STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315414	A. BUILDING ______ B. WING ______	06/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARDELL GARDENS AT TINTON FALLS	**524 WARDELL ROAD TINTON FALLS, NJ 07753**

(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: 56 SAMPLE SIZE: 19 + 3 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 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: a.) assess and obtain a physician's order (PO) for the self-administration of oxygen; b.) label, date, and initial oxygen tubing c.) Care Plan for the self-administration of oxygen and d.) ensure oxygen tubing, equipment, and Executive Order masks were stored in accordance to professional standards of practice. This deficient practice was identified for 1 of 3 residents reviewed for Executive Order 26, 4.b. (Resident #13) and was evidenced by the following. On 6/8/21 at 11:04 AM, the surveyor observed Resident #13 sitting in his/her room. The resident	F 695	1. The Executive Order 26, 4.b. for resident #13 was cleaned. The Executive Order 26, 4.b. was replaced and was labeled and dated and is being stored in a plastic bag when not in use. Resident #13 was assessed by the Interdisciplinary team and was deemed capable of self-administrating oxygen and Executive Order therapy. Resident was educated on the proper procedure to self-administer oxygen and Executive Order therapy including appropriate storage of both items. Resident #13 was capable of performing successful return demonstration on both therapies. A physician order was obtained	7/14/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 06/21/2021

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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Continued From page 1

was receiving Executive Order 26, 4.b. (Executive Order 26, 4.b.
Executive Order 26, 4.b.
connected to an Executive Order 26, 4.b. Executive Order 26, 4.b.
set at Executive Order 26, 4.b.
). The surveyor also observed a Executive Order 26, 4.b.
Executive Order 26, 4.b.
that was not in use with an uncovered mask and tubing connected to the machine and placed in a drawer ontop of clear plastic bags. The Executive Order 26, 4.b. was observed to be soiled with brownish spots. The resident stated that he/she Executive Order 26, 4.b.
he surveyor observed an opened gallon of distilled water next to the Executive Order 26, 4.b. Executive Order 26, 4.b., which the resident stated that he/she used that water to Executive Order 26, 4.b.. When asked, the resident stated that he/she knew how to use the Executive Order 26, 4.b. and Executive Order 26, 4.b. so staff did not assist him/her.

The surveyor reviewed the medical record for Resident #13.

According to the Admission Record, the resident was admitted Executive Order 26, 4.b.

A review of the most recent quarterly Executive Order 26, 4.b. Executive Order 26, 4.b. an assessment tool dated Executive Order 26, 4.b., reflected that the resident had a Brief

F 695

for both Executive Order 26, 4.b. and Executive Order 26, 4.b. for resident Executive Order 26, 4.b. for self-administration and residents care plan has been updated.
2. All residents that are on Executive Order 26, 4.b. have the potential of being affected by this practice. The Interdisciplinary team will review those residents to determine if any of those residents are capable of self-administering Executive Order 26, 4.b..
3. Nursing Staff have been in-serviced on identifying and notifying the Interdisciplinary of residents that are showing safety competency of self-administration of Executive Order 26, 4.b.. Nursing staff have been in-serviced on appropriate storage of Executive Order 26, 4.b. in plastic bags when not in use. Nurses was also educated on the cleaning of Executive Order 26, 4.b. Executive Order 26, 4.b. and canisters as per facility policy. Nursing staff were also in-serviced on checking all residents on Executive Order 26, 4.b. ensuring residents is receiving the appropriate Executive Order 26, 4.b. flow rate as per physician order.
4. The DON/designee will be checking all residents that are using oxygen and Executive Order 26, 4.b. for appropriate Executive Order 26, 4.b. and oxygen tubing storage, when not in use and for cleanliness of the Executive Order 26, 4.b. Executive Order 26, 4.b.
The DON/designee will audit residents receiving Executive Order 26, 4.b. to ensure that they are receiving the appropriate flow rate as per physicians order. Nurses will also be checking oxygen flow rate as ordered for all residents on oxygen therapy as written on the Physician Order Sheet (POS) and Treatment Administration Record (TAR) assuring that

