STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315339	A. BUILDING _____ B. WING _____	03/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT ORADELL	600 KINDERKAMACK ROAD ORADELL, NJ 07649

(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 Survey date: 3/11/2021 Census: 91 Sample: 5 A COVID-19 Focused Infection Control Survey was conducted by the New Jersey Department of Health. The facility was found not to be in compliance with 42 CFR §483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19.	F 000		
F 880 SS=E	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	F 880		5/7/21

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

Electronically Signed | 04/05/2021

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F 880	Continued From page 1 arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and	F 880		

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F 880	Continued From page 2 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 review of records, it was determined that the facility failed to a.) ensure that workers are knowledgeable of the cleaning chemical used in the workplace for 3 of 3 staff; and, b.) practice appropriate hand hygiene for 2 of 8 staff observed in accordance with the Centers for Disease Control and Prevention guidelines for infection control to mitigate the spread of COVID-19. This deficient practice was evidenced by the following: A review of the U.S. CDC's Cleaning and Disinfecting Your Facility, updated on 1/5/2021, included, "Practice routine cleaning of frequently touched surfaces. High touch surfaces include tables, doorknobs, light switches, countertops, handles, desks, phones, keyboards, toilets, faucets, sinks, etc. Disinfect with a List N: disinfectants for use against SARs-CoV, the virus that causes COVID 19. For electronics, such as tablets, touch screens, keyboards, remote controls, and ATMs, consider putting a wipeable cover on electronics. Follow the manufacturer's instructions for cleaning and disinfecting. Dry surface thoroughly and wear appropriate PPE when cleaning or disinfecting frequently touched surfaces and electronics." Additional considerations for employers: "Educate workers performing cleaning, laundry, and trash pick-up to	F 880	I. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? > The 80% Alcohol Solution labelled hand sanitizer was removed from the affected area and replaced sanitizing wipes that have documentation on the label attesting their effectiveness for cleaning this type of equipment and the required contact time. > RN#1 and RN#2 were both in-serviced on the required type of sanitizing wipes that can be used for cleaning blood pressure monitoring equipment and the required contact time for each type of disinfectant in use in the facility. > HK#1 was in-serviced on the required contact time for each type of disinfectant in use at the facility. >HK#2 and HK#3 were both in-serviced on proper hand hygiene after the removal of gloves. II. How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? > Residents on [redacted]	

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F 880	Continued From page 3 recognize the symptoms of COVID-19. Develop policies for worker protection and provide training to all cleaning staff on-site prior to providing cleaning tasks. Ensure workers are trained on the hazards of the cleaning chemicals used in the workplace in accordance with OSHA's Hazard Communication Standard." According to the U.S. CDC guidelines Hand Hygiene Recommendations, Guidance for Healthcare Providers for Hand Hygiene and COVID-19, page last reviewed 1/8/2021 included, "Hands should be washed with soap and water for at least 20 seconds when visibly soiled, before eating, and after using the restroom. Immediately after glove removal." It further specified the procedure for hand hygiene which included, "When cleaning your hands with soap and water, wet your hands first with water, apply the amount of product recommended by the manufacturer to your hands, and rub your hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. Rinse your hands with water and use disposable towels to dry. Use a towel to turn off the faucet. Other entities have recommended that cleaning your hands with soap and water should take around 20 seconds. Either time is acceptable. The focus should be on cleaning your hands at the right times." 1. On 3/11/21 at 9:01 AM, the Director of Nursing (DON), in the presence of the Licensed Nursing Home Administrator (LNHA), informed the surveyors that [redacted] residents tested [redacted] for [redacted] in the facility. On that same date and time, the DON informed the surveyors that there were [redacted] in the	F 880	had the potential to be affected. III. What measures will be put into place or what systemic changes will you make to ensure that the deficient practice will not recur? > Housekeeping staff were in-serviced on the required contact time for each type of disinfectant in use at the facility. > Housekeeping staff were in-serviced on proper hand hygiene after the removal of gloves. > Route Cause Analysis was done and it was determined that housekeeping staff should take more time on assignments allowing them to take the required steps methodically. > Licensed Personnel were in-serviced on the approved sanitizing wipes required for sanitizing blood pressure monitoring equipment and the identifying documentation on the required sanitizing wipes. > Route Cause Analysis was done and it was determined that only approved types of sanitizing wipes should be supplied to patient care areas to avoid confusion. > Topline Staff & Infection Preventionist completed Nursing Home Infection Preventionist Training Course Module 1 - Infection Prevention & Control Program. > Frontline Staff were shown the following	

