STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315147	A. BUILDING ______ B. WING ______	C 02/13/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW GROVE MANOR	**101 NORTH GROVE STREET EAST ORANGE, NJ 07017**

(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 CENSUS: 126 SAMPLE SIZE: 29 +19 Complaint#: NJ00132578 A Recertification Survey was conducted to determine compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. Deficiencies were cited for this survey.	F 000		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are	F 584		2/28/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 02/28/2020

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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in good condition;

§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv);

§483.10(i)(5) Adequate and comfortable lighting levels in all areas;

§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and

§483.10(i)(7) For the maintenance of comfortable sound levels.
This REQUIREMENT is not met as evidenced by:
NJ00132578

Based on observation, interview, record review, and review of pertinent facility documentation, it was determined that the facility failed to ensure:
a.) A resident unit and a resident room was free of the [redacted]. This deficient practice was identified in 1 (Resident #100) of 43 rooms observed on 4 of 4 nursing units.
b.) The shower temperatures were at a comfortable level. This deficient practice was identified for 1 of 4 shower rooms observed and for 2 of 6 residents who attended the Resident Council Meeting, Resident #10 and #118.
These deficient practices were evidenced by the following:

1. On 2/5/2020 at 9:20 AM, the surveyor entered the [redacted] Floor unit via the stairwell. Upon entering the unit, the surveyor noted a [redacted] in the hallway by the stairwell. At that time, the surveyor observed Resident #100 sitting in a

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I. CORRECTIVE ACTION:

- Resident #100 was offered a room change on 2/11/20, resident declined. Room was deep-cleaned, [redacted] was eliminated. Resident #100 expressed satisfaction.
- Assigned CNAs were disciplined/counseled for failing to conduct rounds, failure to provide incontinence care to Resident #100's roommate, and for failure to appropriately dispose of a soiled incontinence brief.
- Assigned CNAs were counseled to conduct hourly checks for incontinence episodes for Resident #100's roommates.
- All CNAs were counseled to transfer heavily soiled/saturated linen directly to the laundry chute, rather than placing in bags in the soiled linen receptacles in the hallway.
- On 2/11/20, the plumbing /

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wheelchair outside his/her room and facing the nurses station. The resident had their shirt collar over their nose and was pinching their nose with their hand. At that time, the surveyor attempted to interview Resident #100 but the resident was not able to [redacted]. The resident began to use gestures to tell the surveyor that his/her room [redacted]. The surveyor and the resident entered the resident's room together, and noted a [redacted] in the resident's room. Resident #100 pointed to a roommate, and the surveyor observed the roommate in bed with a [redacted] on the bed sheet. Resident #100 then showed the surveyor a personal air freshener by the bedside and the resident wanted the surveyor to smell the air freshener. The surveyor asked the resident if the air freshener was for the [redacted] in the room and was the [redacted] present every day. The resident nodded their head "yes" to both questions.

At 10:44 AM, the surveyor returned to the room of Resident #100 and the surveyor observed that the room still [redacted]. The surveyor observed the resident's roommate was still on the same bed sheet with the [redacted] on it, as the sheets had not yet been changed.

At 12:12 PM, the surveyor returned to the resident's room a third time. The resident's room continued to [redacted]. At that time there were no staff present in the resident's room. The surveyor noted a [redacted] sitting on the bedside table, not bagged and exposed to the air, in the resident's room. The bed sheet with the [redacted] was still on the roommate's bed.

F 584

temperature concern in the [redacted]-floor shower was fixed.

II. IDENTIFY OTHER INSTANCES:

All residents on have the potential to be affected.

III. SYSTEMIC CHANGE:

- CNAs have been educated to bring heavily soiled/saturated linen directly to the laundry chute.
- All CNAs were in-serviced on frequency of rounding / incontinence checks, and instructed to increase the frequency of rounding for residents identified as having more frequent incontinent episodes.
- All CNAs were in-serviced that any concern with water temperature should be immediately reported to the supervisor so that the issue could be addressed as quickly as possible. CNAs were also educated that in the event of a water temperature concern in the shower, if the issue cannot be fixed immediately, residents are to be offered the option of receiving a shower on another unit or receiving a bed bath.

IV. MONITOR CORRECTIVE ACTION:

- Every month for the next three months, two residents per unit will be interviewed about satisfaction with the unit

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F 584	Continued From page 3 At 12:35 PM, the surveyor observed Resident #100 crinkle his/her face and using gestures the resident indicated that the room still [redacted] [redacted]. At 1:03 PM, the surveyor observed the room of Resident #100 which continued to [redacted]. At that time, the surveyor observed that the [redacted] was no longer on the night stand and the same [redacted] [redacted] was still on the roommate's bed. At 1:15 PM, the surveyor observed that the hallway to the [redacted] Floor stairwell continued to have a [redacted]. As soon as the surveyor entered the stairwell, the [redacted] dissipated. The next day on 2/6/2020 at 9:18 AM, the surveyor entered the [redacted] Floor unit via the stairwell. Upon entering the unit, the surveyor noted a [redacted] in the hallway by the stairwell. The surveyor then knocked and entered the room of Resident #100. The surveyor noted a [redacted] in the resident's room. The surveyor then asked Resident #100 if there were any odors in the room, and the resident shook his/her head "yes" and pointed to his/her roommate and then gestured to the [redacted]. The surveyor then observed the resident's roommate on a bed sheet that had a new [redacted], smaller in size. The surveyor noted a [redacted] was again present in the room. The surveyor asked Resident #100 about the frequency of the smell of [redacted] in the room, using "yes" or "no" questions. Resident #100 shook his/her head "yes" that the [redacted] was present everyday. The surveyor	F 584	environment, particularly relating to odor and water temperature. These interviews will be conducted by the Director of Environmental Services. • Director of Maintenance/designee will check the shower temperatures daily for 4 weeks. • Results will be reviewed at the quarterly QA meeting..	

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attempted to ask if the resident had told a staff member about the [redacted], and the resident nodded "yes", but was unable to communicate who he/she told. The surveyor asked if a nurse was informed, and the resident nodded "yes."

The surveyor reviewed the medical record for Resident #100.

A review of the annual 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 score of [redacted] with some forgetfulness.

