STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315002	A. BUILDING _____ B. WING _____	08/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT SOMERSET VALLEY	1621 ROUTE 22 WEST BOUND BROOK, NJ 08805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS STANDARD SURVEY: 08/16/19 CENSUS: 56 SAMPLE: 18 The facility is not in substantial compliance with the requirements of 42 CFR Part 483, Subpart B, for long term care facilities.	F 000		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical	F 604		9/5/19

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

Electronically Signed | 09/06/2019

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F 604	Continued From page 1 symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to a.) obtain a physician's order for the use of bilateral hand mitts and b.) follow the facility's policy and procedure for the use of restraints. This deficient practice was identified for 1 of 1 resident reviewed for the use of physical restraints, Resident #49, and was evidenced by the following: On 08/13/19 at 7:30 PM, during the initial tour of the facility, the surveyor observed Resident #49 lying in bed. The resident was receiving [redacted] Resident #49 was [redacted] Review of the physician's Order Summary Report did not reveal an order in the medical record for [redacted] for this resident. The Order Summary Report, dated 08/01/19, included a physician's order for an [redacted] On 08/14/19 at 9:18 AM, the surveyor returned to the resident's room and observed Resident #49 sleeping in bed. The resident's [redacted]	F 604	The order and care plan were updated for resident #49 on 8/13/19. MDS was corrected and updated for resident #49. Residents with restraints had the potential of being affected. Audit was conducted on all residents to ensure no resident has restraints in place without assessment, order and care plan. Nurses and Certified Nursing Assistants were in-serviced on ensuring any resident requiring restraint is assessed, and has an order and care plan in place. DON or designee will conduct audit of assessments, orders, and care plans weekly for 1 month then monthly to monitor for completion with residents with restraints. DON or designee will report findings of audit to the Quality Assurance Committee quarterly for 2 Quarters.	

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F 604	Continued From page 2	F 604		

[redacted] Resident #49 was [redacted]

Review of the resident's Order Summary Report, dated 08/13/19, revealed that a physician's order was obtained on 08/13/19 at 8:38 PM for [redacted]

On 08/14/19 at 10:35 AM, the surveyor interviewed a Certified Nursing Assistant (CNA) who stated that Resident #49 had been [redacted] The CNA confirmed that Resident #49 had the [redacted] on since 07/24/19. The CNA also stated that Resident #49 did not have [redacted] on during a prior admission because the resident was eating at that time.

The surveyor reviewed the resident's medical record which revealed the following:

The resident's Admission Record indicated that Resident #49 was admitted to the facility from the hospital on [redacted]. The resident had a prior admission date of [redacted] The resident's diagnoses included: [redacted]

The August, 2019 progress notes reflected one entry by nursing since admission to reference the use of [redacted] for Resident #49. This was a Late Entry, dated 08/12/19 at 11:00 AM which revealed, "observed [redacted] - MD

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F 604	Continued From page 3 informed obtained order for [redacted] This notation was created and entered into the electronic medical record on 08/13/19 at 7:46 PM, which was 16 minutes after the surveyor observed Resident #49 [redacted]. The Psychiatrist progress noted, dated 08/14/19, revealed, "Per case worker, Patient requires [redacted] 24 hours/day as part of [redacted]." Review of the Admission/5-Day Minimum Data Set (MDS), an assessment tool, dated [redacted] and signed by the MDS Coordinator on [redacted], revealed the resident was [redacted] The MDS did not indicate that Resident #49 had any restraints. The MDS Coordinator completed a Significant Correction to the prior comprehensive basement MDS with an assessment reference date of [redacted]. This MDS was completed/signed by the MDS Coordinator on [redacted] and did indicate that "other" restraints were used while the resident was in bed and that these restraints were used "less than daily." Review of the resident's ongoing Care Plan initiated on 07/24/19 indicated that the [redacted] were not addressed. On 08/14/19 at 11:24 AM, the surveyor interviewed the MDS Coordinator who stated that he completed the Significant Correction to the prior comprehensive assessment MDS for Resident #49. The MDS Coordinator stated that he did not complete the original Admission/5-day	F 604		