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F 695	Continued From page 2 Executive Order 26, 4.b. A review of the Physician's Order sheet dated Executive Order reflected a PO for Executive Order 26, 4.b. Executive Order 26, 4.b. An additional order included to Executive Order 26, 4.b. There was an additional PO for Executive Order 2 Executive Order 26, 4.b. Execu Executive Order 26, 4.b. There was no indication in these orders that the resident Executive Order 26, 4.b. A review of the individualized Care Plan (CP) included a focused area dated Executive Order 26, 4.b. and last revised on Executive Order 26 that I have Executive Order 26, 4.b. Executive Order 26, 4.b. ncourage the Executive Order 26, 4.b. and Executive Order at night as I am non-compliant at times; give medications as ordered by physician; monitor for signs and symptoms of respiratory distress and report to physician as needed; and oxygen setting via NC as ordered. The CP did not reflect self-administration of oxygen. A review of the Interdisciplinary Progress Notes included a Nurse's Notes (NN) dated Executive Order which reflected that the resident was Executive Order 26, 4.b. A review of an additional NN dated Executive Order reflected that the resident stayed in his/her room all shift on Executive Order 26, 4.b.	F 695	the appropriate flow rate are being self-administered and that the nurses are signing the TAR for Oxygen therapy per facility policy. These audits will be done weekly for the first 4 weeks and then monthly for the next 3 months. The Interdisciplinary team will review all residents on oxygen therapy by their scheduled care plan meetings to determine if the resident is able to self-administer oxygen therapy safely. The results of these audits will be shared with the Quality Assurance team at the Monthly and quarterly meetings which will make further recommendations based on the results of the audits.	

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F 695	Continued From page 3	F 695		

On 06/09/21 at 09:24 AM, the surveyor observed the resident in their room being administered Executive Order 26, 4.b. The Executive Order 26, 4.b. was observed soiled still with the same brownish spots and the Executive Order mask and tubing was observed uncovered on top of an opened drawer.

On 06/09/21 at 10:00 AM, the surveyor observed the resident by nurse's station with a Executive Order 26 Executive Order 26, 4.b. . At this time, the resident's Physician approached and asked if he/she were using their Executive Order machine every night. The resident verified yes, and the Physician stated that it was good because he/she needed to wear it daily.

On 06/10/21 at 09:05 AM, the surveyor interviewed the Director of Nursing (DON) who stated that the facility currently had no residents who were self-administering any medications. The DON stated that prior to any resident self-administering medications, they would have to be assessed to make sure competent enough, a PO indicating self-administration of medication would be obtained, medication would be stored in a locked closet, and staff would continue sign the Medication Administration Record (MAR) or Treatment Administration Record (TAR) since the nurses were still required to monitor the administration. At this time, the DON confirmed when asked that no one was administering their own oxygen, nebulizer, or Executive Order treatments.

On 06/10/21 at 10:32 AM, the surveyor observed the resident self-propelling down hallway from their room towards nurse's station. The resident was being administered Executive Order 26 via the Executiv from a Executive Order 26, 4.b. . At this time, the surveyor

