the surveyor observed	F 880		

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a stop sign outside of the Resident #160's door. This sign directed anyone entering the room to stop and please check in at the nurse's station before entering. The surveyor further observed that there was no bin containing PPE outside or in close proximity to the resident's room. The surveyor observed the resident lying in bed produce several [redacted]. The surveyor observed the Licensed Practical Nurse (LPN) from the [redacted] and the CNA both wearing masks inside the resident's room and assisting the resident up in bed. The LPN and CNA were not wearing a gown and gloves. The surveyor interviewed a visitor with Resident #160 who was not wearing PPE while in the room with the resident. The visitor indicated that the LPN and CNA had just changed the resident's mattress to an air mattress. The visitor further indicated that he/she was not aware of the need for PPE while visiting the resident.

On 9/26/19 at 11:15 AM, the surveyor interviewed the LPN who was assisting Resident #160 in bed. The LPN stated that the stop sign did not mean anything and stated that no additional care or precautions were required for the resident.

On 9/26/19 at 11:17 AM, the surveyor observed Resident #160 lying in bed wearing [redacted]. The surveyor overheard the resident emit another [redacted]

The surveyor reviewed the medical record for Resident #160.

A review of the resident's Admission Record (an admission summary) reflected that the resident was admitted to the facility on [redacted] and

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F 880	Continued From page 22 re-admitted on [redacted] and had diagnoses which included but were not limited to encounter for [redacted]. A review of the September 2019 Physician Order Sheet contained an order dated [redacted] for [redacted] and a [redacted]. There was no evidence in the order sheet for an order for [redacted] precautions. A review of the resident's ICP which had been revised on [redacted] did not reflect that the resident had an [redacted], was on [redacted] precautions or care interventions related to the resident having an [redacted] 5. On 9/26/19 at 11:32 AM, the surveyor observed outside room 109 a stop sign which indicated to stop and please check in at the nurse's station before entering. The surveyor observed the south unit LPN enter Room [redacted] wearing a mask and gloves, hand the call bell to the resident and exit the room. The surveyor did not observe the LPN perform hand hygiene when she exited room [redacted] The LPN then walked down an adjacent hallway and was handed a temporal thermometer from another nurse. The surveyor observed the LPN walk over to the treatment cart and apply a gown, gloves and mask. The LPN then entered Room [redacted] to take the temperature of the resident in the room. The LPN did not clean the multi-use temporal thermometer before and/or after taking the temperature of the resident in room [redacted] The LPN then placed the thermometer on the resident's bedside table.	F 880		

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F 880	Continued From page 23	F 880		

6. On 9/26/19 at 11:53 AM, the surveyor interviewed a CNA who worked on the south unit at the facility. The CNA stated that about [redacted] ago on a [redacted], the residents on south wing "started to get sick and were [redacted]" so they had to separate the residents. The CNA further stated that they would separate the residents who had symptoms of the [redacted] infection and bring them in the TV room and the other residents without symptoms were designated to stay in the activity room. The CNA stated that the stop signs outside of the resident's room indicated that the staff were required to apply a gown, gloves, and a mask prior to entering the resident rooms because the residents "were sick."

On 9/26/19 at 11:57 AM, the surveyor interviewed the LPN on the [redacted] who stated that the [redacted] outbreak started last week on a [redacted]. The LPN further stated that that the stop signs outside of the resident's room were a precautionary measure, meaning that staff had to apply a mask before entering the resident's rooms so the infection doesn't spread. The LPN stated that if staff were going into the resident's room to provide direct patient care then they would have to put on a gown, glove and a surgical mask.

On 9/26/19 at 12:23 PM, the surveyor conducted a follow up interview with the RN/CN who stated that the facility's [redacted] outbreak started last [redacted]. The RN/CN stated that the resident's that were identified as being symptomatic were encouraged to stay in their rooms. The RN/CN further stated that the confused residents who presented with signs and symptoms of a [redacted] infection and were also

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F 880	Continued From page 24	F 880		

considered fall risks were not left in their rooms alone. These residents were cohorted (grouped) together in the activity room.