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F 604	Continued From page 4 physical restraint section of the MDS. He stated that the person who completed the Admission/5-day MDS did not capture the [redacted]. The MDS Coordinator stated that on one occasion the resident was [redacted]. The MDS Coordinator then showed the surveyor a physician's order for [redacted] mitts ordered on 08/13/19 at 23:00 hours (11:00 PM). The MDS Coordinator stated, "That's a new order." He stated that Resident #49 had a [redacted] and the [redacted] notes indicate that the resident was [redacted]. The staff put them on the resident. The MDS Coordinator also stated, "There was one occasion during the look-back period when they were on, but there was no order so they were removed." The MDS Coordinator also stated that he revised the MDS when he had seen the note by the Nurse Practitioner for the [redacted], dated 08/01/19. This Progress Note included the following plan: [redacted] On 08/14/19 at 12:27 PM, the surveyor initiated a telephone conversation with the resident's Guardian/Emergency Contact #1, who stated that [redacted] visited Resident #49 two to three times a week. [redacted] stated that the reason for the [redacted] was that Resident #49 [redacted]. The Guardian indicated that the resident had [redacted] at the hospital and when he/she was transferred to this facility, Resident #49 wore the same type of [redacted] that he/she wore in the hospital. [redacted] further stated that when [redacted] came to visit at this facility, [redacted] took the [redacted] off	F 604		

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F 604	Continued From page 5 to exercise the resident's [redacted] and cut his/her fingernails. [redacted] stated that Resident #49 had the [redacted] since [redacted] was transferred from hospital. The Guardian also stated that [redacted] would like to have the resident changed from the [redacted] used by the facility to something lighter or something like [redacted] like he/she wore at the group home where Resident #49 used to reside. [redacted] explained that a different type of [redacted] would give the resident a chance to have his/her [redacted] lie flatter. [redacted] stated that [redacted] would [redacted] his/her [redacted] so that they wouldn't cramp up. The Guardian stated that [redacted] would like Resident #49 to wear something more flexible. The surveyor asked if [redacted] had signed a consent for the [redacted] replied that [redacted] didn't think [redacted] signed any consent for the [redacted] stated that the only thing that [redacted] recently signed were the usual papers with the Social Worker on Thursday. On 08/14/19 at 12:48 PM, the Director of Nursing (DON) stated that a facility representative called and spoke to the resident's Emergency Contact #2 last night, who was going to relay the need for a restraint consent to the Guardian/Emergency Contact #1. This verbal consent, dated 08/14/19, was in the resident's medical record. The consent indicated that the [redacted] were to be used for the target behavior of [redacted] On 08/15/19 at 8:41 AM, the surveyor asked the Administrator for a copy of the Assessment for Restraints for Resident #49. On 08/15/19 at 9:43 AM, the surveyor asked the DON if the assessment was in the electronic medical record. She stated that her Assistant Director of Nursing (ADON) was getting it for her.	F 604		

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F 604	Continued From page 6	F 604		

The DON stated, "The ADON was the one who wrote it. It was on a form."

On 08/15/19 at 9:50 AM, the DON provided the surveyor with the Physical Restraint Assessment/Reduction form dated 08/12/19. The form revealed the restraint team signatures included only that of the ADON. There was no input from any other facility staff members.

The surveyor reviewed the facility's Physical Restraint Policy, effective 12/15/11, and revised on 10/13/2017, which revealed the following "Process:"

"1. Completed assessments are reviewed by the interdisciplinary team (IDT) and may included additional information or findings from rehabilitation notes, activities documentation, and social service notes."

"2. If restraint use is indicated, provide education to the resident (when appropriate) and/or the responsible person on the potential risks and benefits of restraint use, including the medical symptom(s) being treated.
2.1 Obtain the signature of the resident (if the resident is able) and/or the responsible person indicating informed consent to restraint use on the consent form."

"6. Obtain an order from the physician specifying the reason for restraint use as it relates to the medical symptom(s)."