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F 880	Continued From page 4 facility. The [redacted], identified as the [redacted] unit, was [redacted] into a [redacted] and [redacted]. The DON stated that the [redacted] was [redacted] with a [redacted] and [redacted] and the [redacted] with a [redacted] She further noted that the [redacted] was the [redacted], the [redacted] was the [redacted]), and the [redacted] was the [redacted]. On 3/11/21 at 9:55 AM, during the tour on the [redacted] unit, Registered Nurse#1 (RN#1) informed the surveyor that she uses 80% alcohol for disinfecting the blood pressure (bp) apparatus and that included the computer, bp cuff, and wire. RN#1 showed the surveyor where she kept the alcohol 80% solution, and she pulled it out of the bp apparatus basket. RN#1 told the surveyor that she would spray down the bp and let it dry. RN#1 was not able to tell the surveyor the contact time of the alcohol spray. At 10:53 AM, during the tour of the [redacted] unit, RN#2 informed the surveyor that she uses 80% alcohol for disinfecting the bp apparatus, and it was in every bp pole baskets in the facility. RN#2 then showed the surveyor the disinfectant that was in the bp pole basket. The surveyor read the container of the disinfectant, and it revealed that it was a hand sanitizer, did not include a contact time, and specification that it can be used for disinfecting bp equipment. The container indicated that it should be used for disinfecting hands. Furthermore, RN#2 could not state the hand sanitizer's contact time that was being used for disinfecting the bp apparatus.	F 880	videos from the CDC Covid-19 Prevention Messages for Front Line Long-Term Care Staff: - Keep Covid-19 Out - Sparkling Surfaces - Clean Hands IV. How the corrective action(s) will be monitored to ensure the deficient practice will not recur i.e., What program will be put into place to monitor the continued effectiveness of the systemic change? > Infection Control Preventionist/designee will conduct an audit on 3 housekeeping staff 3x a week x 2 weeks then monthly x 3 months on his/her compliance with the required contact time for each type of disinfectant in use at the facility. > Infection Control Preventionist/designee will conduct an audit on 3 housekeeping staff 3x a week x 2 weeks then monthly for 3 months on his/her compliance with proper hand hygiene after removal of gloves. > Infection Control Preventionist/designee will conduct an audit on 3 nurses 3x a week x 2 weeks then monthly x 3 months on his/her compliance with the use of the correct type of sanitizing wipes when cleaning blood pressure monitoring equipment and knowledge of the required contact time for these wipes. > The results of these audits will be reviewed by the QA Committee at its	

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F 880	Continued From page 5 2. On 3/11/21 at 11:35 AM, during the tour of the [redacted] unit, the surveyor observed a Housekeeper#1 (HK#1) wiping down a wet handrail with a cloth towel. The surveyor interviewed HK#1, who told the surveyor that she sprayed disinfectant on the handrail, which had a contact time of 3 minutes. The surveyor asked HK#1 if the handrail should still be wet when she wiped it down, and HK#1 said that she waited 3 minutes. HK#1 was not aware that the disinfectant spray contact time was 10 minutes. 3. On 3/11/21 at 10:59 AM, the surveyor observed HK#2 in the [redacted] unit in the hallway, removed his gloves, disposed of gloves in the cleaning cart, and did not perform hand hygiene. HK#2 then entered a resident's room, where HK#3 observed cleaning the room with a pair of gloves. Afterward, HK#3 exited the room, removed gloves, and did not perform hand hygiene. On that same date and time, during the interview, HK#2 stated, "I must have forgotten" when asked by the surveyor why he did not wash his hands after removing gloves. HK#3 said that he should have removed his gloves and washed his hands before exiting the resident's room. At 11:40 AM, the Infection Preventionist Nurse (IPN) informed the surveyors that the nurse should use the purple top disinfecting wipes for cleaning the bp apparatus with one minute contact time, not the hand sanitizer. The IPN stated that the staff should perform hand hygiene after removing gloves and before exiting the resident's room. She further noted that the staff was all educated about disinfecting frequently touched surfaces, equipment, and contact time.	F 880	quarterly meeting.	

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F 880	Continued From page 6 She indicated that all staff was educated about hand hygiene. At 12:43 PM, the surveyors met with the LNHA, DON and were made aware of the above concerns. A review of the facility Handwashing/Hand Hygiene Policy that the LNHA provided with a reviewed date of 2/28/20 included, "This facility considers hand hygiene the primary means to prevent the spread of infections. Hand hygiene is the final step after removing and disposing of personal protective equipment. The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections." There was no additional information provided by the facility. NJAC 8:39-19.4 (a) (1) (2) (n)	F 880		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315339 Y1	A. Building B. Wing Y2	5/7/2021 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE ONE AT ORADELL	600 KINDERKAMACK ROAD ORADELL, NJ 07649

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0880 Reg. # 483.80(a)(1)(2)(4)(e)(f) LSC	Correction Completed 05/07/2021	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 3/11/2021	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			