A review of the individualized care plan dated 1/3/2020 for Resident #100 reflected that he/she had a [redacted] Interventions included to anticipate and meet needs, "ensure/provide a safe environment" and "Monitor/document for physical/nonverbal indicators of discomfort or distress, and follow-up as needed."

On 2/12/2020 at 9:28 AM, the surveyor interviewed the Certified Nursing Aide (CNA) assigned to care for the roommate. The CNA stated that her job included incontinence care for residents. She stated that she rounds in the morning and performs morning care on all the residents on her assignment. After she completes morning care, she does rounds again to check to see if any residents had another incontinent episode. She could not speak to how often

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rounds were done. She stated that incontinent briefs should be discarded immediately after the resident's are changed and should not be left in the resident rooms. She added that sheets should be changed if they were dirty, and acknowledged if soiled garments are not removed, it could cause the room to smell of urine. The CNA added that the facility did not have fitted sheets for the beds and only had flat sheets which caused the sheets to sometimes not stay on the bed when residents move around in bed. She stated that the facility would clean the mattresses with a bleach wipe if [redacted] got on a mattress. The CNA denied that anyone in the past had told her of a [redacted] in any resident room.

At 9:37 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) who acknowledge that [redacted] should be changed as soon as possible. The LPN denied an awareness of a [redacted] in the resident's room and denied that anyone in the past had told her of a [redacted] in the resident's room.

At 9:41 AM, the surveyor interviewed the Registered Nurse (RN), who stated she was not aware of Resident #100's concerns of the [redacted] [redacted] in the room. She acknowledged that soiled garments should be removed once identified.

On 2/13/2020 at 11:14 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) in the presence of the survey team. The LNHA stated that Resident #100's room was made clean and acknowledged that that CNA staff should not have left the [redacted] sheets

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and [redacted] on the resident's bed side table. The LNHA added that the roommate for Resident #100 should be checked for incontinence episodes every one hour due to an [redacted] in order to prevent the [redacted] in the room from occurring.

On 2/11/2020 from 10:35 AM to 11:00 AM, the surveyor conducted the resident council group meeting. Two of the six residents that attended the group interview resided on the [redacted] floor. Both these residents stated that the [redacted] floor smelled of [redacted]. Resident #10 stated that he/she watched what the staff did when they changed the sheets. The resident stated that they took the [redacted], put them in a plastic bag, and then placed them in the carts on the unit. The resident stated that it would make more sense for the staff to immediately put the [redacted] [redacted] down into the laundry chute so they weren't left sitting on the unit [redacted]. The resident further stated that the plastic bag and the carts weren't odor-proof.

2. At this same Resident Council Group meeting Resident #118 stated that when he/she took a shower the water would come out cold. The resident further stated that the facility told the residents that they fixed the water temperatures but last time he/she took a shower he/she had to wait 20 minutes for the water to heat up. The resident stated, "I took a cold shower and it was unpleasant." Resident #10 stated that the water in the shower room was cold. The resident stated that the facility was aware of it and the water had been cold for some time. The resident stated, "it's not like [the water was] not hot, it just doesn't get

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hot." The resident stated that the water temperature was probably 60 degrees and it would be alright if the water temperature would at least be 72-73 degrees. The resident further stated that the Certified Nursing Aide (CNA) would fill a basin from the sink with hot water and pour it over his/her head for warm water. The resident stated that pouring the basin over his/her head was better then taking a cold shower, but he/she would have preferred a hot shower and not have water dumped over his/her head.

On 2/11/2020 at 11:17, the surveyor conducted an interview with the Maintenance Director (MD) who stated that water temperatures were checked once a week on every unit in the facility and he kept a record of this. The MD stated that he wanted the water temperatures to be 110 degrees Fahrenheit or below. The MD was unable to speak to the low end range of the water temperatures. The surveyor asked the MD if the residents or staff complained to him about the water temperatures being cold. The MD stated that last month the staff and residents on the fifth floor noticed the water temperature was cold, so the facility fixed the issue. The surveyor asked the MD to check water temperatures with the surveyor in the shower rooms in the facility.

On 2/11/2020 at 11:22 AM, the surveyor and the MD prepared to check the temperatures of the water in 4 of 4 unit shower rooms. At that time, the MD obtained and calibrated a handheld infrared thermometer in the presence of the surveyor.

The surveyor observed that 1 of 4 shower rooms ([redacted] Floor) did not have a comfortable water temperature.

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At 11:24 AM, the MD turned the water on in the [redacted]-floor shower room. The surveyor felt the water coming out of the shower and it was cold to touch. The MD stated, "that's cold right now."

At 11:26 AM, the water temperature recorded in the [redacted]-floor shower room read 63.4 degrees Fahrenheit using his infrared thermometer.

At 11:36 AM, the surveyor asked the MD what the appropriate temperature range for residents should be and the MD stated that he was unsure.

At 12:12 PM, the MD stated that he had used the wrong thermometer to check the water temperatures because he was unsure of which thermometer to use. He asked the surveyor if the water temperatures could be checked again with the appropriate thermometer. The surveyor asked the MD why he didn't use the correct thermometer the first time when they were testing the temperatures. The MD stated that he didn't know which one to use and wasn't sure, but now knew that the water temperatures were supposed to be checked using a probe thermometer. He could not speak to if the infrared or probe thermometer was used for the daily testing of the water.

At 12:35 PM, the surveyor conducted an interview with the Licensed Nursing Home Administrator (LNHA) who stated that the appropriate and comfortable water temperatures for residents was to ensure the temperatures ranged from 95 to 110 degrees Fahrenheit.

