STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315384	A. BUILDING ______ B. WING ______	08/15/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROSE MOUNTAIN CARE CENTER	**ROUTE 1 & 18 NEW BRUNSWICK, NJ 08901**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS STANDARD SURVEY: 8/15/19 CENSUS: 93 SAMPLE: 24	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to identify and evaluate bruising for a resident that was receiving a medication with bruising as a side effect. This was identified for Resident #81, who was 1 of 24 residents reviewed for quality of care. This deficient practice was evidenced by the following: On 8/8/19 at 1:50 PM, the surveyor interviewed Resident #81. The resident was sitting in a wheel chair in the resident's room. The resident pulled up the [redacted] to show the surveyor [redacted] to the [redacted]. There were approximately [redacted] present. The resident told the surveyor that [redacted] were	F 684	Rose Mountain Care Center Standard Survey of 8/15/19 F648, 483.25 Element One, Corrective Action: Resident #81: The resident was seen by the attending physician and orders were written to discontinue the [redacted]. In addition to the daily body checks being done by the CNAs and the twice weekly body checks being done by the CNAs during the resident shower, the Unit Manager will perform a weekly documented body check for the resident. Element Two: Identification of other residents: All residents receiving [redacted]	9/10/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 09/06/2019

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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F 684	Continued From page 1 also present on the [redacted] The resident explained that the staff was aware, and had informed the resident that the [redacted] was from the medication the resident was taking. The resident denied abuse by anyone. On 8/9/19 at 10: 00 AM, the surveyor reviewed the medical record which revealed that the resident was admitted to the facility on [redacted] with diagnoses which included [redacted]. The Physician's Order Sheet (POS) contained an order for [redacted] orally daily for [redacted] The surveyor reviewed the Medication Administration Record (MAR) and confirmed that the resident received all of the doses of [redacted] and [redacted] since admission. There was no documentation in the record of [redacted]. There were no nurses notes that mentioned the [redacted]. The nursing admission assessment dated [redacted] did not list the [redacted]. The resident had a care plan dated 7/25/19, which listed a problem of: [redacted]. Staff interventions included monitor skin daily during care, report any changes to the nurse, and monitor for [redacted] The surveyor reviewed the resident's initial Minimum Data Set Assessment (MDS), an assessment tool used by the facility. The Brief Interview of Mental Status (BIMS) score was [redacted]	F 684	therapy have the potential to be affected by this practice. Element Three: Systemic Changes: All residents receiving [redacted] therapy shall have an additional weekly body check performed by the Unit Managers. The results of these assessments will be reported to the DON (Director of Nursing). Any abnormal findings shall immediately be communicated to the resident's attending physician for further action as needed. The nursing staff was re-educated on the need to report any skin changes promptly to the Unit Managers and to the resident's attending physician. Element Four: Quality Assurance: Assessment results shall be reported to the QAPI committee and the Administrator by the DON on a quarterly basis for further action as needed. Date of completion: 9/10/19	

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F 684	Continued From page 2 [redacted] On 8/13/19 at 1:30 PM, the surveyor observed the resident self propelling in their wheelchair in the hallway. There was a [redacted] that hadn't been observed on previous observations. On 8/14/19 at 10:30 AM, the surveyor interviewed the Unit Manager (UM) and asked if she had noticed the [redacted] of the resident's [redacted]. She said she would let the doctor know. The surveyor asked the UM if she noticed the [redacted]. The UM said she did not know about it. The surveyor then asked the UM if skin checks were being done for the resident. The UM stated that skin checks were done on Saturdays. The UM reviewed the weekly skin assessment form and then stated, "Nothing was documented, so they must be new." The surveyor reviewed the weekly skin assessment form dated 8/11/19. Next to the resident's name, Skin Clear was checked. The surveyor informed the UM that the [redacted] were shown to the surveyor on 8/8/19 by the resident. The UM stated that she would ask the Certified Nursing Assistant (CNA) if she noticed any [redacted] and why she did not document it. On 8/14/19 at 10:45 AM, the surveyor spoke to a CNA who confirmed that she took care of Resident #81 on Monday during the 3-11 shift. The CNA stated that she helped the resident go to the bathroom. The CNA said she noticed the [redacted] but didn't report it because, "It looked like old." On 8/14/19 at 11:00 AM, the surveyor reviewed the resident's record which revealed an	F 684		

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F 684	Continued From page 3	F 684		

consult dated The consult sheet did not mention any . The surveyor then reviewed nurses notes dated 8/13/19 weekly charting which read: noted redness. There was also a nurses note dated 8/13/19 3-11 p.m. which read: and 8/13/19 on 11-7 p.m. which read:

On 8/14/19 at 1:18 PM, the surveyor interviewed the attending physician of Resident #81. The physician stated that the were used for secondary prevention. She added that the resident had a in the past. The physician stated that she wrote an order to hold the for now but to continue the . The physician said she thought the was because of the medication. The physician further stated that the was a medication side effect not a complication of in combination with . The physician said there were no other signs of . She also stated that she did not feel the was a side effect of the The physician added that she had not seen the resident prior to them being admitted to the facility and she would see the resident again in 7-10 days.

