STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	062105	A. BUILDING: _____ B. WING _____	11/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOPATCONG CENTER	390 RED SCHOOL LANE PHILLIPSBURG, NJ 08865

(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 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 560	8:39-5.1(a) Mandatory Access to Care (a) The facility shall comply with applicable Federal, State, and local laws, rules, and regulations. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of pertinent facility documentation, it was determined the facility failed to maintain the required minimum direct care staff-to-resident ratios as mandated by the state of New Jersey. This deficient practice was evidenced by the following: Reference: NJ State requirement, CHAPTER 112. An Act concerning staffing requirements for nursing homes and supplementing Title 30 of the Revised Statutes. Be It Enacted by the Senate and General Assembly of the State of New Jersey: C.30:13-18 Minimum staffing requirements for nursing homes	S 560	HOW ANY CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE DEFICIENT PRACTICE: All residents present in the facility were affected by the deficient practice on the dates and shifts noted. The Center will maintain the NJ minimum direct care staff -to- resident ratios HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE	12/1/21

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

Electronically Signed | 11/18/21

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S 560	Continued From page 1 effective 2/1/21. 1. a. Notwithstanding any other staffing requirements as may be established by law, every nursing home as defined in section 2 of P.L.1976, c.120 (C.30:13-2) or licensed pursuant to P.L.1971, c.136 (C.26:2H-1 et seq.) shall maintain the following minimum direct care staff -to-resident ratios: (1) one certified nurse aide to every eight residents for the day shift; (2) one direct care staff member to every 10 residents for the evening shift, provided that no fewer than half of all staff members shall be certified nurse aides, and each staff member shall be signed in to work as a certified nurse aide and shall perform certified nurse aide duties: and (3) one direct care staff member to every 14 residents for the night shift, provided that each direct care staff member shall sign in to work as a certified nurse aide and perform certified nurse aide duties b. Upon any expansion of resident census by the nursing home, the nursing home shall be exempt from any increase in direct care staffing ratios for a period of nine consecutive shifts from the date of the expansion of the resident census. c. (1) The computation of minimum direct care staffing ratios shall be carried to the hundredth place. (2) If the application of the ratios listed in subsection a. of this section results in other than a whole number of direct care staff, including certified nurse aides, for a shift, the number of required direct care staff members shall be rounded to the next higher whole number when the resulting ratio, carried to the hundredth place, is fifty-one hundredths or higher. (3) All computations shall be based on the midnight census for the day in which the shift begins.	S 560	SAME DEFICIENT PRACTICE: All residents have the potential to be affected by this deficient practice. WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMATIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: ROOT CAUSE ANALYSIS was used to determine why the deficient practice occurred. The deficient practice occurred due to the inability to hire enough staff to maintain the NJ minimum direct care staff-to- resident ratios. Agency staff is currently being utilized to help maintain staff-to- resident ratios. State approved CNA classes are being conducted at this Center to increase CNA staffing. Proof of recruitment efforts will be emailed. The Administrator, Director of Nursing and Staffing Coordinator were re-educated on the NJ minimum staffing mandate.The Center will continue its recruiting efforts using various forms of media to increase the number of applicants. The Center will form external partnerships with schools who train students and transition them into CNAs. The Center will convert temporary CNAs into permanent CNAs. The Center will also have weekly staffing calls with the regional support team. HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT	

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S 560	Continued From page 2 d. Nothing in this section shall be construed to affect any minimum staffing requirements for nursing homes as may be required by the Commissioner of Health for staff other than direct care staff, including certified nurse aides, or to restrict the ability of a nursing home to increase staffing levels, at any time, beyond the established minimum ... A review of "New Jersey Department of Health Long Term Care Assessment and Survey Program Nurse Staffing Report" for the period beginning September 26, 2021 and ending October 9, 2021 revealed the following: The facility was not in compliance with the State of New Jersey minimum staffing requirements of CNAs during the 7:00 AM - 3:00 PM shift on 9/26/21, 9/27/21, 9/28/21, 9/29/21, 9/30/21, 10/1/21, 10/2/21, 10/3/21, 10/4/21, 10/5/21, 10/6/21, 10/7/21, 10/8/21, and 10/9/21. The facility was not in compliance with the State of New Jersey minimum staffing requirements of CNAs during the 3:00 PM - 11:00 PM shift on 9/26/21, 9/28/21, 9/29/21, 9/30/21, 10/1/21, 10/2/21, 10/4/21, 10/5/21, and 10/7/21. The facility was not in compliance with the State of New Jersey minimum staffing requirements of CNAs during the 11:00 PM to 7:00 AM shift on 9/30/21, 10/2/21, 10/4/21, 10/5/21, 10/6/21, and 10/7/21. On 10/19/21 at 1:00 PM, the surveyor discussed the staffing ratio concerns with the Administrator and Director of Nursing, who stated they were aware of the staffing ratio criteria and that they are attempting to hire new CNAs and offer incentives.	S 560	RECUR: THE Human Resources Manager, Staffing Coordinator and Director of Nursing will maintain a list of current recruiting efforts and document the results of these efforts five days a week. The Administrator will audit the the daily staffing sheets to determine if Center is meeting the minimum staff-to -resident ratios. The Administrator and Director of Nursing or Designee will report these findings at QAPI monthly x 3 months. The QAPI Committee will evaluate the effectiveness of this plan to ensure substantial compliance is achieved and will determine if further monitoring and evaluation is required.	