At 1:04 PM, the MD and LNHA calibrated the probe thermometer to check water temperatures

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F 584	Continued From page 9 in the presence of the surveyor. At 1:06 PM, the MD turned on the water in the [redacted]-floor shower room. The surveyor felt the water and the water felt cool to touch. At 1:09 PM, the water temperature recorded in the [redacted]-floor shower room was 82.0 degrees Fahrenheit. The surveyor reviewed facility's Water Temperature Checklist for the past three months. The Water Temperature Checklist indicated that on 11/5/19 and on 1/8/2020 the [redacted]-floor shower room temperatures were recorded as 108 degrees Fahrenheit. The Water Temperature Checklist did not indicate what type of thermometer was used to check the water temperatures. A review of the facility's Safety of Water Temperatures Policy dated 7/2019 included, "1. Water heaters that service resident rooms, bathrooms, common areas, and tub/shower areas shall be set to temperatures between 95 F and 110 F. 2. Maintenance staff is responsible for checking thermostats and temperatures controls in the facility and recording these checks in a maintenance log." NJAC 8:39-33.7(h), 8:39-31.4(a), 8:39-31.4(c)	F 584		
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	F 684		2/28/20

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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:
NJ00132578

Based on observation, interview, record review, and review of pertinent facility documents it was determined that the facility failed to:
a.) Address the appropriate behavioral and [redacted] management for a resident with [redacted] which was identified for 1 of 4 residents reviewed (Resident #2) in addition to 81 residents observed but not reviewed on 4 of 4 nursing units for [redacted],
b.) Ensure the safe management of a fluid restriction ordered by the physician for 1 of 1 residents on a fluid restriction (Resident #91).

These deficient practices were evidenced by the following:

1. On 2/5/2020 at 9:20 AM, the surveyor entered the [redacted] Floor unit via the stairwell. Upon entering the unit, the surveyor noted a [redacted] in the hallway by the stairwell. At that time, the surveyor observed a resident sitting in a wheelchair outside their room and facing the nurse's station. The resident had their shirt collar over their nose and was pinching their nose with their hand. At that time, the resident began to use gestures to tell the surveyor that his/her room [redacted]. The surveyor and the resident entered the resident's room together and noted a [redacted] in the resident's room. The resident pointed to Resident #2's living space.

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I. CORRECTIVE ACTION:

" A 3-day hourly incontinence diary was initiated for Resident #2 on 2/19/20, as a means of assessing actual frequency of incontinent episodes, as well as refusals of incontinence care. Based on the results, it was determined that Resident #2 requires scheduled prompted voiding; scheduled prompted voiding was initiated 2/22/20, Resident #2's care plan was updated accordingly.
" Assigned CNAs were disciplined/counseled for failing to conduct rounds, failure to provide incontinence care to Resident #2, and for failure to appropriately dispose of a [redacted] [redacted].
" On 2/17/20 resident #90 was re-educated by the Nurse Practitioner(NP) and the Dietitian about the reason for the fluid restriction order and the risks of noncompliance with the recommendation. Despite education, resident#90 expressed a preference not to comply with the fluid restriction, the fluid restriction was discontinued.

II. IDENTIFY OTHER INSTANCES

" Residents with increased

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The surveyor observed Resident #2 lying in bed on a flat sheet. The flat sheet was not secured to the mattress and partially exposed the blue mattress. The flat sheet had a visibly soiled, [redacted] on it and there was no incontinence pad or draw sheet under the resident. The resident's blue sweatpants showed visible signs of [redacted] at that time. The resident's head was under another top flat sheet.

At 9:23 AM, a Certified Nursing Aide (CNA) entered the resident's room and asked Resident #2 if he/she was going to finish eating breakfast. Resident #2 responded with his/her head still covered under the sheet, "No." The CNA looked at the resident's breakfast meal and saw that the resident ate 100% of the oatmeal and 100% of the fruit. The CNA stated that the resident loved oatmeal and fruit. At that time, the surveyor attempted to further interview the CNA, but the CNA stated that she was not the CNA assigned to care for Resident #2, but that she just came in to check on the resident and pick up the tray. The CNA present in the room did not address the [redacted] in the room or address the resident's [redacted] with the [redacted] [redacted].

At 9:36 AM, a second surveyor observed Resident #2 in bed and corroborated the surveyor's findings timed at 9:20 AM.

At approximately 10:00 AM, a third surveyor entered the [redacted] floor via the stair well, and noted a [redacted] immediately upon entering the unit.

At 10:44 AM, the surveyor returned to the room of

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incontinence needs have the potential to be at risk.
" Residents with fluid restrictions have the potential to be at risk.

III. SYSTEMIC CHANGE:

" Based on CNA interview, the facility identified residents who require more-frequent-than-usual incontinence care. 3-day hourly incontinence diaries were initiated for those residents. Based on the results, individualized interventions were implemented and the care plans were updated accordingly.
" All CNAs were in-serviced on frequency of rounding / incontinence checks, and instructed to increase the frequency of rounding for residents identified as having more frequent incontinent episodes.
" All CNAs were educated to notify the nurse if a resident requires increased incontinence care so that the resident□s incontinence care needs can be appropriately assessed.
" All CNAs were educated about fluid restrictions and instructed to check with the nurse before offering fluids to residents with fluid restrictions.
" All CNAs were re-educated regarding the CNA communication sheet, with information about each resident□s care requirements including ADL care, safety interventions, and diet restrictions.

IV. MONITOR CORRECTIVE ACTION:

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F 684	Continued From page 12 Resident #2 and noted that the room still [redacted] The surveyor observed Resident #2 was still lying on the same flat sheet with the [redacted] on it and still wearing the same blue sweatpants that had visible signs of [redacted] and no incontinence pad or draw sheet was under the resident. The blue mattress was exposed. The surveyor observed that the resident's head was no longer under the sheet. The surveyor attempted to interview Resident #2 but the resident would only answer yes or no questions. The resident denied that he/she was currently [redacted] and denied needing assistance with [redacted]. At approximately 10:50 AM, the surveyor observed the Licensed Practical Nurse (LPN) enter the resident's room and look at Resident #2. The surveyor observed that the LPN did not speak to the resident during her encounter. She then exited the room and told the surveyor that the assigned CNA was assisting another resident at that time. At 12:12 PM, the surveyor returned to the resident's room a third time. The resident's room continued to [redacted]. Resident #2 was in bed and was no longer wearing the blue sweatpants. The resident was positioned in a manner that his/her legs and incontinent brief were exposed. The surveyor noted that the resident was now wearing a clean incontinent brief but was still lying on same flat sheet with a [redacted] around the resident's lower body. The surveyor observed a [redacted] not bagged and exposed to the air directly on top of the resident's bedside table. There was no staff present in the room.	F 684	" For the next three months, DON / Assistant Director of Nursing(ADON) will check the CNA communication sheet weekly to ensure information is being updated appropriately. " For the next month, Assistant Director of Nursing(ADON) will conduct weekly room checks of all residents with fluid restriction order, to ensure additional fluids are not being provided to residents. " For the next three months, Assistant Director of Nursing(ADON) or designee will conduct weekly random room checks to ensure timeliness of incontinence care. " Results will be shared at quarterly QA meeting.	

