STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315142	A. BUILDING _____ B. WING _____	10/30/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LLANFAIR HOUSE CARE & REHABILITATION CENTER	1140 BLACK OAK RIDGE ROAD WAYNE, NJ 07470

(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 DATE: 10/30/2020 CENSUS: 110 SAMPLE: 22 + 3 closed records 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 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release	F 583		12/11/20

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

Electronically Signed | 11/15/2020

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F 583	Continued From page 1 of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to deliver unopened mail in a timely manner for 1 of 22 residents reviewed; Resident #7. This deficient practice was evidenced by the following: On 10/23/20 at 11:39 AM, the surveyor observed Resident #7 seated on the edge of the bed in their room. Resident #7 greeted the surveyor, and after obtaining the resident's permission agreed to be interviewed. At that time, Resident #7 told the surveyor that a staff member delivered an opened letter, belonging to the resident "about two weeks ago." Resident #7 was unable to recall who delivered the opened letter that was addressed to the resident from Social Security Administration. The resident was upset and stated, "They don't need to know what I'm getting, it's private." The surveyor reviewed the Admission Record that indicated Resident #7 was admitted to the facility with diagnoses that included [redacted]. The surveyor reviewed the [redacted] Annual	F 583	Element #1 The deficiency cited has been corrected; all mail addressed to residents has been delivered to each respective resident or to their resident representative or Power of Attorney/legal Guardian. An updated policy and procedure has been reviewed and revised to reflect a process in which this Facility will respect our resident□s rights to Personal privacy, including the right to privacy In his or her oral (that is, spoken) written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a	

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F 583	Continued From page 2 Minimum Data Set (MDS), an assessment tool that reflected a Brief Interview for Mental Status (BIMS) score of [redacted] indicating that Resident #7 was cognitively intact. On 10/26/20 at 11:32 AM, the surveyor interviewed Resident #7, who showed the surveyor the envelope that they had received opened. The surveyor observed that it was post marked [redacted]. Resident #7 stated that the letter was delivered to them more than a month after the post marked date. The surveyor asked Resident #7 if this concern was brought to anyone's attention in the facility. The Resident replied that they brought it to the attention of the Director of Social Services (DSS). Resident #7 stated that the DSS explained that the residents mail had mistakenly been transferred to the Business Office and opened by the Business Manager. On 10/28/20 at 11:03 AM, the surveyor met with the Director of Social Services (DSS), who explained that the recreation staff generally deliver mail to residents. On 10/28/20 at 11:11 AM, the surveyor met with the Director of Recreation (DOR) who stated that the mail was received and sorted by the receptionist and the recreation staff delivered the mail to the residents. The DOR further stated that the recreation staff does not deliver any business related mail, only personal letters. The DOR added that all Social Security Administration and bills were directed to the business office. The DOR specified that if resident's were alert and oriented, they should receive all of their mail. The surveyor asked the DOR which residents were alert and oriented.	F 583	postal service. Element #2 All residents have the potential to be affected by the alleged deficient practice. Element #3 The policy and procedure for personal privacy □ resident mail has been reviewed and revised. The Director of Recreation and Director of Social Service were re-educated on upholding resident□s rights to privacy in his or her oral, written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered Through a means other than a postal service. A resident mail disposition tool has been created to determine the disposition of all Current residents. A representative from the recreation department will receive mail, letters, And other materials addressed to current Residents in the facility. The Social Service Director will Maintain a resident mail disposition of all Current residents in the facility. A representative from the recreation department will refer to the resident mail	

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F 583	Continued From page 3 The DOR replied, "I don't know." The surveyor asked the DOR if she provided the receptionist with a list of residents who were alert and oriented who were supposed to have received all of their mail. The DOR told the surveyor that she did not have a list. On 10/28/20 at 11:15 AM, the surveyors met with the receptionist who explained that all business mail went to the business office and personal mail was directed to the DOR for resident distribution. On 10/28/20 at 11:30 AM, the surveyors met with the Administrator who explained there was no longer an onsite business office and that it was the Account Receivable Business Office Manager (ARBOM) who had opened Resident #7's mail. On 10/28/20 at 11:36 AM, the surveyors met with the DOR and DSS in the presence of the Administrator. The DOR explained that all financial mail went to the business office. The DSS concurred with the DOR. The Administrator stated that the mail should not have been sorted and sent off site and that all alert and oriented residents should have received their mail when it was delivered by the postal service. The surveyors asked the three staff members (DOR, DSS and Administrator) how the receptionist would know which residents were alert and oriented. The three staff members (DOR, DSS and Administrator) could not establish that the receptionist was presented the information to know this. On 10/28/20 at 12:00 PM, the surveyors accompanied the Administrator to the reception	F 583	Disposition form when sorting resident mail, Letters, packages and other materials Delivered to the facility for the resident. All resident mail, letters and packages will be Distributed promptly by a representative from the recreation department To alert and oriented residents. Resident mail, letters and packages for non-alert And oriented residents will be forwarded to The resident representative and/or their Power of Attorney or Legal guardian. Element #4 The Social Services Director/Designee will audit the resident mail disposition tool monthly x 3 months for compliance. Findings will be reported at the monthly QAPI meetings. Distribution of resident mail will be observed by the Director of Social Work weekly x 4 weeks and monthly X 3 months for compliance. Findings will be reported at the monthly QAPI meetings.	