On 8/14/19 at 12:00 PM, the surveyor spoke with the Director of Nursing (DON), the Assistant Director of Nursing, and the Administrator. The surveyor expressed concern with the resident having and being on . The surveyor spoke to them about the weekly skin assessment form being inaccurate, the CNA not reporting the , and nursing not documenting the or reporting it to the physician.

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F 684	Continued From page 4 On 8/15/19 at 11:00 AM, the DON confirmed that the nurse should have followed-up on the [redacted] and should have started an investigation and notified the physician. On the same day at 12:00 PM, the surveyor reviewed the facility's policy and procedure titled: Change in Resident's Condition or Status which read: Procedure/Responsibilities/Actions: 1. The Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician or On Call Physician when there has been: b. A discovery of injuries of an unknown source c. A reaction to medication d. A change in the resident's physical/emotional/mental condition. N.J.A.C. 8:39-27.1 (a)	F 684		
F 805 SS=D	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility documentation, it was determined that the facility failed to prepare liquid in the proper consistency for 1 of 4 residents (Resident #41) reviewed on a modified diet. This deficient practice was evidenced by the following:	F 805	Rose Mountain Care Center Standard Survey of 8/15/19 F805, NJAC 8:39-27.1(a) Element One: Corrective action: Resident#41 was immediately served tea that was of nectar thick consistency. The FSD re-educated the DA who inappropriately mixed the tea for Resident #41.	9/10/19

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F 805	Continued From page 5 On 8/9/19 at 12:22 PM, the surveyor observed Resident #41 sitting in a wheelchair at a table in the Main Dining Room (MDR) during the lunch meal observation. The resident was feeding themselves a pureed diet and the meal ticket on the table revealed an order for Nectar Thick Liquids (NTL). There was a cup of a hot brown liquid at their place setting. At 12:26 PM, the surveyor approached the table of Resident #41 and confirmed the consistency of the liquid identified as hot tea with the Certified Nursing Assistant (CNA) who confirmed that it was a thin consistency and not nectar thick. At that time, the Unit Manager (UM) came to the table and checked the consistency of the hot tea beverage that was at Resident #41's place setting. The UM stated that the resident's liquid tea should be nectar thick. The resident did not consume the thin liquid tea. At 12:55 PM, the surveyor interviewed the Food Service Director (FSD) who confirmed that a Dietary Aide (DA) prepared the thickened beverage of nectar, honey and pudding thick liquids. She added that the procedure for making the nectar thick tea was to put water in the pitcher with tea bags to brew. The tea bags were then removed and the thickener was added to the pitcher and it was blended with a whisk. The FSD stated that the pitcher was 1.5 quarts and that it required 16 teaspoons to obtain a nectar thick consistency. The FSD showed the surveyor the canister of the powered thickening product identified as Instant Food Thickener. According to the manufacturer recommendations identified on the back of the canister it read: Recommended usage for 4 fl oz Serving, Nectar	F 805	Element Two: Identification of other residents: All residents with physician orders for thickened liquids have the potential to be effected by this practice. Element Three: Systemic changes: All residents having physician orders for thickened liquids shall have their hot liquids thickened at point of service by a licensed professional nurse. Thickening of liquids will no longer be done in the dietary department. The professional nurses have been in-serviced on the proper use of the thickening agent. Pre-thickened juices and cold beverages are being purchased and delivered to the residents with their meals as per the physician orders. The Assistant Nursing Director and facility supervisors shall ensure that the new procedure is being followed by the professional nurses at each meal. The FSD has instituted a tray line check on each tray at the end of the tray line to ensure the food and drinks on the tray match the meal ticket for each resident. Element Four: Quality Assurance: The Director of Nursing will do random audits monthly to ensure that thickening of liquids for the residents is being performed correctly by the licensed professional nurses. Results of these audits shall be reviewed quarterly by the	

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F 805	Continued From page 6	F 805		

Like Hot Coffee/Tea was one tablespoon plus one teaspoon (1 Tbsp + 1 Tsp) or 0.67 fluid ounces. (1.5 US quarts equals 48 US fluid ounces.) The facility did not have a recipe for the preparation of thickened liquid in a bulk quantity.