7. On 9/26/19 at 10:23 AM, the [redacted] Licensed Practical Nurse (LPN) informed the surveyor that over the weekend, the facility had an outbreak of [redacted] infections among the residents. The facility had two separate activity rooms; one designated for "sick" residents and one designated for "non-sick" residents. The LPN stated that just to communicate with a resident, the surveyor would just need to wear a mask and gloves, but that the surveyor should keep a clear distance, and if getting close to the resident a gown was necessary. The surveyor observed the following:

a.) Room [redacted] a a stop sign outside the door which directed those entering the room to see the nurse prior to entering. There was no personal protective equipment (PPE) located outside the door or within close proximity.

b.) At 10:28 AM, the [redacted] LPN stated that Resident #37 had an [redacted] infection and a mask and gloves were required to enter the room, and a gown to go near the resident. The resident had pushed the call bell and was requesting hot water and tea. The LPN donned only a mask and gloves to bring in the tea. The LPN came out of the room, removed the mask and gloves in the hallway disposing of them in the medication cart trash container. The surveyor observed that the LPN did not perform hand hygiene. The LPN then rummaged through the medications in the drawer of the medication

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cart. The LPN then closed the cart and donned a mask and gloves and returned to Resident #37's room to bring him/her a cup with a spoon. The LPN then exited the room, removed the mask and gloves in the hallway and disposed of them in the treatment cart trash container. The surveyor observed that the LPN did not perform hand hygiene. The LPN then proceeded to Room [redacted] that had no stop sign or PPE outside the door to speak with Resident #48.

c.) At 10:35 AM, the Activity Aide was observed inside the activity room designated as the "infected activity room." The Activity Aide wore a mask and gloves only. The surveyor observed the Activity Aide remove her gloves in the activity room and don new gloves. There was no hand hygiene in-between removing the old gloves and donning new gloves.

d.) At 10:38 AM, the South Unit LPN wheeled Resident #21 out of the "infected" activity room into the resident's room. The resident was not wearing a mask. There was no observed stop sign to see the nurse or PPE located outside of the resident's door. At 10:42 AM, the LPN was observed on the telephone requesting a stop sign. The LPN instructed the R/CNA to stand outside the doorway and allow no one to go into the room until she got back. The R/CNA was observed inside the room with Resident #21 wearing gloves only. The LPN came back and instructed the R/CNA to get out of the room, since the resident was [redacted] too much. The LPN placed a stop sign outside the door.

e.) At 10:51 AM, the surveyor observed a stop sign and PPE outside of Resident #49's room. The door to the room was closed. The

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F 880	Continued From page 26 surveyor knocked, slowly opened the door, and observed the CNA standing over Resident #49. The CNA stated she had just finished the resident's care and needed to get the hoyer lift to transfer the resident out of bed into the wheelchair. The CNA was observed wearing only gloves and no mask or gown. The CNA removed her gloves in the room and grabbed the garbage bags with her bare-hands and brought the garbage bags down the hall to the soiled utility room. The CNA did not perform hand hygiene after disposing of the bags. f.) At 11:07 AM, the surveyor observed stop signs located outside Room [redacted] and Room [redacted]. There was no PPE located outside the doors. 8. On 9/30/19 at 9:33 AM, the Activity Aide informed the surveyor that when inside the "infected" activity room, you need to wear a gown, gloves, and mask. When you are leaving the room, all PPE was to be disposed of in the trash located next to the door inside the room, and hand hygiene would be performed. The Activity Aide stated that she should have been wearing a gown along with the gloves and mask during activities, but she was not on [redacted]. On 9/30/19 at 11:23 AM, the RN/CN informed the surveyor that Resident #48 did not have an [redacted] infection. The resident's roommate had symptoms of an [redacted] infection so the facility was monitoring Resident #48. On 10/2/19 at 10:03 AM, the surveyor observed a used/disposed of gown and mask in Treatment Cart[redacted]. The LPN stated that PPE should not be discarded on the treatment cart, but inside	F 880		