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At 12:35 PM, the surveyor observed that the [redacted] was still in direct contact with the resident's bedside table, not bagged and exposed to the air and Resident #2 was still in the same position as observed at 12:12 PM. There were no staff present in the room.

At 1:03 PM, the surveyor observed a lunch tray now positioned on the resident's bedside table where the [redacted] had once been. The incontinent brief was no longer in the room. The surveyor observed that the resident was still on the same [redacted] flat sheet but now had two disposable incontinent pads placed on top of the soiled sheets.

The next day on 2/6/2020 at 9:18 AM, the surveyor entered the [redacted] Floor unit via the stairwell. Upon entering the unit, the surveyor noted a [redacted] in the hallway by the stairwell. The surveyor then knocked and entered the room of Resident #2. The surveyor noted a [redacted] was in the resident's room. The surveyor observed Resident #2 moving around in the bed on a flat sheet, the movement caused the flat sheet to expose 50% of the blue mattress and the resident was in direct contact with the mattress. The flat sheet under the resident was [redacted] with a new, [redacted]. The resident again denied that he/she was [redacted] and again denied that he/she needed assistance.

The surveyor reviewed the medical record for Resident #2.

A review of the Admission Record face sheet (an admission summary) reflected that the resident

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was admitted to the facility with diagnoses which included [redacted]

A review of the most recent quarterly Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, dated [redacted] reflected that the resident had a brief interview for mental status score of [redacted] indicating a [redacted] The assessment reflected that the resident was [redacted]). The MDS indicated that the resident had not exhibited behaviors of rejecting care in the last seven days.

A review of the resident's individualized care plan dated 1/8/2020 reflected that the resident had a performance deficit in activities of daily living (ADL) due to [redacted]. Interventions included that the resident required extensive hands-on assistance with personal hygiene and toileting related to incontinence. The care plan also included that Resident #2 had a history of being resistive/refusing care. Interventions included that if [Resident #2] resists any type of care, reassure the resident, leave and try again in 5-10 minutes. If possible, negotiate a time to engage in the resident's decision-making process and return at that agreed upon time. Interventions on the care plan further included for nursing to monitor/record/report to the physician as needed any mood patterns of depression, anxiety, sad mood as per facility behavior monitoring protocols.

The care plan dated 1/8/2020 further reflected

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F 684	Continued From page 15 that the resident had [redacted] [redacted] Interventions included to clean the [redacted] episode, check resident as required for [redacted], change clothing as needed after [redacted] episodes, and an intervention dated 10/27/19 that the resident was to be provided with well protective under garments to avoid soiling and maintain dignity. The care plan did not address the resident's specific type of [redacted] and the frequency of that [redacted]. A review of the Bowel and Bladder Assessment dated 1/14/2020 reflected that the resident was usually aware of the need to toilet, but was very [redacted] [redacted]. It further reflected that the resident never voids appropriately without [redacted], and the resident's skin was intact. The assessment score indicated that the resident was a candidate for timed/scheduled toileting. A review of a Monthly Summary within the electronic Progress Notes (ePN) dated 1/23/2020 at 11:39 reflected that Resident #2 had periods of resistance with hygiene care in which staff had to give the resident time and then return to provide care, and that the resident was followed by [redacted] A review of a Behavior Note dated 1/28/2020 at 3:24 AM reflected that the resident "refuses hygiene care in AM easily redirected." There was no documented evidence within the ePN's that reflected the resident was resisting care that would have impacted the ability of staff	F 684		

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to perform [redacted] care that corresponded with the observation on 2/5/2020 and 2/6/2020.

A review of the Psychoactive Medication Monitoring sheet for February 2020 used for the monitoring of behaviors, was blank, and did not reflect that the resident was exhibiting any behaviors of resisting care or if the [redacted] episodes were a behavior or the [redacted] [redacted]

On 2/10/2020 at approximately 9:50 AM, the third surveyor entered the [redacted] floor via the stair well and noted a faint [redacted] immediately upon entering the unit.

On 2/12/2020 at 9:26 AM, the surveyor observed Resident #2 in bed on a clean flat sheet. There was no draw sheet or disposable [redacted] pad under the resident. There was [redacted] of [redacted] at that time.

At 9:28 AM, the surveyor interviewed the CNA assigned to Resident #2 that day. The CNA stated that she floats between the units but that she was very familiar with Resident #2. The CNA stated that the resident had moments of confusion and exhibited behaviors that included not wanting to be touched and will sometimes scream. The CNA stated that when the resident doesn't want to be touched, she and other staff will just try to talk to the resident or come back at another time. She added that if the resident still refuses she will let the nurse know of the resident's refusals to accept care. She stated that the resident was "more often than not" compliant with care for her. The CNA continued to explain that the resident liked to spend the morning shift in bed and that he/she usually got

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up later in the afternoon and walked independently in their room and hallways. The CNA added that the resident was a [redacted] [redacted] but his/her skin was fully intact. The surveyor asked what a "[redacted]" meant, and the CNA stated that the resident would produce a [redacted] with each [redacted] episode and that it would often go all the way through to the sheets. She stated that she would have to clean the mattress with a bleach wipe when that happens, then replace the sheets and provide [redacted] care. She stated the key was to change the resident quickly after that happens. She was unable to give a timeframe as to how often residents were checked for [redacted]. She was unsure whether the resident's [redacted] was a behavior issue or if it was an inability to [redacted] [redacted]. The CNA also added when changing a resident's [redacted] brief, it would be placed in a clear plastic bag and tied. She stated it would be immediately discarded and brought to the soiled utility room. She could not speak to a circumstance in which a soiled [redacted] would be left at the bedside and not bagged and discarded after care was provided.