"10. The care plan should address the use of the restraint as a problem, not as an intervention and must include how the resident may request staff assistance and how needs will be met during use

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F 604	Continued From page 7 of the restraint, such as for re-positioning, hydration, meals, using the bathroom and hygiene." On 08/16/19 at 8:46 AM, the survey team met with the Clinical Resource Coordinator, Administrator, and ADON. At that time, the Clinical Resource Coordinator presented the following statement: "[redacted] - upon final review of the medical record, there was no order obtained for the [redacted]. An order was entered and the omission addressed prior to discussion with the survey team. The team updated the record to reflect the use of the [redacted] at that time. On 8/15/19 a formal IDT note was entered to also provide clarity of the medical record. The team was unable to locate an order for the [redacted] prior to 8/13/19." The DON also added a Clinical Progress Note to the resident's medical record, which revealed that Resident #49 "was admitted to the facility on [redacted]. The hospital had sent [redacted] upon transfer which were at the bedside. [redacted] have intermittently been applied and since 08/12/19, the resident has required the [redacted] consistently. The care plan was reviewed and revised as well as current orders were placed on the chart as of 08/13/19." The note also indicated that the resident's group home was contacted, "related to the type of [redacted] used related to [redacted] care transition." NJAC 8:39-27.1 (c)	F 604		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans	F 658		9/5/19

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F 658	Continued From page 8 The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to follow physician orders a.) when administering a [redacted] medication with parameters to 1 of 18 residents reviewed for medications (Resident #150); b.) during the [redacted] care observation for 1 of 1 nurse observed; and c.) for applying [redacted] for 1 of 1 resident reviewed for devices (Resident #49). This deficient practice was evidenced by the following: Reference: New Jersey Statutes Annotated, Title 45, Chapter 11. Nursing Board. The Nurse Practice Act for the State of New Jersey states: "The practice of nursing as a licensed practical nurse (LPN) is defined as performing tasks and responsibilities within the framework of casefinding; reinforcing the patient and family teaching program through health teaching, health counseling and provision of supportive and restorative care, under the direction of a registered nurse or licensed or otherwise legally authorized physician or dentist." 1. During the initial tour on 08/13/19 at 8:00 PM, the surveyor observed Resident #150 sitting in a wheelchair wearing eyeglasses with eyes closed. Review of the Admission Record revealed Resident #150 was admitted to the facility on [redacted] with diagnosis [redacted]	F 658	1. The order of the [redacted] for resident #150 was clarified by the MD to reflect hold for [redacted]. Residents receiving [redacted] have the potential to be affected. Audit was completed on residents receiving [redacted] to ensure MD's order is followed. Nurses were in-serviced to ensure MD's orders including parameters for administration are followed. DON or designee will audit records of residents receiving [redacted] weekly for 4 weeks then monthly for 5 months to ensure parameters are followed. DON or designee will report any findings to the Quality assurance Performance Improvement committee for 2 quarters. 2. LPN #1 was interviewed and treatment was redone according to doctor's order. Residents with multiple [redacted] have the potential to be affected. Upon observation, no residents identified as affected. Nurses were educated regarding completing treatments consistent with	

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F 658	Continued From page 9 [redacted] The ongoing care plan, initiated 05/02/19 and revised on 07/15/19, revealed a focus for [redacted] with the intervention to "Administer medication per physician orders." Review of the physician orders revealed an order for [redacted] give one tablet every 12 hours as needed for [redacted]. The order included a parameter to give for [redacted] 0 with a start date of 05/22/19. (The blood pressure is recorded as two numbers. The first number represents the systolic blood pressure [SBP] which indicates how much pressure your blood is exerting against your artery walls when the heart beats. The second number represents the diastolic blood pressure [DBP]which indicates how much pressure your blood is exerting against your artery walls while the heart is resting between beats.) Review of the Medication Administration Records (MAR) for the months of May, June, July and August of 2019 revealed the following: The May 2019 MAR revealed that [redacted] was administered on 05/23/19 for a [redacted] on 05/25/19 for a [redacted] and on 05/27/19 for a [redacted] The June 2019 MAR revealed that [redacted] was administered on 06/14/19 for a [redacted], on 06/17/19 for a [redacted] and on 06/26/19 for a [redacted].	F 658	physician orders and confirming treatment location for residents with multiple [redacted]. DON or designee will complete wound treatment observation monthly and report findings will be presented to the Quality Assurance Performance Improvement quarterly for 2 quarters. 3. [redacted] were applied to resident #49's feet. Residents with [redacted] have the potential of being affected. Residents with orders for [redacted] have been observed and no other residents affected. Licensed staff were in-serviced on applying [redacted] as per physicians orders. DON or designee will observe residents with orders for [redacted] weekly for 4 weeks then monthly for 5 months to ensure placement as per Physician's order. DON or designee will report findings of [redacted] to the Quality Assurance Performance Improvement committee quarterly for 2 quarters.	