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F 583	Continued From page 4	F 583		

area where many letters, addressed to residents of the facility were piled in a cardboard box awaiting pick up by the ARBOM. The Administrator asked the Receptionist which residents were alert and oriented. The receptionist replied, " I don't know that."

On 10/28/20 at 1:10 PM, the surveyors interviewed the ARBOM (via teleconference), in the presence of the Administrator. The ARBOM stated that she picked up the mail in August and September sorted it and brought back what needed to be delivered to residents. She further stated she had not picked up the mail for the month of October and that she should have only picked up items that were addressed to the facility or mail that read "Representative Payee."

The surveyors asked the ARBOM if she ever received mail that she didn't need. The ARBOM told surveyors that she opened the mail addressed to Resident #7 by mistake, put it on the corner of her desk and planned to address it at a later time but had "forgotten about it." Approximately 2 weeks ago, the ARBOM was notified by the DSS that Resident #7 had never received their mail from the Social Security Office. It wasn't until that time that ARBOM remembered opening the letter. She then sent Resident #7's mail over to the DSS to be delivered to Resident #7. The ARBOM stated that she had the mail on her desk for over a month and should have contacted the resident when she mistakenly opened it.

At that time, the Administrator and surveyors inspected the mail held in the cardboard box for the ARBOM. Inspection of the letters held at the reception area for ARBOM pick up, did not

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F 583	Continued From page 5 present any mail addressed " Representative Payee." cardboard box were addressed to the residents of the facility. The Administrator stated that all mail addressed to the residents of the facility should have been delivered promptly and not sorted and sent to the Corporate business office. On 10/28/20 at 2:00 PM, the surveyor requested facility Policy's & Procedure's for the delivery of resident's unopened mail in a timely manner. No further information regarding resident's mail distribution in the facility was supplied. N.J.A.C. 8:39-4.1 (19)	F 583		
F 812 SS=D	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.	F 812		12/11/20

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F 812	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to maintain the environment and equipment of the kitchen in a sanitary manner to prevent contamination from foreign substances and potential for the development a food borne illness. This deficient practice was evidenced by the following: On 10/22/2020 at 11:04 AM, in the presence of the Food Services Director (FSD), the surveyor observed the following: 1. The surveyor observed the backsplash of the three-compartment sink which was soiled with green, gray and orange particulates in several areas. A three-compartment sink was being used to both clean and sanitize the soiled pots and pans. 2. The surveyor observed the ice scooper stored in a holder having green particulates at the bottom and corners. 3. The surveyor observed the backsplash of the dishwasher, which was not in use, soiled with gray particulates. The floor under the dishwasher was also observed with food particles and a soiled cup. 5. The surveyor observed the low temperature dishwasher's gauge covered in black particulates that made the numbers in the gauge not visibly clear. At 11:25 AM, when the FSD ran the dishwasher, the wash temperature was observed	F 812	How the corrective action will be accomplished for the resident(s) affected by the deficient practice: The deficient practices identified were immediately rectified. Dietary staff were re-educated on maintaining proper kitchen sanitation practices. 1. The backsplash of the three-compartment sink was scrubbed and cleaned, free from green, gray, and orange particulates. 2. The ice scooper and holder were immediately cleaned and free from soiled green particulates. 3. The backsplash of the dishwasher was cleaned and free from gray particulates. The floor under the dishwasher was cleaned and free from food particles and a soiled cup. 5. The dish machine was immediately serviced. How the facility will identify other residents having the potential to be affected by the same deficient practice: All residents have the potential to be affected by the alleged deficient practice. The Food Service Director/Designee	