At 1:05 PM, the surveyor interviewed the DA that prepared the thickened liquid for the lunch meal. The DA confirmed that he was assigned to mix the hot tea for the lunch meal. The DA stated that he used hot water from the dispenser and puts 5-6 tea bags in a pitcher and once the tea bags were removed, he added the thickener to the hot tea. The DA stated that he mixes half a coffee cup (approximately four ounces) with the hot tea and that he "goes by memory." The DA added that he pours it into the cup, put a lid on it and placed it on the tray for the residents.

On 8/12/19 at 2:00 PM, the surveyor reviewed the facility policy titled: Thickened liquids, last dated 7/25/15, revealed under Procedure:

1. Recommendations for thickened liquids are made by Speech and the Physician.
2. The types of thickened liquids in the facility include the following:
a. Thin - no thickener required
b. Nectar
c. Honey
d. Pudding
3. Staff follow the manufactures recommendations for thickening liquids.

The surveyor then reviewed the facility policy titled, Tray Line Setup - Dietary, dated 1/31/19, which revealed under Procedure:

The tray line will be set up at the beginning of

Administrator and the QAPI committee for further action as needed.

Completion Date – 9/10/19

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F 805	Continued From page 7 each meal for all residents. 1. When service begins, trays are assembled on carts with diet card, condiments, silverware, and napkins. 2. According to the diet called, the main plate is served from the steam table and covered. 3. Bread, salads, desserts, coffee, tea, decaffeinated coffee, milk, and butter are placed on the tray. 4. The tray carts are delivered to the units. N.J.A.C. 8:39 - 17.4(a)	F 805		
F 808 SS=D	Therapeutic Diet Prescribed by Physician CFR(s): 483.60(e)(1)(2) §483.60(e) Therapeutic Diets §483.60(e)(1) Therapeutic diets must be prescribed by the attending physician. §483.60(e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to provide a liquid at the prescribed consistency for 1 of 4 residents (Resident #41), reviewed on thickened liquids. This deficient practice was evidenced by the following: On 8/9/19 at 12:05 PM, the surveyor observed the staff passing meal trays to the residents in the	F 808	Rose Mountain Care Center Standard Survey of 8/15/19 F808, 483.60(e)(1)(2): Element One: Corrective Action: Resident #41 was immediately served tea of nectar thickened consistency. The resident did not drink the thin tea which was removed and replaced with the correctly thickened drink. Staff received immediate re-education about the proper	9/10/19

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F 808

Continued From page 8

Main Dining Room (MDR).

At 12:22 PM, the surveyor observed Resident #41 sitting in a wheelchair (WC) in the MDR during the lunch meal service. The resident was eating independently after set-up assistance by staff. The resident was observed to have a pureed diet of fish, broccoli, applesauce and pudding. There was a plastic mug of a hot brown liquid that appeared to be a thin consistency at the place setting. The meal ticket at the place setting identified that Resident #41 was on a Nectar Thick (NTL) consistency for liquids.

At 12:26 PM, the surveyor interviewed the Certified Nursing Assistant (CNA) present at the table, who confirmed that the hot brown liquid was tea and that it appeared to be a thin consistency. At that time, the [redacted] Manager (EW/UM) arrived at the table and stirred the tea and stated that, "It should be nectar." The CNA then stated, "It should be nectar. Someone didn't stir it with thickener." The EW/UM then removed the cup from in front of the resident.

At 12:33 PM, the EW/UM returned with a cup of tea that had been thickened to a nectar consistency and placed it in front of Resident #41. The surveyor then inquired as to the thickening process for liquids. The EW/UM stated that all beverages that were thickened were mixed in the kitchen, placed on the cart and sent to the floor and that, "We just check it." The surveyor then proceeded to ask who delivered the tray to Resident #41. The EW/UM verbalized that she would find out.

On the same day at 12:55 PM, the surveyor interviewed the Food Service Director (FSD) who

F 808

procedure for thickening liquids.

Element Two, Identification of other residents:
All residents with physician orders for thickened liquids have the potential to be affected by this practice.

Element Three: Systemic changes:
The facility practice of thickening hot liquids in the dietary department prior to meals was discontinued. All hot liquids are now being thickened by licensed professional nurses at point of service and not in the dietary department. The tray ticket shall be checked by the licensed professional nurse to ensure that the resident receives thickened liquids as per the physician order. The nursing assistants have been in-serviced to read the diet cards and to wait for the licensed professional nurses to thicken the liquids as ordered by the physician prior to serving the tray to the resident. Cold thickened liquids are being purchased pre-thickened for use by the residents per their physician orders. Professional nurses have been in-serviced on the procedure for informing the dietary department of any new diet orders, including orders for thickened liquids.