At 9:37 AM, the surveyor interviewed the LPN who stated that Resident #2 was confused and prefers to stay in bed during the day shift. She stated that the resident was more active during the evening shift and would independently walk around the unit and down to the vending machines for snacks. She stated that the resident would usually eat dinner in the day room. The LPN stated that the resident refuses care sometimes, but when informed of this by the CNA, the LPN will approach the resident who then would easily be redirected to comply. The

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LPN stated that the resident lets her do what she needs to do. The LPN denied an awareness of a [redacted] in the resident's room but stated that the resident was a [redacted] The surveyor asked what that meant, and the LPN stated that a [redacted] meant a resident had frequent [redacted] episodes. The LPN was stated that the resident's behaviors included refusing care but that he/she had not had any of those behaviors recently. She stated behaviors of refusing care should be documented in the progress notes. She was unsure about the cause of the resident's [redacted]. The surveyor asked how [redacted] briefs were handled, and the LPN stated that [redacted] briefs were to be discarded in a clear plastic bag and immediately removed from the room. The LPN confirmed they should not be left at the bedside for any length of time after care was performed.

At 9:41 AM, the surveyor interviewed the Registered Nurse/Unit Manager (RN/UM). The RN/UM stated that the resident required partial assistance with care, but was able to self toilet as well. She stated that the resident usually used the toilet during the evening shifts when he/she was up and out of bed as was his/her customary routine. The RN/UM stated that the resident's target behaviors included resistance to care and was followed by the Psychologist. The RN/UM stated that the resident was "easily persuaded" to do what was necessary regarding care. The surveyor asked the RN/UM what "heavy wetter" meant, and she stated it was a term used if when a resident has an [redacted] episode and the [redacted] goes through the [redacted]. She indicated that Resident #2 would [redacted] through an [redacted] with a single void. The surveyor

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asked about the care of residents who would often [redacted] through an [redacted], the RN/UM was unable to speak to what would be done differently. The surveyor asked how often rounds were done, and the RN/UM stated that the CNA's do their rounds in the morning, and then when they are done with morning care, they round again. The surveyor asked if there was a frequency as to how often rounding takes place, and the RN/UM stated there was no specific frequency. At that time the LPN stated to the surveyor and the RN/UM that the CNA's handle the rounding and they know what to do and they do it. Neither the RN/UM or LPN could speak to how often rounding was done for residents who were identified to be residents that would [redacted] through [redacted] briefs with each [redacted] episode.

The RN/UM denied being aware of a [redacted] in any resident room in the past. The RN/UM stated that all behaviors of refusing to be cleaned would be documented in the resident's ePN or the behavior monitoring sheets. She acknowledged that [redacted], soiled sheets/garments should be removed once the resident was identified to be soiled. The RN/UM confirmed that Resident #2 was continent during the evening shift and toileted self independently when he/she chose to be out of bed, but could not speak to during the day shift if the resident's episodes of [redacted] were from the inability to [redacted] or a behavior issue. She was unable to provide the surveyor with documentation addressing the resident's [redacted] or notes from [redacted] addressing the incontinence.

On 2/12/2020 at 10:42 AM, the surveyor

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attempted to conduct a telephone interview with the responsible party for Resident #2 in the presence of the survey team. The responsible party did not respond to the telephone call.

On 2/13/2020 at 11:14 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) in the presence of the survey team. The LNHA stated that the resident's room was made clean and acknowledged that that CNA staff should not have left the [redacted] and [redacted] on the resident's bed side table. The LNHA added that the term [redacted]" was not an acceptable description of their residents and that Resident #2 should be checked for [redacted] episodes every one hour due to [redacted], and that this was done to protect the resident, for infection control purposes and to prevent the [redacted] in the room from occurring. Neither the DON nor the LNHA were able to speak to if the [redacted] episodes were from a behavior issue or an inability to [redacted]. The LNHA acknowledged that it had not been appropriately assessed and determined yet. The facility was unable to provide documented evidence of the resident's behaviors of refusing care during the observations made on 2/5/2020 and 2/6/2020.

A review of the facility's [redacted] Care policy reviewed 11/2019 included that [redacted] residents are checked every two hours to ensure they are dry. "For [redacted] [redacted] residents, resident is changed as often as needed. If a resident refuses [redacted] care or clothes changed, staff should be notified and the interdisciplinary team will try to use whatever interventions are necessary to

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encourage the resident to allow provision of [redacted] care..."

A review of the facility's undated Behavior Monitoring policy included, "At a minimum, the following points must be covered in the note written...what specific behavior does the resident exhibit." It further included that the key point was that if the resident, "exhibits any behaviors at any time, episodic charting must be done at that time."