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S1420	Continued From page 3	S1420		
S1420	8:39-19.5(b)(3) Mandatory Infection Control and Sanitation (b) Each new employee, including members of the medical staff employed by the facility, upon employment shall receive a two-step Mantoux tuberculin skin test with five tuberculin units of purified protein derivative. The only exceptions shall be employees with documented negative two-step Mantoux skin test results (zero to nine millimeters of induration) within the last year, employees with a documented positive Mantoux skin test result (10 or more millimeters of induration), employees who have received appropriate medical treatment for tuberculosis, or when medically contraindicated. Results of the Mantoux tuberculin skin tests administered to new employees shall be acted upon as follows: 3. Any employee with positive results shall be referred to the employee's personal physician or advanced practice nurse and if active tuberculosis is suspected or diagnosed shall be excluded from work until the physician or advanced practice nurse provides written approval to return. This REQUIREMENT is not met as evidenced by: Based on interviews and a review of the personnel files of Five recently hired employees, it was determined that the facility failed to administer the two step Mantoux test (a tool for screening for tuberculosis and for tuberculosis diagnosis) to appropriate employees as required. This deficient practice was evidenced by the	S1420	HOW THE CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE DEFICIENT PRACTICE: The three employees who did not have the two step Mantoux test completed/recorded	12/1/21

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S1420	Continued From page 4 following: On 10/14/21 at 11:00 AM, the surveyor reviewed the health records of five recently hired employees. Of these, Two fit the criteria requiring a two step Mantoux test. There were three new employees that only had the first step of the testing process completed. This was discussed with the Administrator and Director of Nursing (DON) on 10/14/21 at 12:55 PM. On 10/15/21 at 9:50 AM, the Administrator and DON informed the surveyor that they were unable to locate any paperwork to show that the three new employees had their two step Mantoux test done.	S1420	were re-administered the two step mantoux test. Results were recorded on the Genesis Mantoux skin test form and placed in their health file. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THR POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents have the potential to be affected by the same deficient practice. WHAT MEASURES WILL BE PUT INT PLACE OR SYSTEMATIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: Root Cause Analysis was used to determine why the deficient practice occurred. This deficient practice occurred due to a process failure. There was no tracking system in place to identify when new employees were due for their second PPD and no administrative oversight to ensure that the Two Step Mantoux test was completed and documented. A white board will be used to track dates of first and second PPDs for new employees which will be kept in the Assistant Director of Nursing/Infection Preventionist office. When the second PPD is completed, an audit form will be signed by the Licensed Nursing Home Administrator, Human Resources manager and Nursing Administration.	

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S1420	Continued From page 5	S1420	HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR: The results of these audits will be discussed at monthly QAPI meetings x 3 months to ensure compliance.	

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F 000	INITIAL COMMENTS Standard Survey: Census: 100 Sample Size: 23 A Recertification Survey was Conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey. A COVID-19 Focused Infection Control Survey was conducted by the New Jersey Department of Health. The facility was found to be in compliance with 42 CFR §483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices for COVID-19.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not	F 656		12/1/21

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F 656	Continued From page 1 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 develop a comprehensive care to address the treatment needs for Resident [redacted] and Fall Risk for Resident [redacted], 2 of 23 residents reviewed. The deficient practice was evidenced by the following: 1. On 10/15/21 at 12:16 PM, surveyor observed Resident [redacted] in bed with [redacted] going at [redacted]. The resident was awake watching television. There was a [redacted] on the resident's bed. The resident's [redacted]	F 656	HOW ANY CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE DEFICIENT PRACTICE: The Skin Integrity care plan for resident [redacted] was updated on [redacted] to include current treatments for the [redacted] and [redacted]. A comprehensive care plan was initiated on [redacted] for resident [redacted], including fall risk with interventions put into place from a previous fall on [redacted]. These included	