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F 658	Continued From page 10 The July 2019 MAR revealed that [redacted] was administered on 07/07/19 for a [redacted] and on 07/21/19 for a [redacted] The August 2019 MAR revealed that [redacted] was administered on 08/02/19 for a [redacted] and on 08/03/19 for a [redacted]. On 08/15/19 at 1:13 PM, the surveyor interviewed the Licensed Practical Nurse (LPN #1) assigned to Resident #150. LPN #1 stated that she would give the medication when the systolic blood pressure (the first number) was greater than 160. At that time, the Director of Nursing (DON) reviewed the order and stated "that it is not how the doctor wants it, I don't believe." The DON further stated that usually the order is written for the systolic blood pressure. LPN #1 stated that usually it is for one or the other, systolic or diastolic. At that time, the DON called the physician. The DON placed the physician on speaker phone and he stated that the order should have been based on the systolic number. The DON stated that the order should be clarified. At that time, the surveyor interviewed the DON who stated that the pharmacy is the first to review a new order and the pharmacist will contact the facility with any questions or concerns to clarify the order with the physician. Then, monthly, the pharmacist consultant reviews the resident's medications and will recommend anything for the facility to follow up on and correct. Review of the monthly Consultant Pharmacist Review for Resident #150, dated 06/27/19 and 07/29/19, did not reveal any comments for the "as needed" [redacted].	F 658		

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F 658	Continued From page 11 On 8/16/19 at 9:31 AM, the surveyor interviewed the Assistant Director of Nursing (ADON). The ADON confirmed that she wrote the [redacted] order with the blood pressure order parameters of 160/100. The ADON stated the physician wrote the order that way as he was monitoring the [redacted] of Resident #150. The ADON confirmed that she did not question the parameters because "I see [redacted] write that way." The ADON stated that if she was the nurse administering the medication, she would only give the medication if the pressure was greater than the parameters of 160/100. Review of the the Physician/Practitioner Progress Note, dated 5/22/19, revealed "Nurse reports continuous high BP readings sbp 170's-190's. The progress note further revealed the physician added [redacted] every 12 hours prn (as needed) for [redacted]. On 8/16/19 at 10:06 AM, the surveyor interviewed LPN #2 who administered the [redacted] on 05/25/19 to Resident #150 for a [redacted] LPN #2 stated that the resident's blood pressure varies from time to time and the reason she gave the medication was because both numbers (the SBP and DBP) were over the normal range (normal blood pressure means systolic pressure is less than 120 and diastolic pressure is less than 80). LPN #2 stated, she wanted to prevent a [redacted]. 2. On 08/15/19 at 10:48 AM, the surveyor observed LPN #1 and LPN #2 at the treatment cart outside of Resident #2's room as they prepared to administer [redacted] care to the resident. LPN #1 reviewed the treatment orders. She then asked LPN #2 to write the treatment	F 658		

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F 658	Continued From page 12 orders on a sheet of paper for reference. On 08/15/19 at 11:26 AM, LPN #1 removed the dressing from Resident #2's [redacted] At 11:29 AM, she removed a second dressing from a [redacted] located above the [redacted]. On 08/15/19 at 11:37 AM, LPN #1 cleansed the [redacted] located in the region of the [redacted]. At 11:41 AM, she cleansed the [redacted]. On 08/15/19 at 11:44 AM, LPN #1 used a cotton-tipped swab to pack [redacted] into the [redacted] located at the [redacted], applied a 4 x 4 gauze dressing over the [redacted] and covered the area with a foam dressing. On 08/15/19 at 11:49 AM, LPN #1 applied [redacted]. She used a cotton-tipped swab to pack [redacted] into the [redacted] bed. LPN #1 placed a 4 x 4 gauze on top of the [redacted] before she covered the area with a foam dressing. On 08/15/19 at 12:35 PM, the surveyor observed LPN #1 document in the Treatment Administration Record (TAR) that she provided [redacted] care to Resident #2. LPN #1 first signed out the following order: [redacted] Apply to [redacted] topically every day shift for [redacted]." She then signed out the second treatment: "Cleanse [redacted] with NSS pat dry pack loosely with [redacted], cover with comfort foam dressing prn (as needed) may substitute foam drsg (dressing) for super	F 658		