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F 880	Continued From page 27 the room prior to exit. On 10/2/19 at 2:25 PM, the DON informed the survey team that she keeps in-servicing staff based on the local health department's recommendation to wear a gown, mask, and gloves every time they go into an infected room. A review of the line listing (a tracking list of residents consisting of infection data) updated on [redacted] reflected a total of 33 residents that exhibited [redacted] symptoms. The line listing reflected that a total of 17 residents exhibited symptoms with an initial onset date of [redacted]. The line listing reflected: One resident infected on the [redacted] on [redacted] One resident infected on the [redacted] on [redacted] Two residents infected on the [redacted] on [redacted] Five residents infected on the [redacted] on [redacted] Eight residents infected on the [redacted] on [redacted]. Four residents infected on the [redacted] on [redacted]. Five residents infected on the [redacted] on [redacted] One resident infected on the [redacted] on [redacted] One resident infected on the [redacted] on [redacted]. One resident infected on the [redacted] on [redacted]. One resident infected on the [redacted] on [redacted] One resident infected on the [redacted] on	F 880		

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F 880	Continued From page 28 [redacted]. One resident infected on the [redacted] on [redacted] The line listing did not reflect a date of onset for one of the residents. 9. A review of the line listing dated [redacted] reflected that Resident #24's onset date of the [redacted] started on [redacted]. A review of the line listing reflected that the resident presented with a [redacted] The surveyor reviewed the medical records for Resident #24. A review of the September 2019 Physician Order Sheet (POS) reflected that the resident was admitted to the facility on [redacted] and had diagnoses which included but were not limited to [redacted]. A further review of the September 2019 POS reflected a Physicians Order (PO) dated [redacted] but there was no evidence of a physician order to initiate droplet precautions. A review of the resident's Individualized Care Plan (ICP) revised on [redacted] did not reflect that the resident had an [redacted], was on [redacted] precautions or care interventions related to the resident having an [redacted] 10. A review the line listing dated [redacted] reflected that Resident #53's onset date of the	F 880		

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F 880	Continued From page 29 [redacted] illness started on [redacted]. A further review of the line listing reflected that the resident presented with a [redacted] and an [redacted] t indicative of an infection). The line listing reflected the resident was discharged home on [redacted]. The surveyor reviewed the medical records for Resident #53. A review of the resident's Admission Record face sheet (an admission summary) reflected that the resident was admitted to the facility on [redacted] and had diagnoses which included but were not [redacted] A review of the resident's September 2019 Physician Order Sheet reflected an order dated [redacted] for a [redacted] to rule out an [redacted] This order sheet also contained additional physician orders for medications for treatment of Resident #53's [redacted] which included: A PO dated [redacted] for [redacted]. A PO dated [redacted] for [redacted] PO dated [redacted] for [redacted] tab by mouth every 12 hours for seven days for [redacted] A PO dated [redacted] for [redacted] mg by mouth every eight hours for five days. There was no evidence of a physician's order to initiate [redacted] precautions. A review of the resident's ICP dated [redacted] did not reflect that the resident had an [redacted], was on [redacted] precautions or care interventions related to the resident having an [redacted].	F 880		

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F 880	Continued From page 30 11. A review of the line listing dated [redacted] did not reflect that Resident #23 had an infection or that the roommate of Resident #23 had an infection. This did not correspond with the the stop sign to stop and see nurse before entering the room (indicative of the necessity to perform transmission-based precautions) and PPE outside of the residents' room. The surveyor reviewed the medical records for Resident #23. A review of the resident's Admission Record reflected that the resident was admitted to the facility on [redacted] and had diagnoses which included but were not limited to history of [redacted]. A complete review of the resident's medical record did not reflect documented evidence that the resident had a [redacted] illness or symptoms of a [redacted] illness. 12. A review of the line listing dated [redacted] reflected that Resident #160's onset of [redacted] illness was [redacted]. The line listing further reflected that the resident had a [redacted] and was discharged to the hospital on [redacted] and re-admitted on [redacted]. On 9/26/19 at 12:49 PM, the surveyor interviewed the LNHA who stated that the infection was challenging to track. The LNHA further stated he was the person responsible for completing the line listing because it was all on his computer, and he was in the process of "Trying to get it solid. As much as possible." He stated that he	F 880		