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F 656	Continued From page 2 were wrapped with [redacted]. The surveyor reviewed Resident [redacted]'s electronic medical record (EMR) that revealed the following: According to the Admission Record, Resident [redacted] was admitted to the facility with diagnoses that included [redacted]. The Annual Minimum Data Set (MDS) an assessment tool dated [redacted] indicated that the facility performed a Brief Interview for Mental Status and the results showed a score of [redacted] out of [redacted] which indicated the resident had no [redacted]. According to the electronic Treatment Administration Record (eTAR), the resident physician's orders to provide treatments to the [redacted]. There was documentation on the eTAR that the nurses were performing the treatments as ordered. Upon review of the resident's care plans, the surveyor observed that there wasn't a comprehensive care plan developed to address the current treatments to the areas mentioned above. On 10/19/21 at 10:36 AM, the surveyor spoke to the Director of Nursing (DON), who was responsible for the development of care plans, regarding no care plan was developed to address Resident [redacted] current treatments. No additional information was provided.	F 656	a TABS alarm, consistent checking on the resident to anticipate needs and offering snacks for comfort and calming. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME PRACTICE: All residents who are at risk for falls and/or have skin impairments have the potential to be affected by this same deficient practice. These residents were identified by audit and their care plans will be reviewed to ensure that a comprehensive care plan is in place for fall risk and/or skin integrity. WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMATIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: Root Cause Analysis was used to determine why the deficient practice occurred. This deficient practice occurred due to a process failure. Resident care planning did not have an interdisciplnary approach which resulted in the failure to develop a person centered, comprehensive cae plan for treatment needs and fall risk. Interdisciplinary Team members were assigned care planning focus tasks and are responsible to initiate the care plan within 24-48 hours. The Interdisciplinary Team members were also reeducated on Policy and Procedure re:	

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F 656	Continued From page 3 2. On 10/12/21 at 1:03 PM, the surveyor observed Resident [redacted] in the resident's room. The resident was on transmission based precautions with proper signage noted at the entrance of the resident's room. The surveyor reviewed Resident [redacted] EMR that revealed the following: According to the Admission Record, Resident [redacted] was admitted to the facility with diagnoses that included [redacted] The [redacted] Admission MDS revealed that Resident [redacted] was [redacted] impaired. The nursing Progress Notes indicated that on [redacted] the resident fell due to confusion while climbing out of bed without assistance. The Event Summary Report revealed that on [redacted] Resident [redacted] fell out of bed and was found on the floor by facility staff. The facility documented that under Corrective Actions: "TABS alarm added to resident to replace bed alarm. Consistent checking of resident to anticipate needs. Give snacks for comfort/ calming." The Nursing Documentation V10 completed on [redacted] indicated that the resident had several risk factors for falls which included a history of falls prior to admission and was taking several medications that increased the risk for falls. The surveyor reviewed the resident's care plan and observed that the facility had not developed a comprehensive care plan to address the resident's risks for falls, to update it to include the	F 656	the development of a comprehensive person centered care plan for every resident. HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR: Weekly audits x 4 weeks and then monthly x 3 thereafter of resident care plans will be completed by Nursing Management or Designee to ensure that fall risk and skin integrity care plans are comprehensive and patient centered. Results of these audits will be discussed in monthly QAPI.	

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F 656	Continued From page 4 [redacted] fall with interventions listed on the Event Summaary. On 10/18/21 at 12:07 PM, the surveyor spoke to the Administrator and the DON The DON stated that she would have expected to see a fall risk care plan in place for this resident. A review of the facility policy titled Person-Centered Care Plan revised 7/1/19, revealed that the facility must "develop and implement a baseline person-centered care plan within 48 hours" and that "a comprehensive, individualized care plan will be developed within 7 days after completion of the comprehensive assessment for each patient". N.J.A.C 8:39-11.2(e)	F 656		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to maintain professional standards of practice by not documenting that a resident was receiving [redacted] and not monitoring [redacted] according to the physician's orders for 1 of 2 residents (Resident [redacted]) reviewed.	F 695	HOW ANY CORRECTIVE ACTION WILL BE ACCOMPLISHED FOR THOSE RESIDENTS FOUND TO BE AFFECTED BY THE DEFICIENT PRACTICE: THE E-MAR for Resident [redacted] was updated on [redacted] to include [redacted]	12/1/21