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F 812	Continued From page 7 to be at 110 degrees F. The surveyor continued to observe the dish machine temperature and at 11:30 AM, the dish machine temp was observed to be at 120 degrees F. On 10/23/2020 at 10:12 AM, the surveyor in the presence of another surveyor with the FSD observed the dish machine in use. The FSD explained that the dish machine was a low temperature machine, allowing the hot water temperature to be at or above 120 degrees Fahrenheit (F) and no higher than 140 degrees F to operate appropriately. The surveyor observed the gauge display for the water temperature to be 110 degrees F. The surveyor observed to the right of the dish machine in the area designated as cleaned two dish racks which contained one rack of ten insulated lids and one rack of eight resident dining trays. The surveyor observed the FSD remove an additional rack of ten insulated lids from the dish machine. At this time, the Dietary Aide (DA) transferred one rack of ten insulated lids to the insulated lid drying rack. At 10:16 AM, the Pot Washer (PW) stated that he checked the water temperature prior to utilization of the dish machine and the temperature was at 120 degrees F. The PW stated that he checked the temperature throughout the dish washing process to ensure the temperature was appropriate. The surveyor continued to observe the dish machine temperature gauge with the FSD. At 10:20 AM, the dish machine reached 120 degrees F. At 10:31 AM, the FSD calibrated a thin probed digital thermometer to 32 degrees F. The FSD	F 812	Will inspect the kitchen environment and equipment daily to ensure the kitchen is sanitary to prevent contamination from foreign substances and potential for the development of a food borne illness. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not reoccur: The Food Service Director/Designee will audit the backsplash of the three compartment sink daily x7 days, then weekly x3 weeks, then monthly x3 months for compliance. Findings will be reported at the monthly QAPI meetings. The Food Service Director/Designee will audit the ice scooper daily x7 days, then weekly x3 weeks, then monthly x3 months for compliance. Findings will be reported at the monthly QAPI meetings. The Food Service Director/Designee will audit the backsplash of the dishwasher daily x7 days, then weekly x3 weeks, then monthly x3 months for compliance. Findings will be reported at the monthly QAPI meetings. The Food Service Director/Designee will audit the floor under the dishwasher daily x7 days, then weekly x3 weeks, then monthly x3 months for compliance. Findings will be reported at the monthly QAPI meetings. The Food Service Director will audit the	

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F 812	Continued From page 8 tested the dish machine water temperature which indicated the dish water was at 123 degrees F. This reflected the same temperature as the dish machine's water gauge. The FSD stated that the dish machine was serviced yesterday, and the temperature was 125 degrees F. At this time, the FSD instructed the PW to re-wash all the insulated lids and dishware previously washed. The FSD stated that anything washed below 120 degrees F would not be appropriately cleaned and sanitized. The surveyor reviewed the facility's Customer Service Report from the dish machine company dated 10/22/2020. The report included that the dish machine temperature was low as a result of not flushing warm water before filling. The report indicated that the dish machine was running at 125 degrees F. A review of the facility's Dishwashing In-service Training dated and revised 6/4/13 included that the low temperature dish machine should register for both the wash and rinse 120 degrees F. The FSD was designated to spot check the dish machine temperature log to assure proper sanitizing of dishes. On 10/23/20 at 01:22 PM, the surveyor brought the above concerns to the attention of the Administrator. There was no further information supplied by the facility.	F 812	dish machine temperature log daily x 7 days then weekly X3 weeks, then monthly X3 months for compliance. Results will be reported at the monthly QAPI meetings.	
F 880 SS=D	NJAC 8:39-17.2(g) Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		12/11/20

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F 880	Continued From page 9 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (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:	F 880		

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F 880	Continued From page 10 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined that the facility failed to: a) ensure that contracting agents who provided services to residents were familiar and adhered to infection practice guidelines according to the facility's policy, Contracting Agents Policy and Center for Disease Control (CDC). This deficient practice was identified for 2 of 22 residents, (Residents #59 and #85) observed during lab procedures rendered by a Certified Phlebotomy Technician (trained	F 880	Element #1 Residents #59 and #85 were assessed by the DON/designee for any ill effects of the alleged deficient practice by the Certified Phlebotomy Technician during the lab procedures on 10/23/2020. No ill effects were noted. CPT was provided a 1:1 education by the DON on proper infection control practices on 10/23/2020.	