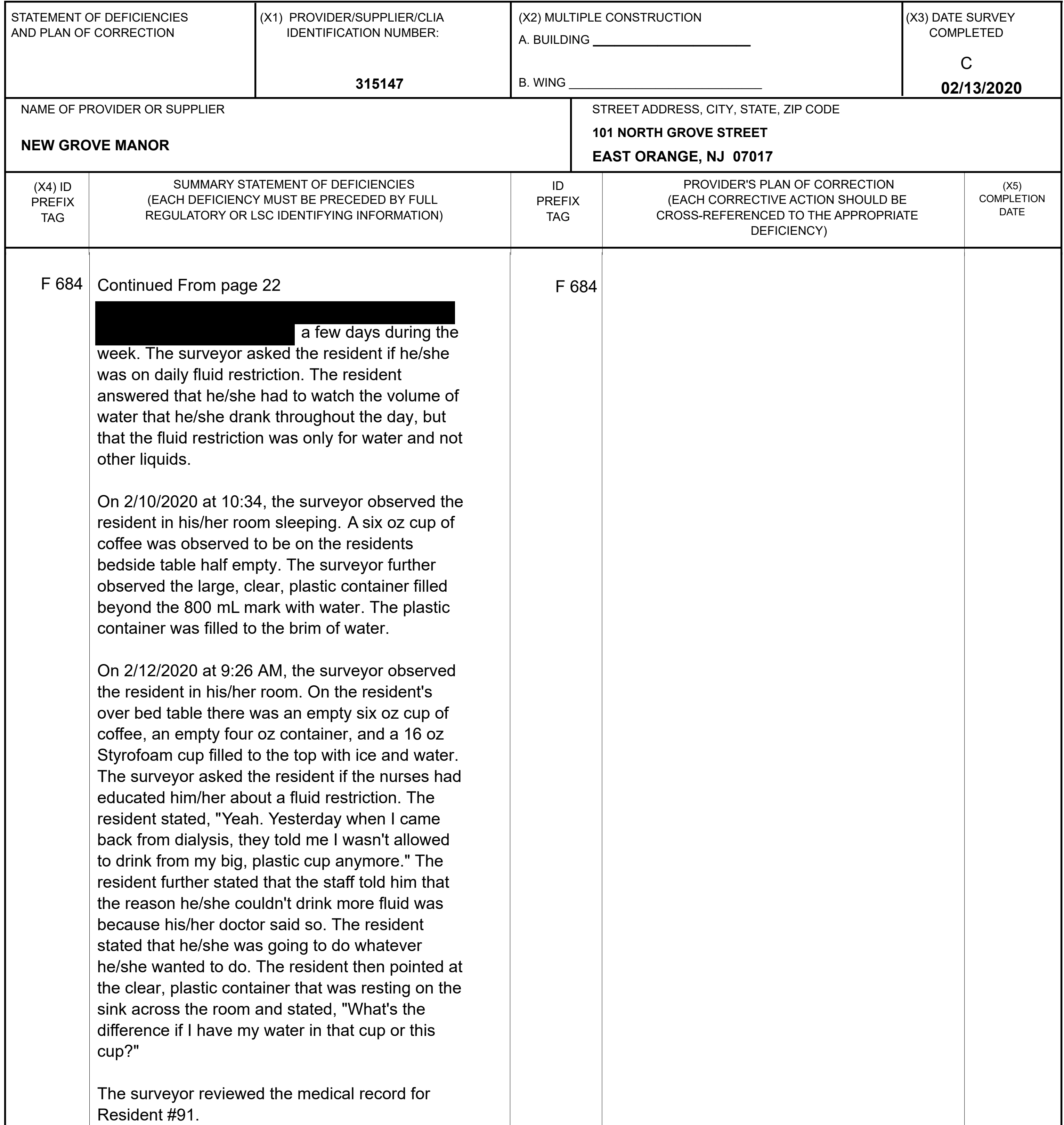
2. On 2/5/2020 at 11:03 AM, the surveyor observed Resident #91 in bed with his/her eyes closed. The surveyor observed the following liquids in the resident's space:

a.) a large clear, empty plastic drinking container with measurement markings used to indicate the volume of fluid occupied in the container.
b.) a four ounce (oz) [redacted]
c.) a 16 oz (480 milliliters) (mL) Styrofoam cup filled with water on the over bed table in the resident's room.

On 2/10/2020 at 9:25 AM, the surveyor observed the resident awake and sitting in bed. The surveyor observed the following liquids in the resident's space:

a.) The large clear, plastic drinking container filled with 100 mL of water.
b.) six oz cup of coffee full and on the resident's over bed table.

At that time, the surveyor conducted an interview with the resident who stated that he/she was doing, "OK" and went to the [redacted] center



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[redacted] a few days during the week. The surveyor asked the resident if he/she was on daily fluid restriction. The resident answered that he/she had to watch the volume of water that he/she drank throughout the day, but that the fluid restriction was only for water and not other liquids.

On 2/10/2020 at 10:34, the surveyor observed the resident in his/her room sleeping. A six oz cup of coffee was observed to be on the residents bedside table half empty. The surveyor further observed the large, clear, plastic container filled beyond the 800 mL mark with water. The plastic container was filled to the brim of water.

On 2/12/2020 at 9:26 AM, the surveyor observed the resident in his/her room. On the resident's over bed table there was an empty six oz cup of coffee, an empty four oz container, and a 16 oz Styrofoam cup filled to the top with ice and water. The surveyor asked the resident if the nurses had educated him/her about a fluid restriction. The resident stated, "Yeah. Yesterday when I came back from dialysis, they told me I wasn't allowed to drink from my big, plastic cup anymore." The resident further stated that the staff told him that the reason he/she couldn't drink more fluid was because his/her doctor said so. The resident stated that he/she was going to do whatever he/she wanted to do. The resident then pointed at the clear, plastic container that was resting on the sink across the room and stated, "What's the difference if I have my water in that cup or this cup?"

The surveyor reviewed the medical record for Resident #91.

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A review of the Admission Record face sheet reflected that the resident had diagnoses which included

A review of the resident's most recent significant change MDS dated reflected that the resident had a BIMS score of

A review of the resident's individualized comprehensive care plan dated 12/16/19 reflected a focus area that the resident had impaired behaviors manifested by resistance and refusal of showering, care, treatments, and refusing weights. The goal of the care plan reflected for the resident to be cooperative with care and treatment through the next review date. The care plan interventions included to document efforts at encouraging appropriate cares, treatments, and compliance.

A further review of the care plan revised on 2/5/2020 reflected a focus area that the resident had potential for nutritional problem due to diet and a 1200 mL daily fluid restriction. The goal of the care plan reflected that the resident would comply with recommended diet daily through review date. The care plan interventions included to provide and serve diet as ordered to promote adequate hydration with nutrition per RD recommendations and the physician's order.

A review of the resident's progress notes dated 1/8/2020 reflected a note written by the Registered Dietician (RD) which indicated that the

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resident was recently re-admitted to the facility and placed a 1200 mL/day fluid restriction. The note indicated that the resident had been known to drink large amounts of coffee during the day. The note further reflected that the RD would follow-up to educate the resident on the fluid restriction.

A review of February 2020 Physician Order Sheet (POS) reflected an undated physician's order for a daily fluid restriction of 1200 mL/day on hemodialysis days Tuesday, Thursday, and Saturday.

The dietary department will provide fluids as follows:

Breakfast = 360 mL,
Lunch = 0 mL,
Dinner = 360 mL,
Snack 120 mL.
Total mL's for meals: 840 mL.

Additional fluids to be provided by nursing with medications:
7:00 AM - 3:00 PM shift = 120 mL,
3:00 PM - 11:00 PM shift =120 mL,
11:00 PM - 7:00 AM shift =120 mL.
Total mL's with medication to equal 360 mL.

A further review of the February 2020 POS reflected an undated physicians order for fluid restriction 1200 mL/day on non-hemodialysis days on Monday, Wednesday, Friday, and Sunday.

The dietary department will provide fluids as follows:
Breakfast = 360 mL,

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Lunch = 120 mL,
Dinner = 360 mL.
Total mL's for meals: 840 mL.