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	315002	A. BUILDING _____ B. WING _____	08/16/2019

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F 658	Continued From page 13 absorbent BID (twice daily) every day and evening shift for [redacted] care." On 08/15/19 at 1:35 PM, the surveyor interviewed LPN #1, who stated that both orders that she charted as administered pertained to the [redacted] as it was considered one [redacted]. She further stated that she applied [redacted] to the [redacted] and not to the [redacted] bed located above the [redacted] at the [redacted]. On 08/16/19 at 9:45 AM, the surveyor interviewed LPN #2 who stated that she did [redacted] rounds and was responsible to communicate with the physician for [redacted] treatment orders. LPN #2 indicated that she was familiar with Resident #2's [redacted] care orders and treatments. The surveyor asked LPN #2 if [redacted] was supposed to be applied to Resident #2's [redacted]? She stated, "Not to my knowledge. No, it's supposed to be in the [redacted]." On 08/16/19 at 8:51 AM, the Clinical Resource Coordinator (CRC) stated that the Director of Nursing (DON) interviewed LPN #1 and provided a written summary of the [redacted] care that was provided to Resident #2. The written summary documented that LPN #1 stated that she did two separate treatments to the same [redacted]. According to the summary, LPN #1 further stated that she reviewed the treatment orders prior to [redacted] care but confused the application. On 08/16/19 at 12:07 PM, the surveyor interviewed the CRC who stated that LPN #1 administered [redacted] into Resident #2's [redacted] rather than to the [redacted] as ordered. The CRC confirmed the [redacted]	F 658		

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F 658	Continued From page 14	F 658		

presents as [redacted] but is considered one [redacted]. The bridge between both [redacted] is a [redacted]

Review of the Visit Report for Resident #2, dated 08/13/19, revealed Multi [redacted] Chart Details and Assessment by the Advanced Nurse Practitioner (ANP). The document revealed that Resident #2 had a [redacted] The treatment recommendations were: [redacted] The ANP documented a [redacted] and the type was described as an [redacted] that measured [redacted] (no unit of measurement provided). The treatment recommendations were Inferior [redacted]

3. On 08/13/19 at 7:30 PM, during the initial tour of the facility, the surveyor observed Resident #49 in bed. The resident was awake and alert, but [redacted]. At that time, the surveyor observed that the resident's [redacted] and [redacted].

On 08/13/19 at 7:52 PM, the surveyor reviewed the resident's medical record which revealed that the physician's August, 2019 Order Summary Report included an order, dated 7/24/19, for [redacted] on [redacted] at all times, may remove for hygiene. The start date for this order was 07/25/19.

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F 658	Continued From page 15 On 08/13/19 at 8:17 PM, the surveyor observed Resident #49 in bed. The resident's [redacted] were [redacted]. There were [redacted] on [redacted] On 08/14/19 at 9:19 AM, the surveyor observed Resident #49 sleeping in bed. The resident's [redacted]. There were [redacted] On 08/14/19 at 9:38 AM, the Certified Nursing Assistant (CNA) entered the room and began to provide morning care to Resident #49. On 08/14/19 at 10:30 AM, the surveyor observed Resident #49 out of bed to a chair next to the bed. The resident was wearing the [redacted] at that time. On 08/14/19 at 1:23 PM, the surveyor initiated a telephone call to the resident's Guardian/Emergency Contact #1. The Guardian stated that [redacted] visited Resident #49 two to three times a week. [redacted] stated that when Resident #49 was in the hospital he/she [redacted]" on [redacted] while in bed. The Guardian described the devices as [redacted] [redacted] said that the hospital removed the [redacted] at the end of his/her stay. At this facility, [redacted] had seen Resident #49 in and out of bed. The Guardian stated that [redacted] did not notice that Resident #49 had worn any type of [redacted] when she had visited. [redacted] stated that when [redacted] visited, the resident was wearing only socks. On 08/14/19 at 1:35 PM, the surveyor interviewed the CNA, who stated that Resident #49 wore the	F 658		