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F 880	Continued From page 31 started to track the infections on 9/18/19. On 9/26/19 at 2:11 PM, the survey team interviewed the LNHA and the Director of Nursing (DON). The LNHA stated that the outbreak was first identified on [redacted] and he was unsure of what constituted an outbreak, so he stated he contacted the local health department. The DON stated that according to the local health department an outbreak was more than one individual showing the same signs and symptoms of an infection. The DON further stated that on [redacted] there was a cluster of individuals on the [redacted] that had a fever and/or [redacted]. The DON stated that the local health department recommended that garbage cans be placed by the exits in the resident's rooms so the staff could easily dispose of the PPE before exiting. The LNHA acknowledged there were no easily accessible trash cans at the exit of each room, but stated the possibly staff had moved them. The surveyor asked the DON and LNHA about the accuracy of the line listing versus what was observed on the units, and the LNHA stated that he believed it was accurate but that he would have to look at it again. He indicated that every resident room that had a sign on the door should be on the line listing and vice versa. The LNHA stated that "all residents were considered exposed" to the the infection, so they were closely watching all residents for signs of infection. The survey team asked the DON what her role in infection control was as it related to the [redacted] outbreak at the facility. The DON stated that her role was to perform an assessment of the residents who were	F 880		

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symptomatic of an infection because that would be carried over into the surveillance aspect.

The survey team asked the DON if the staff had been educated on infection control and [redacted] precautions related to the recent [redacted] outbreak. The DON stated that the staff were in-serviced on how to appropriately apply PPE and what PPE equipment to wear. The DON stated that the staff were in-serviced that if the resident was showing signs and symptoms of an active infection the staff would be required to gown, glove, and mask prior to entering the resident's room. The DON further stated that for residents that were asymptomatic of an infection the staff were in-serviced to apply a mask and gloves when caring for the residents. The DON stated that staff were in-serviced on hand hygiene which required them to wash their hands with warm soap and water for 20 seconds and then use a paper towel when turning off the faucet. The DON did not explain when it was appropriate for hand hygiene to be performed. The LNHA stated that staff were required to wash hands when they were visible soiled.

The DON provided the surveyors in-service sign in sheets. The DON was unable to provide documented evidence that all the facility staff had been in-serviced on infection control during the outbreak. She acknowledged that she did not have documented evidence that the staff observed providing care on [redacted] had attended the in-services

On 10/3/19 at approximately 11:30 AM, the LNHA and DON were unable to provide documented evidence of infection tracking from [redacted] until [redacted] when the LNHA stated they started

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tracking the respiratory outbreak. The DON acknowledged that there was no consistent tracking of infections after 8/9/19 due to a shifting of new positions. The LNHA acknowledged that had there been live tracking of infections at the time of the outbreak it would have been identified sooner. The LNHA acknowledged that the outbreak should have been reported to the local county department of health on [redacted] The DON acknowledged that the residents with the symptoms of a [redacted] infection did not have a physician's order and/or an updated individualized care plan for [redacted] precautions. She acknowledged all the resident's on the line listing should have had that, and that they had just started implementing that on all the resident's last night. She stated that when the resident's were added to the active line listing that their physician order's and care plans should have been immediately updated by the assigned nurse. She could not speak to why it had not been done until surveyor inquiry.

A review of the facility's Infection Control Program Policy and Procedure revised 9/2019 reflected, "The Infection Preventionist Nurse (IPN) in collaboration with the facility interdisciplinary team members will monitor, investigate, control and prevent infections in the facility through audits and surveillance reflecting current Center for Disease Control (CDC) guidelines."

The facility's Isolation Precaution Policy and Procedure dated revised 9/2019 reflected, [redacted] masks are required if coming within (3) feet of the resident. Gloves are required if resident or items in residents rooms are to be touched. Gowns are to be worn if rendering personal care."