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F 695	Continued From page 4 walked past the resident's room and heard a hissing sound. On 6/10/21 at 10:35 AM, the surveyor accompanied by the Licensed Practical Nurse (LPN #1) entered Resident #13's room and observed the Executive Order 26, 4.b. attached to the Executive Order 26, 4.b. unbagged and undated laying directly on the floor and that the Executive Order 2 Executive Order 26, 4.b. was still on. At this time LPN #1 turned off the Executive Order 26, 4.b.; confirmed that the Executive Order 26, 4.b. should be labeled, dated, and placed in a bag; and discarded the Executive Order 2 Executive Orde. At this time, the surveyor pointed out the soiled Executive Order 26, 4.b. to LPN #1 who stated that the stains were probably coffee and needed to be cleaned off by the nurse. LPN #1 also confirmed that the Executive Orde mask should be stored in a bag. When questioned why the Executive Order 2 was still on and who put the Executive Order 26. Executive Order 2 on the resident, LPN #1 stated that there was another LPN (LPN #2) who was here this morning and left the facility around 10:00 AM who probably put the Executive Order 2 on the resident. LPN #1 stated that the resident was non-compliant with care at times and tried to administer their own oxygen and Executive Orde treatments. On 6/10/21 at 10:45 AM, the surveyor and LPN #1 joined the resident by the Executive Order 26, 4.b.. The resident at this time informed them that he/she had removed themselves from and turned off the Executive Order 26, 4.b. and placed themselves on the Executive Order 26, 4.b.. At this time, LPN #1 confirmed that the Executive Order 2 was being Executive Order 26, 4.b. at Executive Ord instead of the ordered Executive Orde The resident stated that he/she increased the Executive Order 2 flow since the tank felt empty. Upon questioning, the resident stated that	F 695		

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F 695	Continued From page 5 he/she administered their own Executive Order 2 and Executive Order machine treatments and they were educated on how to do this by the nurse. The resident stated that he/she does not recall signing anything to administer their own Executive Order 26 and denied ever being told that the Executive Order 26, 4.b. needed to be stored in bags. The resident stated that he/she tried to make sure only that the Executive Order 26, 4.b. Executive Orde were not on the floor. When the resident was asked who cleaned their Executive Order 2 Executive Order 26, 4.b. and when it was cleaned, the resident stated that they were unaware of the answer. On 6/10/21 at 10:59 AM, LPN #1 checked the resident's Executive Order 26, 4.b.) which was Executive Order 26, 4.b.). At this time LPN #1 informed the resident that he would change the Executive Order 26, 4.b. and set the Executive Order 26, 4.b. Executive Order 26, 4 On 6/11/21 at 9:18 AM, the surveyor interviewed the DON in the presence of the Licensed Nursing Home Administrator (LNHA) who stated that the nurses cleaned the Executive Order 26, 4.b. and Executive Order 26, 4.b. with germicidal wipes; Executive Order 2 Executive Orde was stored in a plastic bag when not in use, changed weekly with a label indicating date and initials of who changed it; and Executive Orde masks were store in plastic bags when not in use. The DON stated that residents were not permitted to change from Executive Order 26, 4.b. to Executive Order 2 tank without being assessed and a PO to self-administer Executive Order 26 At this time, the surveyor informed the DON and LNHA of their observation of Resident #13. A review of the facility's Self Administration of	F 695		

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F 695	Continued From page 6 Medication policy dated 12/2020 and revised 2/21 included that when the resident expressed the desire to self-administer medications, the Interdisciplinary Team evaluate to determine if the criteria for self-administration is met. If the resident is permitted to self-administer medications, the PO will reflect that resident may self-administer medications. A review of the facility's Oxygen Administration policy dated 4/2/2020 and revised 10/2020 included that oxygen will be administered per physician's order to aid in breathing. The policy also included to date and initial tubing and humidifiers when started each week and to clean oxygen tank daily with germicidal wipes. NJAC 8:39-11.2(b); 27.1(a)	F 695		
F 836 SS=D	License/Comply w/ Fed/State/Locl Law/Prof Std CFR(s): 483.70(a)-(c) §483.70(a) Licensure. A facility must be licensed under applicable State and local law. §483.70(b) Compliance with Federal, State, and Local Laws and Professional Standards. The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. §483.70(c) Relationship to Other HHS Regulations. In addition to compliance with the regulations set forth in this subpart, facilities are obliged to meet	F 836		7/14/21