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F 658	Continued From page 16 [redacted] on a daily basis. The CNA stated that he did not know what the evening shift did about the [redacted]. The CNA stated that he was going to put the resident to bed now and that Resident #49 [redacted] in bed. On 08/16/19 at 8:46 AM, the CRC stated that the Director of Nursing will initiate in-services to ensure that staff [redacted] according to the physician's orders.	F 658		
F 880 SS=D	NJAC 8:39- 27.1 (a) 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;	F 880		9/5/19

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F 880	Continued From page 17 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents 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.	F 880		

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F 880	Continued From page 18 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 minimize the potential spread of infection to residents for 1 of 3 nurses observed during medication pass on the [redacted]. This deficient practice was evidenced by the following: On 08/15/19 at 8:20 AM, the surveyor observed the Licensed Practical Nurse (LPN) take the [redacted] of Resident #200. The LPN took the [redacted] machine into the resident's room, applied gloves and cleaned the [redacted] cuff with an antimicrobial wipe before immediately placing the [redacted] cuff on the resident's [redacted]. The surveyor further observed that the [redacted] cuff was visibly wet and the LPN did not remove her gloves or wash her hands after cleaning the BP cuff. When the cuff was starting to inflate, the resident stated, "It hurts. Please take it on the [redacted] The LPN removed the [redacted] cuff, wiped the [redacted] cuff with an antimicrobial wipe and then placed it in the basket on the BP machine. The surveyor then observed the LPN take a smaller [redacted] cuff, clean the [redacted] cuff with an antimicrobial wipe and immediately place the [redacted] cuff on the resident's [redacted]. The surveyor observed that the [redacted] cuff was visibly wet when applied to the resident's [redacted] and that the LPN did not remove her gloves or wash her hands after disinfecting the [redacted] cuff. After the [redacted] was taken, the LPN removed the [redacted] cuff from the resident's [redacted] after the reading registered on the [redacted] machine. The LPN wiped the [redacted] cuff with an	F 880	No residents were effected. Residents utilizing the [redacted] cuff had the potential to be affected. Licensed nurses were in-serviced on infection control policies, ie; hand washing and cleaning of equipment. Competencies were completed for the nurses regarding cleaning equipment and hand washing. DON/Staff educator or designee will observe 3 nurses cleaning equipment and hand washing weekly for 4 weeks and monthly for 3 months. Staff educator will report findings to the Quality Assurance Performance Improvement committee quarterly for 1 quarter.	

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F 880	Continued From page 19 antimicrobial wipe and then placed the [redacted] cuff in the basket on the [redacted] machine. The LPN then wiped the [redacted] machine, removed her gloves and washed her hands. On 08/15/19 at 9:06 AM, the surveyor interviewed the LPN. The LPN stated that she should have removed her gloves after she cleaned the machine. The LPN and the surveyor reviewed the antimicrobial container instructions. The LPN stated, "one minute will pass as I wipe one side [of the [redacted] cuff] and then the other." Review of the "Disinfecting" directions on the antimicrobial wipe container revealed, "Use one or more wipes, as necessary, to thoroughly wet the surfaces to be treated. Treated surfaces must remain visibly wet for one minute to achieve complete disinfection of all pathogens listed on this label." The directions also revealed to "Allow surfaces to air dry." Review of the facility's policy, Cleaning and Disinfection of Resident-Care Items and Equipment, edited 03/01/2019, revealed, "Reusable resident care equipment will be decontaminated and/or sterilized between residents according to manufacturers' instructions." Review of the facility's policy, Handwashing/Hand Hygiene, reviewed 03/04/2019, revealed "Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: ...i. After contact with a resident's intact skin; ...l. After contact with objects (e.g., medical equipment) in the immediate vicinity of the resident; m. After removing gloves."	F 880		

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F 880	Continued From page 20 On 08/16/19 at 8:45 AM, the surveyor interviewed the Clinical Resource Coordinator (CRC). The CRC stated the LPN had attended training related to infection control and handwashing on 06/25/19, 05/17/19 and 03/7/19. The CRC further stated the nurses were provided education related to cleaning equipment after each resident use so that there is proper dry time between residents and nurses were also reminded about proper glove use (removal and washing hands). NJAC 8:39-19.4	F 880		