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F 880	Continued From page 11 professional that draws blood for medical testing) (CPT) as evidenced by the following: Based on observation and interview, it was determined that the facility failed to follow appropriate infection control procedure while serving meal trays to the residents. This deficient practice was observed during dining observation in one of the 3 units and was evidenced by the following: On 10/23/20 at 10:48 AM the surveyor observed Resident #59 lying in bed. The surveyor observed the CPT apply gloves and place the supply carrier with attached sharps container (hard plastic container used to safely dispose of blood-contaminated needles) on the overbed table located outside of Resident 59's room without cleaning the table or placing a clean barrier between the caddy and the table. The surveyor observed the CPT wearing gloves and a facemask enter Resident #59's room and perform the blood draw. On 10/23/20 at 10:55 AM, the surveyor observed the CPT exit Resident #59's room, pick up the supply carrier with sharps container attached, put on gloves, gather her supplies, place the caddy on the floor outside of Resident #85's room and enter the room. The surveyor observed Resident #85 was seated in a wheelchair with the overbed table positioned in front of them. The Phlebotomist set two vacutainers, a tourniquet and small roll of tape on the resident's bed without first putting down a clean barrier. The CPT did not remove the resident's personal items and clean the overbed table or place a clean barrier down before she placed the gauze and alcohol swab directly onto the contaminated table.	F 880	Residents #306, #307, #308 & #104 were assessed by the DON/designee for any ill effects of the alleged failure to follow appropriated infection control procedure while serving meal trays to residents on 10/28/2020. No ill effects were noted. CNA #1, CNA #2 and LPN# were provided 1:1 education and PPE Competency by the ADON on 10/29/2020. Element #2 All residents have the potential to be affected by the alleged deficient practice. Element #3 Licensed staff were educated by the ADON on 11/12/2020 on the following: Nursing staff in-serviced on need to escort vendor provider technicians while in the building to ensure that Infection Control and Prevention (ICP) protocols are followed. Vendor ICP Audit Tool will be used to monitor compliance. All staff are re-educated by the ADON by 12/11/2020, to ensure proper PPE usage and observation on IPC protocols for residents on transmission-based precautions. Element #4 DON or designee will audit vendor sign-in sheets and audit tools weekly x 2 months, then monthly x 4 months.	

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	315142	A. BUILDING _____ B. WING _____	10/30/2020

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F 880	Continued From page 12 On 10/23/20 at 11:00 AM, the CPT explained to the resident that she would be drawing blood, applied the tourniquet to the resident's left lower arm, cleaned the left hand with the alcohol, prepared the needle and performed the blood draw. After filling both vacutainers the CPT removed the tourniquet, removed the needle and applied the 4x4 gauze to the open venipuncture site. The CPT removed the gloves, washed her hands and left the room. On that same day, at that same time, the surveyor observed the CPT with gloves in her hands pick up the caddy from the floor, put it on top of the overbed table in the hallway and while doing so dropped one of the gloves on the floor. The CPT picked the glove off the floor and put it on. She then used a disinfectant wipe and cleaned the bottom of the supply caddy but did not clean the overbed table where she had placed the caddy that had been placed on the floor. The CPT removed her gloves, discarded them in Resident 85's trash can and exited the room without washing or sanitizing her hands. The surveyor called out to the CPT and attempted an interview however the CPT rushed down the hall and out the double coded locked unit. The surveyor went to the [redacted] to interview the CPT but she had already left that unit and was informed by another surveyor that the CPT had exited the building. A review of Resident #59's Face Sheet documented that the resident had diagnoses that included but were not limited to [redacted]	F 880	Unit Managers, Supervisors, ADON and DON will observe a minimum of 10 staff members entering isolation rooms weekly for appropriate use of PPE for 6 weeks and then 5 staff members weekly for the next 4 months and then 5 staff members monthly for the next 6 months. Results of audits will be reported to the QAA Committee Quarterly for any trends and recommendations.	

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A review of Resident #85's Face Sheet documented that the resident had diagnoses that included but were not limited t [redacted]

On 10/23/20 at 2:27 PM, the surveyor met with the facility Administrator and Director of Nursing, who stated that the CPT should not have placed her supply caddy on the floor, should not have left the supply caddy/ sharps container unattended and should have followed appropriate Infection Control Guidelines.

On 10/27/20 at 2:00 PM, the surveyor attempted a telephone interview with the CPT but was informed by the HR Coordinator the CPT was not available. The surveyor left a message and requested call back from the CPT and the North Regional Supervisor. Neither staff member returned the surveyor's call.