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F 695	Continued From page 5 This deficient practice was evidenced by the following: On 10/13/21 at 10:23 AM, the surveyor observed Resident [redacted] sitting on the bed with [redacted] On 10/14/21 11:37 AM, the surveyor observed Resident [redacted] lying across the bed with [redacted] running at [redacted], watching television. The resident informed the surveyor that the resident uses the [redacted] all the time. The surveyor reviewed Resident [redacted]s electronic medical records that revealed the following: According to the Admission Record, Resident [redacted] was admitted to the facility with diagnoses that included [redacted]. The Quarterly Minimum Data Set an assessment tool dated [redacted] indicated that the facility performed a Brief Interview for Mental Status interview and Resident [redacted] scored a [redacted] which determined the resident was [redacted] intact. According to the Order Summary Report, Resident [redacted] had a physician's order dated [redacted] as needed for [redacted] Post treatment evaluate [redacted] Resident [redacted] had two care plans that had interventions that addressed the resident's [redacted] needs. The interventions included [redacted] and monitor	F 695	use and [redacted] per the MD order on every shift to support supplemental [redacted] use. HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents who have [redacted] orders as needed have the potential to be affected by the same deficient practice. An audit of residents with MD orders for as needed [redacted] use was done. The E-MARs of these residents will be checked by the unit manager or designee to ensure that the [redacted] use and the [redacted] levels are documented per the MD order. WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMATIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: ROOT CAUSE ANALYSIS was used to determine why the deficient practice occurred. This deficient practice occurred due to a knowledge deficit by the nurses to document [redacted] use as needed and the [redacted] levels for resident [redacted]. Nurses will be re-educated on Policy and Procedure for [redacted] Use in order to maintain professional standards of practice. HOW THE FACILITY WILL MONITOR	

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	315202	A. BUILDING _____ B. WING _____	11/01/2021

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F 695	Continued From page 6 [redacted] as ordered and report abnormalities to physician." The electronic Medication Administration Record (eMAR) revealed the physician's order was on the eMAR but there was no documentation from [redacted] that the [redacted] were being monitored and that the resident was receiving [redacted] daily. On 10/15/21 at 10:36 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) assigned to Resident [redacted]. She stated that "since covid [the resident] had been receiving [redacted] but [the resident] doesn't need it." The LPN also stated that she hasn't been monitoring [redacted] and hasn't been documenting on the eMAR that the resident was receiving [redacted] On 10/15/21 at 12:55 PM, the surveyor spoke to the Administrator and Director of Nursing regarding the above concerns. There were no additional information provided. NJAC 8:39-27.1(a)	F 695	ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR: Monthly audits x 3 months will be completed by Nursing Management or Designee to ensure that residents receiving [redacted] as needed have appropriate documentation on the E-MAR to include use and [redacted] levels according to the physician's order. Results of these audits will be discussed in monthly QAPI.	
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	F 880		1/12/22

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F 880	Continued From page 7 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 (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	F 880		

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F 880	Continued From page 8 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, interviews, and review of pertinent facility documentation, it was determined that the facility staff failed to follow appropriate infection control guidelines for Personal Protective Equipment (PPE), handwashing, and disinfection of shared medical equipment for 1 of 3 nurses observed during medication pass observation. This deficient practice was evidenced by the following: On 10/18/21 at 8:20 AM, the surveyor observed a Registered Nurse (RN) during medication pass observation on the [redacted] floor of the facility. The RN was wearing a N 95 mask (a filtering facepiece respirator) with the two straps of the face mask around her neck. At 8:28, the RN entered the room of Resident [redacted] and donned (put on) clean gloves. The RN administered oral medications to the resident, gave the resident a [redacted] and applied a [redacted] to the resident's [redacted]	F 880	HOW ANY CORRECTIVE ACTION WILL BE ACCOMPLISHED FORTHOSE RESIDENTS FOUND TO BE AFFECTED BY THE DEFICIENT PRACTICE: The observed RN was re-educated re: the deficient practices for resident [redacted] by the Director of Nursing on 10/18/21. Resident [redacted] will receive care from staff wearing their PPE appropriately, with hand hygiene performed between doffing and donning new gloves, and with disinfected shared medical equipment. Residnet [redacted] was discharged. The observed RN was re-educated re: the deficient practices for resident [redacted] by the Director of Nursing on 10/18/21. Resident [redacted] will receive care from staff wearing their PPE appropriately and with disinfected shared medical equipment to monitor vital signs. The shared medical equipment that was used for resident # [redacted] was cleaned on 10/18/21 by the observed RN before use on any other resident.	