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F 836	Continued From page 7 the applicable provisions of other HHS regulations, including but not limited to those pertaining to nondiscrimination on the basis of race, color, or national origin (45 CFR part 80); nondiscrimination on the basis of disability (45 CFR part 84); nondiscrimination on the basis of age (45 CFR part 91); nondiscrimination on the basis of race, color, national origin, sex, age, or disability (45 CFR part 92); protection of human subjects of research (45 CFR part 46); and fraud and abuse (42 CFR part 455) and protection of individually identifiable health information (45 CFR parts 160 and 164). Violations of such other provisions may result in a finding of non-compliance with this paragraph. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of facility provided documentation, 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 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	F 836	F836 1. The facility will staff the nursing units as per state guidelines. This will be accomplished by offering extra shifts to current staff when needed and by using nursing agencies. 2. All residents have the potential to be affected by this cited practice. 3. The staffing coordinator was in-serviced on staffing ratio for staff-to-resident as mandated by the state of New Jersey for each shift. 4. The Administrator/designee will review the daily staffing sheets to ensure that the minimum staff-to-resident ratio is met. This review will be done weekly for the first 4 weeks and then monthly for the next 3 months. The results of this audit will be shared with the Quality Assurance team at the Monthly and quarterly meetings which will make further recommendations based on the	

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F 836	Continued From page 8 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. 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	F 836	results of this audit.	

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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 ...

On 6/8/2021 at 12:40 PM, the surveyor interviewed the Certified Nurses Aide (CNA) regarding the emptying of Executive Order 26, 4.b. Executive Ord During this interview, the CNA informed the surveyor that she was caring for 15 residents today. The surveyor asked if that was her usual assignment and the CNA stated that the Executive Order 26 usually had three CNAs, but "sometimes there are four." The census for this unit today was Execu residents.

On 6/9/2021 at 12:05 PM, the surveyor interviewed the Licensed Practical Nurse (LPN #1) regarding CNA scheduling and assignments. LPN #1 supplied the surveyor with a copy of that day's CNA assignment for the unit titled "Executive Ord Assignment Evening Shift." When questioned why the form indicated "Evening Shift", LPN #1 stated that he had just grabbed an assignment sheet for three CNAs and did not pay attention to the form's name. LPN #1 stated the unit had assignment sheets depending on how many CNAs were scheduled for that shift. LPN #1 when asked stated that the unit usually had two or three CNAs and rarely a fourth CNA. LPN #1 confirmed the unit's census was Execu residents for the day.

At this time, the surveyor reviewed the CNA assignment sheet for that day which reflected that there were three CNAs assigned for the day shift. The surveyor verified that there were only three CNAs working that shift.

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On 06/10/21 at 09:15 AM, LPN #2 provided the surveyor a copy of the CNA assignment schedule for the day listing four scheduled CNAs. LPN #2 stated, "usually we have three but today is four for help." LPN #2 stated that the fourth CNA was agency staff and had only been at the facility "a couple times." When asked what the unit's resident census for today was, LPN #2 stated "31."

On 06/11/21 at 10:00 AM, the surveyor reviewed the Unit 3 CNA assignment sheets provided by the facility for 6/8/21 and 6/11/21, which both reflected that three CNAs were assigned for each day. The surveyor then reviewed the facility provided Daily Nursing Schedule obtained from 6/8/21 to 6/14/21 which included the following staff to resident ratio:

6/8/21 - Unit 3 (Census 31) Day Shift CNA: 10.3 residents
6/9/21 - Unit 3 (Census 32) Day Shift CNA: 10.7 residents
6/10/21 - Unit 3 (Census 32) Day Shift CNA: 8 residents
6/11/21 - Unit 3 (Census 31) Day Shift CNA: 10.3 residents
6/12/21 - Unit 3 (Census 31) Day Shift CNA: 10.3 residents
6/13/21 - Unit 3 (Census 32) Day Shift CNA: 10.7 residents
6/14/21 - Unit 3 (Census 32) Day Shift CNA: 8 residents

Five of the seven day shifts did not meet the minimum required ratio of one CNA to eight residents.