Element Four: Quality Assurance:
The Director of Nursing will perform monthly randomaudits of meal service to ensure that residents are being served the correct diet, including thickened liquids, as ordered by their attending physician. The results of these audits shall be report

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F 808	Continued From page 9 confirmed that the dietary aide (DA) prepared the beverage consistencies of nectar, honey and pudding. The FSD added that the nectar thick consistency was not watery and would appear like a syrup consistency. The FSD then stated that the nectar tea was prepared in a pitcher with tea bags placed in the water. She continued, that the tea bags were then removed from the water and thickener was added to the pitcher and then whisked. The FSD stated that the pitcher was 1.5 quarts and that 16 teaspoons was whisked into the tea and it was allowed to sit for 3-5 minutes prior to pouring. At 1:05 PM, the surveyor interviewed the Porter (DA) who had been assigned to the mixing of beverages. The DA stated that he made the tea with the hot water that he poured into the clear pitcher. The DA stated that he was unsure of the size of the pitcher. The DA continued and said that he added 5 to 6 tea bags, dabbed it 4-5 times in the hot water and then added the thickening agent. The DA stated, that he added about half a cup and that, "I just used my memory." The DA then pointed to an eight ounce mug and stated that he just used half of the mug (approximately four ounces). The DA then added that he stirred it and automatically poured it into a cup and put a lid on it and placed it on the cart for distribution to the residents. At 1:17 PM, the surveyor interviewed the Registered Dietician (RD) over the phone. She stated that she came to the facility a couple times a week and that Resident #41 had recently been re-admitted to the facility following a hospitalization. The RD added that Resident #41 had been placed on a NTL consistency after the hospitalization. The RD added that, "We would	F 808	quarterlyto the Administrator and the QAPI committee for further action as needed on a quarterly basis. Date of completion: 9/10/19	

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F 808	Continued From page 10 have carried the order over from the hospital." The RD continued, that the resident had been followed by the speech therapist for oral dysphagia (difficulty chewing) and mild pharyngeal dysphagia (difficulty swallowing). The RD confirmed that all liquids were thickened by the kitchen staff. At 2:30 PM, the surveyor reviewed the current Physician's Order Sheet (POS) with revealed a re-admission date of 7/22/19 and revealed a physician's diet order of Regular, Pureed with Nectar Thick Liquids. At 2:54 PM, the surveyor again interviewed the DA who stated that he had been trained by the Assistant Dietary Supervisor on the procedure for thickening liquids. The DA said he had last been trained in May 2018. At 2:59 PM, the FSD stated that nursing hand delivers the diet orders to the kitchen and that it was then entered into the computer on a "Tray Card System." The FSD added that prior to entering the diet order, it was verified and entered to identify any changes and then the meal ticket was printed out for the next meal. The FSD also stated that the product does not come with a measuring spoon from the manufacturer. At 3:21 PM, the Assistant Dietary Supervisor provided the surveyor with a copy of the meal card dated 8/7/19, Lunch. The Assistant Dietary Supervisor stated that she was responsible for printing the meal tickets weekly on Sunday or Monday. She added that the meal ticket was dated 8/7/19, because it had been printed on Wednesday for the week. The Assistant Dietary Supervisor then added that any updated diet	F 808		

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F 808	Continued From page 11	F 808		

orders would be reflected immediately on the meal ticket to reflect the diet change.

The surveyor then reviewed Resident #41's most recent quarterly Minimum Data Set (MDS), an assessment tool, dated [redacted], which revealed under Section C, Cognitive Pattern, Staff Assessment for Mental Status indicated Resident #41 had a problem with [redacted] Under Section G, Functional Status, Eating, indicated that the resident required supervision (oversight, encouragement or cueing) and set-up help only.

The surveyor then attempted to interview Resident #41 with the use of an interpreter. The resident was unable to identify their diet.

On 8/12/19 at 2:00 PM, the surveyor reviewed the facility policy titled: Thickened liquids, last dated 7/25/15, revealed under Procedure:

1. Recommendations for thickened liquids are made by speech and the Physician.
2. The types of thickened liquids in the facility include the following:
a. Thin - no thickener required
b. Nectar
c. Honey
d. Pudding
3. Staff follow the manufactures recommendations for thickening liquids.