On 10/28/20 at 8:43 AM, the surveyor attempted a telephone interview with the CPT but again was told she had not been available. The surveyor conducted a telephone interview with the Human Resource Coordinator (HRC) who stated that the CPT had a history of Infection Control concerns and that she would be in-serviced that afternoon. The HRC further stated that the caddy should not be placed on the floor, should be cleaned and that all supplies should be placed on top of a clean barriers.

On 10/27/20 at 10:59 AM, the Administrator presented the Undated Vendor Policy "Phlebotomist Code of Conduct." The policy stated, "Practice Infection Control: demonstrate appropriate concern for the patients' safety and

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yourself by following the guidelines for Universal Precautions. The Centers for Disease Control and Prevention (CDC) documented: "Universal Precautions are used for all patient care. They're based on a risk assessment and make use of Infection Control Practices and Personal Protective Equipment (PPE) that protect healthcare providers from infection and prevent the spread of infection from patient to patient."

On 10/28/20 at 10:20 AM, the Director of Nursing presented the policies related to infection control and phlebotomy care.

The surveyor reviewed the vendor policy dated 3/30/20 "Personal Protective Equipment" policies supplied to the facility by the vendor and presented to the surveyor by the facility DON. The policy stated, "Only bring with you the needed phlebotomy supplies into the room. Place needed supplies into plastic bag," Place paper towels on table and place equipment on the towels. Once drawn, place tubes into biohazard bag and then double bag it" and "Hands should be washed with soap and water or hand sanitizer when changing or removing gloves."

On 10/27/2020 at 11:27 AM, the surveyor was in the [redacted] Unit where residents were placed to observe for any signs and symptoms of COVID 19.

The surveyor observed a Certified Nurse's Assistant (CNA #1), wearing N95 mask enter Resident #306's room to serve the lunch tray. Resident #306 was on droplet and contact precautions. Two signs were posted on the wall

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at the entrance to the resident's room. The signs read to "Make sure eyes, nose, and mouth are fully covered before room entry"; "Put on gloves before room entry"; "Put on gown before room entry". The CNA was observed inside the room setting up Resident #306's lunch tray. The surveyor interviewed CNA #1 who stated that she forgot to wear the Personal Protective Equipment (PPE's) prior to entering the resident's room.

The surveyor observed an Licensed Practical Nurse (LPN), wearing an N95 mask enter Resident #307's room to serve the lunch tray. Resident #307 was on a droplet and contact precautions. Two signs were posted on the wall before entering the resident's room. The signs read to "Make sure eyes, nose, and mouth are fully covered before room entry"; "Put on gloves before room entry"; "Put on gown before room entry". The surveyor interviewed the LPN who agreed that she did not wear the right PPE's before entering Resident #307's room who was on isolation for observation of COVID 19 signs and symptoms. The LPN further stated that the proper PPE must be donned prior to entering the isolation rooms included, face shield, N95 mask, gloves and gown.

The surveyor observed CNA #2, wearing a surgical mask and disposable gown enter Resident #308's room to serve the lunch tray. Resident #308 was on a droplet and contact precautions. Two signs was posted on the wall at the entrance to the room. The signs indicated to "Make sure eyes, nose, and mouth are fully covered before room entry"; "Put on gloves before room entry"; "Put on gown before room entry". CNA #2 stated that the staff does not have to wear gloves, face shield and gown if they

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don't have to stay in the resident's room to set up the tray. The surveyor continued to observe CNA #2 who proceeded to Resident #104's room to serve the lunch tray. Resident #104 was on droplet and contact precautions. Two signs were posted on the wall at the room entrance. The sign indicated to "Make sure eyes, nose, and mouth are fully covered before room entry"; "Put on gloves before room entry"; "Put on gown before room entry". Prior to entering the resident's room, CNA #2 was observed wearing a surgical mask. The CNA entered the room, put on a gown, but no gloves, then set up the resident's meal tray, sat down in a chair and started feeding Resident #104.

At 12:07 PM, the surveyor reported to the Unit Manager (UM) assigned on the unit regarding the above concern. The UM agreed that CNA #1, CNA #2 and the LPN were not wearing the proper PPE indicated for the isolation in place. The UM further stated that for the Residents that were placed on droplet and contact precautions, any staff entering the resident rooms must wear gown, gloves, face shield and N95 mask.

NJAC 8:39-19.1 (b)
NJAC 8:39-19.4 (a)