Additional fluids to be provided by nursing with medications:
7:00 AM - 3:00 PM shift = 120 mL,
3:00 PM - 11:00 PM shift =120 mL,
11:00 PM - 7:00 AM shift =120 mL.
Total mL's with medication to equal 360 mL.

A review of the February 2020 Medication Administration Record (MAR) reflected that the nurses were signing that the resident was receiving the ordered volume of fluids and compliant with the dietary and nursing fluid restrictions for meals during each shift on [redacted] days and on [redacted] days.

A complete review of the resident's progress notes did not reflect that the resident was non-compliant with his/her fluid restriction or had received the education on the daily fluid restriction.

On 2/12/2020 at 9:39 AM, the surveyor interviewed the resident's regularly assigned day shift Certified Nursing Aide (CNA) who stated that the resident was alert and oriented and could make his/her needs known. The CNA stated that the resident was compliant with care and the CNA gave the example that this morning he had told the resident that he was going to wash the resident and the resident allowed it. The surveyor asked the CNA if the resident was on a fluid restriction. The CNA stated that recently we have had to watch the volume of liquids the resident drank. The CNA gave the example that the

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resident's coffee cup would only come half full of coffee and before it used to be full. The surveyor asked the CNA if the staff had to monitor the volume of water the resident drank. The CNA stated that the resident could have as much water as he/she wanted and that there was no restriction on water.

On 2/12/2020 at 9:44 AM, the surveyor interviewed the resident's LPN who stated that the resident was alert and oriented and could verbalize his/her needs. The LPN stated that the resident had been more compliant with care since his/her recent re-admission to the facility. The LPN stated that when the resident had returned to the facility, the resident came back to the facility on a fluid restriction. The LPN told the surveyor that the fluid restriction was broken down between the dietary and nursing departments, and that the volume of fluid that the resident drank was recorded in the MAR and monitored by staff. The LPN stated that the resident was compliant with the fluid restriction of the liquid that was provided to him/her by the dietary staff, but she was unsure what would happen if the resident ordered take-out food. The LPN stated that the resident never voiced concerns to her about being on the fluid restriction. The LPN stated that the staff was responsible for following the physician's order related to the fluid restriction and if the resident was non-compliant with the fluid restriction, she would notify the RD, [redacted] center, social worker, and resident's doctor immediately. The LPN stated, "the whole intention would be to try and educate the resident on the need for the fluid restriction."

On 2/12/2020 at 12:36 PM, the surveyor

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F 684	Continued From page 27 interviewed the RD who stated that she was in communication with the RD at the [redacted] center and the RD at the [redacted] center had educated the resident on the importance of the fluid restriction. The RD further stated that the nursing department had never communicated to her that the resident had been non-compliant with the fluid restriction and it was the nurse's job to make sure that the physician's order was followed. The RD stated that she was unaware if the CNA staff were educated about the resident being on a fluid restriction. On 2/13/2020 at 10:51 AM, the Licensed Nursing Home Administrator (LNHA) in the presence of the DON and the survey team stated that the resident's CNA was not aware that the resident was on a fluid restriction. The LNHA acknowledged that the CNA's did not have access to the care plans which were on the computer, and that there was no care plan or kardex for CNAs to know how to care for each resident, since they went computerized in November 2019. He confirmed the care plans had not been printed and available for CNAs in the mean time. He could not speak to how shift to shift report with the CNAs was communicated. He acknowledged that there was no documented evidence of the resident's noncompliance with the fluid restriction or that the physician had been notified that the resident was noncompliant. He confirmed it should have been done and documented. A review of the facility's Fluid Restriction Policy and Procedure revised on 1/2020 included that, "4. The Nursing Services will be responsible for tracking and documenting the total volume consumed in accordance with facility policy."	F 684		

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F 684	Continued From page 28 NJAC 8:39-27.1(a)	F 684		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. 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: a.) maintain kitchen equipment to prevent microbial growth and b.) air dry kitchen equipment and resident dining trays in a manner to prevent microbial growth. This was evidenced by the following: On 2/5/2020 at 10:05 AM, the surveyor toured the kitchen with the Food Service Director (FSD) and observed the following:	F 812	I. CORRECTIVE ACTION Kitchen equipment that were wet nested were washed and air-dried separately. Kitchen equipment that was pitted and discolored were removed and discarded. II. IDENTIFY OTHER INSTANCES All residents have the potential to be	2/28/20

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F 812	Continued From page 29 1. On the cutting board rack, there were eight large cutting boards stacked and wet nested with water in between them. The FSD confirmed that the cutting boards should have been completely dried before stacking and being put away. 2. There were four large cutting boards (two red and two blue in color) and one small blue cutting board located on the cutting board rack. The cutting boards were deeply pitted and discolored throughout the surfaces. The FSD stated that the cutting boards were replaced on an as needed basis and acknowledged that these cutting boards needed to be replaced. 3. On the drying rack, there were eighteen half deep hotel pans stacked and wet nested with water in between them. 4. On the cook's preparation work top, there was one large white cutting board in use. The cutting board was deeply pitted and discolored throughout the surface. 5. In the Cultural Kitchen, there were two stacks of resident dining trays (one stack of red trays and one stack of blue trays). There was a stack of red dining trays, and the surveyor observed the top nineteen trays were wet nested with water between them. The FSD acknowledged that staff needed to be in-serviced on appropriately drying kitchen equipment before stacking. At approximately 10:30 AM that day, the surveyor interviewed the FSD who stated that the wet nested trays were there, because the dish washing machine needed repair that morning so it was currently out of order. The FSD indicated that the trays had been cleaned and stored in that	F 812	affected. III. SYSTEMIC CHANGE Kitchen staff were in-serviced on how to appropriately dry kitchen equipment. FSD designated separate labeled racks for drying and for storage of dry kitchen equipment. QAPI was initiated for the aforementioned concerns. FSD counseled on maintenance, drying , & storage of kitchen equipment to prevent microbial growth IV. MONITOR CORRECTIVE ACTION Daily inspections by the FSD inspects for proper drying and equipment viability. Weekly inspections by the Administrator. Bi-Monthly inspections by the Regional Registered Dietitian(RD). Findings will be presented at the quarterly QA meeting.	