On 8/13/19 at 12:20 PM, the surveyor observed Resident #41 sitting in a WC in the MDR wearing a plastic apron. The EW/UM was observed mixing a thickening powder into the milk and hot tea. Resident #41 then was observed eating and

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ROSE MOUNTAIN CARE CENTER	**ROUTE 1 & 18 NEW BRUNSWICK, NJ 08901**

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F 808	Continued From page 12	F 808		

drinking independently without difficulty. The resident ate 100% of their meal.

On 8/14/19 at 9:08 AM, the surveyor interviewed the Speech Language Pathologist (SLP) who stated that Resident #41 returned from the hospital and was placed on NTL. The SLP confirmed that the resident had a diagnosis of [redacted] and had not been seen by the SLP since [redacted] return on [redacted]

On 8/15/19 at 9:48 AM, the surveyor interviewed Resident #41's primary physician over the phone. The physician stated that the resident had been at the facility for 6-8 months and that they had previously refused to eat. The physician stated that he did not want to change the prescribed diet from their most recent hospitalization. The physician stated the resident preferred the NTL consistency and was now eating, so he continued with that consistency upon readmission to the nursing facility. The physician added that the resident was not at risk for aspiration.

On the same day at 11:40 AM, the surveyor reviewed the approved CNA Competency Evaluation: Feeding Dependent, dated 12/31/18 for the above identified CNA read:

Number 5 read: Checks meal ticket to assure correct resident and correct diet and

A. Thickened Liquids (Nectar/Honey)

The surveyor then reviewed the approved CNA Competency Evaluation: Dining Room Service dated 12/31/18 for the above identified CNA read:

Number 3 read: Verify Diet Order

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F 808	Continued From page 13 N.J.A.C 8:39 - 17.4(a)	F 808		
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 communicable disease or infections should be reported;	F 880		9/10/19

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F 880	Continued From page 14 (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 review of other facility documentation, the facility failed to maintain infection control practices to reduce the risk of infection. This deficient practice was evidenced by the following:	F 880	Rose Mountain Care Center Standard Survey 8/15/19 F880, 483.80(a)(1)(2)(4)(e)(f): Element One: Corrective action: PPE was made available in the soiled laundry room in order to eliminate the	

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On 9/6/19 at 9:21 AM, during surveyor tour of the facility's Laundry Room (LR), the surveyor observed that there were no Personal Protective Equipment (PPE) for the staff in the soiled side of the LR.

On the same day at 9:25 AM, during surveyor interview, the laundry staff member stated that the PPE was located on the clean side of the LR. He then went from the soiled side through the clear plastic slats, that separated the soiled side from the clean side of the LR, to the clean side. He then showed the surveyor a pile of vinyl gloves and a box of masks located on a shelf in the clean side of the LR. He also showed the surveyor cloth hospital gowns that in a barrel placed next to the dryers that he used as a gown to protect himself when loading the soiled linen into the washing machine.

On the same day at 9:31 AM, the surveyor observed the same laundry staff member perform handwashing for 30 seconds under the flow of water. The staff member then reached for the paper towel holder which was empty. He then shook his hands to dry and then turned off the water faucet with his bare hand.

On 8/14/19 at 12:27 PM, during surveyor interview, the Assistant Director of Nursing/Infections Preventionist (ADON/IP) confirmed that it was not proper practice for the staff member to wash his hands under the flow of water and/or, to walk to the clean side of the laundry room from the soiled side to retrieve the PPE that was located on the clean side of the laundry room.

need to go from the dirty room to the clean room to obtain PPE. The laundry worker was in-serviced by the infection control nurse on the proper handwashing technique. He was able to correctly perform a return demonstration of proper handwashing technique.

Element Two: Identification of others:
All residents have the potential to be affected by this practice.

Element Three: Systemic Changes:
PPE will be permanently available in the dirty laundry room in order to eliminate the need to access the clean laundry room for PPE. All laundry workers will be in-serviced upon hire by the Infection Control Nurse ADON or DONfor proper handwashing technique. All employees will be required to perform a return demonstration of the proper handwashing technique following instruction. All laundry workers will be required to attend yearly in-service re-training on proper handwashing given by the infection control nurse.

Element Four: Quality Assurance:
The Infection Control Nurse shall perform randommonthly audits of the handwashing technique of the laundry workers for the next two quarters. The results of all audits will be reportquarterly to the Administrator and the QAPI committee for further action as needed.

Date of completion: 9/10/19

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F 880	Continued From page 16 On 8/15/19 at 10:02 AM, during surveyor interview, the ADON stated that the facility did not have a policy for handwashing. At 12:00 PM, the surveyor reviewed the facility policy titled, Infection Control, with a revised date of 4/18/19, did not contain information regarding the location of PPE. N.J.A.C. 8:39-19.4(a)	F 880		