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F 880	Continued From page 34 A review of the facility's Handwashing/Hand Hygiene Policy and Procedure dated 12/2017 reflected, "This facility considers hand hygiene the primary means to prevent the spread of infections." The Handwashing/Hand Hygiene Policy and Procedure further reflected, "7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: b) Before and after direct contact with residents; i) After contact with a resident's intact skin k) After contact with objects (e.g., medical equipment) in the immediate vicinity of the resident m) After removing gloves n) Before and after entering isolation precaution setting. 8. Hand hygiene is the final step after removing and dispensing of personal protective equipment." A review of the facility's Standard Precaution Policy and Procedure 9/2019 reflected, "Resident-Care Equipment 2. Ensure that reusable equipment is not used for the care of another resident until it has been appropriately cleaned and reprocessed." NJAC 8:39-19.4	F 880		

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S 000	Initial Comments THE FACILITY WAS NOT IN COMPLIANCE WITH THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE, CHAPTER 8:39, STANDARDS FOR LICENSURE OF LONG TERM CARE FACILITIES. 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 THE PROVISIONS OF THE NEW JERSEY ADMINISTRATIVE CODE, TITLE 8, CHAPTER 43E, ENFORCEMENT OF LICENSURE REGULATIONS.	S 000		
S 870	8:39-9.4(e)(1) Mandatory Administration (e) The facility shall notify the Department immediately by telephone (609-633-8981, or 1-800-792-9770 after office hours), followed within 72 hours by written confirmation, of any of the following: 1. Interruption for three or more hours of physical plant services and/or other services essential to the health and safety of residents; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to report to the New Jersey Department of Health (NJDOH) that the facility's dishwashing machine was not in operating condition. This deficient	S 870	S000 This plan of correction constitutes our written allegation of compliance for the deficiencies cited below. However, submission of this plan of correction is not an admission that a deficiency exists or	11/29/19

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

Electronically Signed | 10/25/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	060206	A. BUILDING: _____ B. WING _____	10/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COUNTY MANOR REHABILITATION & HCC	133 COUNTY ROAD TENAFLY, NJ 07670

(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
S 870	Continued From page 1 practice was identified for 1 of 1 dishwashing machines and was evidenced by the following: On 9/26/19 at 9:54 AM during the initial kitchen tour, the Food Service Director (FSD) informed the surveyor that the facility's dishwashing machine had been inoperative since last week. The FSD stated that the dishwashing machine was a high temperature machine, meaning that the final rinse for sanitation had to be 180 degrees Fahrenheit, which the machine was not achieving. The FSD stated that repair company was in the processing of fixing the machine, but they were waiting on a part that was ordered. The FSD indicated that the facility was using all paper products for meal service for their residents. The surveyor observed that the dishwashing machine was not in use. The surveyor reviewed the facility's September 2019 Dishmachine Temperature Log, which indicated that the last day of operational service for the dishmachine was on 9/19/19. On 10/2/19 at 2:28 PM, the Licensed Nursing Home Administrator (LNHA) informed the survey team that the facility was still waiting on a replacement part for the dishwashing machine. The LNHA stated that the facility did not report to the NJDOH about the dishwashing machine being inoperative. The LNHA further stated that he did not typically call the NJDOH when equipment goes down. On 10/3/19 at 11:38 AM, the LNHA informed the survey team that he reported the facility's dishwashing machine's inoperation last night to the NJDOH.	S 870	that one was cited correctly. The plan of correction is being submitted to meet the federal and state regulatory requirement. 1. The corrective action(s) accomplished for the resident found to be affected by the deficient practice: " On 10/2/2019 the administrator reported to the New Jersey Department of Health that the dishwashing machine was not operable. 2. The facility identified other residents having the potential to be affected by the same deficient practice: " All other equipment in the facility was found to be operational. 3. The measures/systemic changes the facility will put into place to ensure that the deficient practice does not recur: " The reportable events policy will be revised to include: report all inoperable equipment that interfere with facilities operations and affect the welfare, safety, or health of residents, employees or visitors. " All Department heads will be in-serviced on the policy change. 4. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur, i.e. what program will be put into place to monitor the continued effectiveness of the systemic changes: " All reportable events will be presented at the Quarterly Quality Assurance Committee meeting as well as at the Governing Body Meeting.	