On 6/11/21 at 12:22 PM, the surveyor in the

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F 836	Continued From page 11 presence of the Director of Nursing (DON), Licensed Nursing Home Administrator (LNHA), and survey team addressed their staffing concerns. At this time, the DON stated that the facility only scheduled three CNAs for Unit 3 because some of these residents provided care for themselves. NJAC-8:39-5.1 (a)	F 836		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:	F 880		7/14/21

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	315414	A. BUILDING ______ B. WING ______	06/14/2021

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(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 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:

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F 880	Continued From page 13 Based on observation, interviews, record review, and review of pertinent facility documentation, it was determined that the facility failed to a.) maintain proper infection control practices for donning (putting on) the appropriate Personal Protective Equipment (PPE) prior to entering an isolation room to prevent the transmission of infection and b.) maintain appropriate hand hygiene practices in accordance with the Center for Disease Control . This deficient practice was identified for 1 of 2 nursing units [Executive Order 26, 4.b.]), and for 2 of 2 residents (Resident #202 and Resident #203) on the Persons Under Investigation (PUI; for possible COVID-19 infection) unit and for observed hand hygiene in the kitchen. This was evidenced by the following: 1. On 06/09/21 at 12:15 PM the surveyor observed two Certified Nursing Aides (CNA), CNA #1 and CNA#2 delivering lunch trays to two residents on the [Executive Order 26, 4.b.] CNA#1 entered Resident #202's isolation room without donning the required PPE, wearing only a surgical mask. CNA#1 had not donned a gown, gloves, N95 (respirator) mask and eye protection posted outside the door to enter an isolation precaution room, that was stocked in a bin outside the resident's room. At this time, the surveyor observed CNA#2, enter Resident #203's room with a lunch tray, wearing only a KN95 mask as PPE. When CNA #1 and CNA#2 exited the room, the surveyor had not observed either CNA perform hand hygiene. There was visible signage for both rooms which indicated it was an isolation room, as well as, stocked PPE isolation bins outside the doors. On 06/09/21 at 12:20 PM, the surveyor interviewed CNA#1 regarding PPE usage before	F 880	1. 1. A Root Cause Analysis was completed to identify the cause of this breakdown in practice and it was determined that it was due to the fact the 2 CNA's were hurrying to deliver the food trays to the residents and were not providing care at the time. They were re-educated on the requirement to have the required PPE even if just entering the room briefly. The 2 CNA s were disciplined for their actions. The kitchen staff was educated on infection control for not practicing hand hygiene after removing a garbage cover. A garbage can with a foot petal was placed by the handwashing sink in the kitchen. 2. All residents have the potential to be affected by this cited practice. 3. A Root Cause Analysis was completed to identify the cause of the breakdown in practice and what the corrective action to be implemented to achieve compliance. As per the DPOC, All Topline staff including the Infection Preventionist completed the Nursing Home Infection Preventionist Training Course Module 1 with competencies validated by the Director of Nursing As per the DPOC, The following videos have been viewed by all front line staff; Keep COVID-19 Out, clean Hands and Use PPE Correctly for COVID-19 The Dietary staff have been in-service on infection control and proper hand hygiene practice. 4. The DON/designee will audit residents in the PUI rooms ensuring that staff is entering the room with the required PPE	

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F 880	Continued From page 14 entering an isolation room who stated that she was "just serving the food and wanted to get it in there fast," but she was not providing patient care. CNA#1 acknowledged that she saw the sign before entering into the room, but "made a mistake" and wanted to serve the resident's food so it would be hot when it was received. CNA#1 stated she was in-serviced on COVID-19, isolation precautions and PPE usage about two weeks prior to today (5/31/21). On 06/09/21 at 12:25 PM, the surveyor interviewed CNA#2 regarding PPE usage before entering an isolation room who stated, "Oh, I should have put on a gown." The surveyor interviewed CNA#2 regarding isolation precautions who stated that she was just serving the food and not providing patient care. If she was providing care, then she would have put on a gown and gloves in addition. CNA #2 stated she wanted to get the food in there fast and hot, but she acknowledged that she saw the isolation sign and knew what that meant. CNA#2 stated she was in-serviced on isolation precautions, COVID-19 and PPE usage about two weeks prior to today (5/31/21). When the surveyor interviewed both CNAs #1 and #2 about what the signage meant, they stated "These rooms are quarantine rooms, which means the residents stay in their rooms and don't mix with other people." Both CNA#1 and CNA#2 acknowledged they should have donned full PPE (gown, gloves, N95 mask, surgical mask, and eye protection) prior to entering the PUI rooms. On 06/10/21 at 09:02 AM, the surveyor interviewed the Licensed Practical Nurse (LPN) on the [redacted] unit who stated that anytime staff entered a PUI room, they must don full PPE,	F 880	and are practicing hand hygiene as required. The Administrator/designee will be checking the kitchen environment assuring that there is an appropriate trash receptacle located at the hand washing sink and that staff is practicing proper hand hygiene. These audits will be done daily for the first 2 weeks, then weekly for the next 4 weeks and then monthly for the next 3 months.	