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F 880	Continued From page 9 thigh. The RN doffed (removed) gloves and immediately donned new gloves. The RN did not perform hand hygiene between doffing the first pair of gloves and donning the new pair of gloves. The RN then measured the resident's vitals using a thermometer, blood pressure cuff, and a pulse oximeter (device used to measure the blood oxygen saturation and heart rate). The medical equipment was not cleaned or sanitized afterwards. At 8:53 AM, the RN began to prepare medications for Resident [redacted]. Resident [redacted] had a sign on their door indicating that they were on isolation precautions and that an isolation gown should be worn in addition to a N 95 face mask and face shield. The isolation gown used by the RN had a strap at the neck and a strap at the waist. The RN donned the isolation gown and tied the strap only at the neck. The RN entered Resident [redacted] s room and measured the resident's vitals including the temperature, blood pressure, pulse, and oxygen saturation using the same thermometer, blood pressure cuff, and pulse oximeter used for Resident [redacted] which had not been sanitized. At 8:59 AM the surveyor interviewed the RN about the observations. The RN stated that the second strap of her N 95 mask should be worn at the crown of her head but that it slipped down. She stated that she should perform hand hygiene between donning and doffing gloves before providing resident care. The RN stated that an isolation gown should be tied at both the neck and the waist. She also stated that shared medical equipment such as a thermometer, blood	F 880	HOW THE FACILITY WILL IDENTIFY OTHER RESIDENTS HAVING THE POTENTIAL TO BE AFFECTED BY THE SAME DEFICIENT PRACTICE: All residents on [redacted] Floor have the potential to be affected by this deficient practice. WHAT MEASURES WILL BE PUT INTO PLACE OR SYSTEMATIC CHANGES MADE TO ENSURE THAT THE DEFICIENT PRACTICE WILL NOT RECUR: Root Cause Analysis was used to determine why the deficient practice occurred. This deficient practice occurred due to a process failure by the nurse to wear her PPE properly, perform hand hygiene between donning and doffing gloves and to sanitize medical equipment between each resident.Upon interview by the Director of Nursing with the observed RN, the RN stated that she was nervous while being observed by the surveyor. Staff will be re-educated on proper PPE usage for gowning and N95 masks, Policy and Procedure for hand hygiene before and after patient care and Policy for cleaning and disinfecting. Staff received the following Directed In-service Training Module 1- Infection Prevention and	

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F 880	Continued From page 10 pressure cuff, and pulse oximeter should be sanitized after use on every resident. At 12:07 PM, the surveyor spoke to the Administrator and the Director of Nursing (DON). The DON stated that PPE should be worn properly, and that medical equipment should be sanitized in between each resident. A review of the facility policy titled, Hand Hygiene revised on 11/15/20, indicated that hand hygiene should be performed before and after patient care. A review of the facility policy titled, Cleaning and Disinfecting revised on 11/15/2020, indicated that multi-patient equipment must be cleaned and disinfected after patient use. N.J.A.C. 8:39-19.4(l)(n)	F 880	Control Program https://www.train.org/main/course/1081350/ Provided to: Topline staff and Infection Preventionist Module 6A- Principles of standard Precautions https://www.train.org/main/course/1081804/ Provided to: ALL STAFF Module 7-Hand Hygiene https://www.train.org/main/course/1081806/ Provided to: ALL STAFF Module 11A-Reprocessing Reusable Resident Care Equipment https://www.train.org/main/course/1081814 Provided to: Topline staff and Infection Preventionist Module 11B-Environmental Cleaning and Disinfection https://www.train.org/main/course/1081815/ Provided to: ALL STAFF CDC Covid-19 Prevention Messages for Frontline Long- term Care Staff Keep Covid-19 Out! https://youtu.be/7srwrF9MGdw Provided to: Frontline Staff CDC Covid-19 Prevention Messages for front line Long-Term Care Staff Use PPE Correctly for Covid-19 https://youtu.be/YYTATw9yav4	

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F 880	Continued From page 11	F 880	Provided to: Frontline Staff HOW THE FACILITY WILL MONITOR ITS CORRECTIVE ACTIONS TO ENSURE THAT THE DEFICIENT PRACTICE IS BEING CORRECTED AND WILL NOT RECUR: Infection control audits via rounding will be completed by Nursing management or designee weekly x 4 weeks then monthly x 3 months and will include donning and doffing of PPE, hand hygiene and sanitizing of medical equipment betwen residents. The results of these audits/rounds will be discussed in monthly QAPI.	