STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315120	A. BUILDING _____ B. WING _____	07/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHATHAM HILLS SUBACUTE CARE CENTER	415 SOUTHERN BLVD CHATHAM, NJ 07928

(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 A COVID-19 Focused Infection Control Survey was conducted by the New Jersey Department of Health. The facility was found to be not 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. Survey date: 7/14/20 Census: 78	F 000		
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;	F 880		8/26/20

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

Electronically Signed | 07/24/2020

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

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F 880	Continued From page 1 §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.	F 880		

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F 880	Continued From page 2 §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 follow acceptable standards of practice for hand hygiene for 3 of 11 facility staff reviewed for adherence to Infection Control Standards of Practice. This deficient practice was identified during the Covid-19 focused survey and was evidenced by the following: On 7/14/20, at 10:10 AM, the surveyor observed the Certified Nursing Assistant (CNA #1) apply soap to his hands, rub them together for 8 seconds and then placed his hands under running water and rub for another 5 seconds. The surveyor asked the CNA how long he should have washed his hands. CNA #1 replied that he should have washed his hands for 20 seconds. The CNA acknowledged he should have wet his hands before applying soap and should have rubbed his hands for 20 seconds outside of running water. On 7/14/20 at 10:51 AM, the surveyor observed the Director of Recreation (DOR) apply soap to her hands, rub them together for 7 seconds and then put her hands under running water. The surveyor asked the DOR how long she should have washed her hands. The DOR replied that she should have washed her hands for 20 seconds. She further stated that she should have wet her hands before applying soap and should have rubbed her hands together for 20 seconds	F 880	I. Two out of the three staff members identified are facility staff and were immediate re-in serviced on correct hand washing and had a competency done with return successful demonstration. One of the three staff members identified was an agency staff member. That staff member has not returned to facility. II. All residents have the potential to be affected by this deficient hand washing practice. III. Infection control policy, specifically hand washing was reviewed by the infection control preventionist. Policy was changed to read " Vigorously lather hands with soap and rub them together, creating friction to all surfaces, for a minimum of 20 seconds (or longer) outside of a moderate stream of running water, at a comfortable temperature" . All staff will be re-inserviced on infection control and hand hygiene across all departments and all shifts. Competencies and return demonstration will be completed with all staff for Handwashing/ Hand Hygiene. An audit was completed and there were no new nosocomial infections in a 2 week lookback. IV. Infection control preventionist or designee will conduct 10 hand hygiene	

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F 880	Continued From page 3 outside of running water. On that same day at 11:55 AM, the surveyor observed the Certified Nursing Assistant (CNA #2) apply soap to her hands and immediately put them under running water. CNA #2 rubbed her hands together under the water for 14 seconds. The surveyor asked the CNA how long she should wash her hands and why she didn't lather and wash her hands outside the running water. CNA #2 replied, " Maybe I was nervous. I should have washed my hands for about 15 or 20 seconds." A review of the facility's policy titled "Handwashing/ Hand Hygiene" revised 4/16/19 revealed the following: 1. Wet hands thoroughly under running water. 2. Apply antimicrobial soap. 3 Vigorously lather hands and rub them together, creating friction to all surfaces, for a minimum of 20 seconds (or longer) under a moderate stream of water. On 7/14/20 at 12:50 PM, the above concerns were discussed with the DON and Administrator. No further information was provided. NJAC: 19.4 (a)	F 880	competency audits observing point of care resident interaction for appropriate hand hygiene across all shifts and departments. Audits will be weekly X 4 weeks then monthly X 3 months. 20% of new hire onboarding and annual education will be audited weekly X 4 weeks to ensure hand washing education and competencies are completed Results of these audits will be reviewed at the Quality Assurance Meeting over the duration of the audit process. The Quantity Assurance committee will determine whether to continue, decrease or discontinue the audit process. Any discrepancies will be reported to the administrator for immediate follow up. 1. The facility conducted a Root Cause Analysis of this deficient practice. The RCA was: · Lack of clarity in hand hygiene policy and procedure · Lack of concentration and anxiety factor · Lacking Quality assurance process · Lack of knowledge and maintaining · Lack of systematic monitoring of hand hygiene practices 2. The education/videos were completed and viewed by all staff.	