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F 880	Continued From page 15	F 880		

even if it was to drop off a lunch tray to that resident. The LPN stated that she regularly oversaw the CNAs to make sure they were in compliance with the isolation room policy.

On 06/11/21 at 09:10 AM, the surveyor interviewed the Director of Nursing (DON) in the presence of the Licensed Nursing Home Administrator (LNHA) regarding PPE usage on the PUI unit. The DON stated that staff needed to don full PPE anytime they into the room, including when they deliver food trays to the resident. All staff members doffed (removed) PPE inside the room prior to exit, and then were required to perform hand hygiene using soap and water or an alcohol based hand rub. The DON confirmed that all staff had been educated on this procedure, and that she and the LNHA did informal audits every day on the floor. The DON stated that the LPN on the unit also monitored what the CNAs did when they provided care to the resident and the LPN would correct any discrepancies with the CNA's care, based on observation, but nothing was formally documented. The DON provided education for the whole facility or the managers will in service specific departments.

On 06/11/21 at 11:00 AM the surveyor reviewed in service training all facility staff. CNA#1 and CNA#2 were both in-serviced on 5/31/21 on Infection control and standard precautions by the DON.

A review of the facility's Contact Precautions policy dated 6/2021, included that "Prior to entering rooms of Residents under Isolation (PUI), all staff must do the following practice: Handwashing prior and after leaving the PUI

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F 880	Continued From page 16 rooms. Hand sanitizer can be used if your hands are not visible soil. 1)Mask must be on covering the mouth and nose. 2)Eye shield or goggle must be on for eye protection. 3)Gown must be worn. 4)Gloves must be worn. 5)All PPE should be taken off and place into the receptacle prior to leaving the PUI room. " 2. On 6/8/21 at 9:56 AM, in the presence of the Food Service Director (FSD), the surveyor washed their hands in the kitchen's handwashing sink prior to kitchen tour. After the surveyor washed their hands, they observed no trash receptacle at the handwashing sink, but observed one large manually covered trash receptacle in the kitchen work area. At this time, the FSD removed the trash receptacle's lid for the surveyor to throw out the paper towel, and placed the lid back on top. The FSD stated that he was ready to begin the kitchen tour and upon questioning there was nothing that he needed to do. At this time, the surveyor asked the FSD if after touching the trash receptacle's lid, if he should wash his hands. The FSD confirmed that his hands needed to be washed and proceeded to wash his hands appropriately. When questioned why there was no trash receptacle at the handwashing sink, the FSD stated that at one point there was a trash receptacle at the handwashing sink, but staff were not emptying that receptacle so he "punished" them by removing the trash receptacle so that staff could not have that "convenience."	F 880		

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F 880	Continued From page 17 On 6/8/21 at 10:05 AM, the surveyor in the presence of the FSD, observed the Cook appropriately wash his hands, but removed the trash receptacle's lid with his clean hands to discard the paper towel, and then placed the lid back on the receptacle. The Cook immediately went to don (put on) gloves. At this time, the FSD informed the Cook that he had to dispose of those gloves and wash his hands again. A review of the facility's Hand-Washing Routine policy dated 12/11 and revised 4/21 included that hands should be washed after touching surfaces such as bedside tables, doorknob, remote control, phones, keyboards, et cetera. NJAC 8:39-19.4(a)(2); 27.1(a)	F 880		