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F 812	Continued From page 30 manner prior to the machine going out of order that morning. The FSD acknowledged that they would have used them that day but instead they would be serving residents using single use, disposable trays and not the wet nested trays. On 2/11/2020 at 12:57 PM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) in the presence of the Director of Nursing, Chief Nursing Officer, and the survey team. The LNHA acknowledged that the kitchen staff were wet nesting kitchen equipment. The LNHA stated that the staff were in-serviced on how to appropriately dry kitchen equipment and going further the kitchen had designated racks for drying and storage of kitchen equipment. The LNHA stated that all cutting boards identified were disposed of and replaced with new cutting boards. The surveyor reviewed the facility's Drying Kitchen Utensil/Pot & Pans policy dated reviewed 7/2019, which included after items were sanitized, they were placed on a wire rack to be air dried. Items were stacked in a manner to prevent wet nesting or pooling of water. NJAC 8:39-17.2(g)	F 812		
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.	F 880		2/28/20

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§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
(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

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F 880	Continued From page 32 disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to dispose of a soiled incontinent brief in a manner consistent with infection control practices. This deficient practice was identified for 1 of 4 residents reviewed for urinary incontinence (Resident #2). The evidence was as follows: On 2/5/2020 at 10:44 AM, the surveyor observed Resident #2 in bed. The resident's bedside table was free of visible contaminants at that time. The surveyor attempted to interview Resident #2 but the resident would only answer yes or no questions. The resident denied that he/she was currently soiled and denied needing assistance with [redacted] care. At 12:12 PM, the surveyor returned to the resident's room and observed Resident #2 in bed.	F 880	I. CORRECTIVE ACTION: Assigned CNA was disciplined/counseled for failure to appropriately dispose of a soiled incontinence brief. II. IDENTIFY OTHER INSTANCES: All residents on have the potential to be affected. III. SYSTEMIC CHANGE: Policy was updated to include procedure for post-handling of s[redacted] All CNAs were in-serviced on how to	

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F 880	Continued From page 33 The resident was under a top sheet, but the resident was positioned in bed in a manner exposing his/her [redacted] brief. The [redacted] brief appeared to be dry and free of visible evidence of [redacted]. The surveyor now observed laying directly on the resident's bedside table was a [redacted] brief not bagged and exposed to the air. There were no facility staff present in the room. At 12:35 PM, the surveyor returned to the resident's room and observed that the [redacted] brief was still in direct contact with the resident's bedside table, not bagged and exposed to the air. The resident was still in the same position as observed at 12:12 PM. There were no staff present in the resident's room. At 1:03 PM, the surveyor observed a lunch tray now positioned on the resident's bedside table directly where the [redacted] was previously located, and the [redacted] was no longer in the resident's room. On 2/12/2020 at 9:28 AM, the surveyor interviewed the resident's assigned Certified Nursing Aide (CNA). The CNA stated that the resident had moments of confusion, and was [redacted] during her shift. The CNA continued to add that when changing a resident's [redacted], it would be placed in a clear plastic bag and tied. She stated it would be immediately discarded and brought to the soiled utility room. She could not speak to a circumstance in which a [redacted] would be left at the bedside and not bagged and discarded after care was provided. At 9:37 AM, the surveyor interviewed the	F 880	appropriately dispose of [redacted] IV. MONITOR CORRECTIVE ACTION: For the next three months, Assistant Director of Nursing(ADON) or designee will conduct weekly random room checks to ensure proper procedure of [redacted] care. Results will be reviewed at the quarterly QA meeting.	

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Licensed Practical Nurse (LPN) who stated that Resident #2 was able to make his/her needs known but was confused and preferred to stay in bed during the day shift. The surveyor asked how [redacted] were handled, and the LPN stated that [redacted] were to be discarded in a clear plastic bag and immediately removed from the room. The LPN confirmed they should not be left at the bedside for any length of time after care was performed.

At 9:41 AM, the surveyor interviewed the Registered Nurse /Unit Manager (RN/UM). The RN/UM stated that the resident required partial assistance with care, but that he/she was able to independently use the toilet during the evening shift when he/she was up. The surveyor inquired about how [redacted] were handled, and the RN/UM stated that they get placed in a clear plastic bag and discarded right away in the trash. The RN/UM confirmed there would never be a time that it should be left on a bed side table. The RN/UM could not speak to the surveyor's observation on 2/5/2020 beginning from 12:12 PM.

On 2/13/2020 at 11:14 AM, the surveyor interviewed the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) in the presence of the survey team. The LNHA stated that the resident's room was made clean and acknowledged that the CNA staff should not have left the [redacted] on the resident's bed side table for any reason. The LNHA acknowledged that [redacted] were to be discarded right away to prevent the [redacted] and for infection control purposes.

A review of the facility's Urinary Incontinence

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Care policy reviewed 11/2019 included that [redacted] residents are checked every two hours to ensure they are dry. The policy did not address the post-handling of [redacted] [redacted]

A review of the facility's updated Patient Care Policy Manual for Housekeeping included that for infection control practices, "All necessary housekeeping and maintenance services are provided to maintain sanitary and comfortable environment, and to help prevent the development and transmission of infections... Resident areas: Cleanse articles soiled with moist body substances as soon as possible." Under the Space and Environment for Sanitation and Waste Management section, included, "Plastic bags are used for solid waste removal from resident care units and supporting departments. Bags are of sufficient strength to safely contain waste from point of origin to point of disposal and are effectively closed prior to disposal."

A review of the facility's Infection Control Guidelines for All Nursing Procedures revised 7/2019, included that "Standard precautions will be used in the care of all residents in all situations regardless of suspected or confirmed presence of infectious diseases. Standard precautions apply to blood, body fluids, secretions, and excretions regardless of whether or not they contain visible blood, non-intact skin, and/or mucous membranes."

According to the Centers for Disease Control and Prevention's (CDC) Guidelines for Environmental Infection Control in Health-Care Facilities updated July 2019 included that care for organic waste "requires gloves and the use of leak-resistant

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F 880	Continued From page 36 plastic bags to discard absorbent material used in the process. The area must be cleaned after visits according to standard cleaning procedures...Barrier protection of surfaces and equipment is useful, especially if these surfaces are a.) touched frequently by gloved hands during the delivery of patient care, b.) likely to become contaminated with body substances..." NJAC 8:39-19.1	F 880		