

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER <b>315235</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED <b>06/29/2020</b>
NAME OF PROVIDER OF SUPPLIER <b>RIVERSIDE NURSING AND REHABILITATION CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP <b>325 JERSEY STREET TRENTON, NJ 08611</b>	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		
F 0880  <b>Level of harm - Minimal harm or potential for actual harm</b>  <b>Residents Affected - Some</b>	<p><b>Provide and implement an infection prevention and control program.</b></p> <p>Based on observation, interview and record review, it was determined that the facility failed to ensure: a) staff properly used personal protective equipment (PPE) according to facility policy and b) perform proper hand hygiene when caring for COVID-19 suspected residents in the Yellow Admission Zone ( 1 of 4 Zones observed). This deficient practice was evidenced by the following: On 6/29/20 at 9:38 AM, during an entrance conference with the Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON) and Infection Preventionist (IP), the ADON stated that the facility was co-horting residents in four zones: Green, Orange, Yellow and Red. The Green Zone included residents who have never tested positive for Covid -19 and have continued to test negative, the Orange Zone (Recovery Zone) included residents that were post 14 days isolation and have had no further symptoms of Covid -19, the Yellow Zone included Persons Under Investigation (PUI) and new admissions, and the Red Zone included Covid positive residents. The 2nd floor unit contained a Green Zone, an Orange Zone, a Yellow Zone and a Red Zone. The Yellow Zone had 9 residents and the Red Zone had one positive Covid resident. The 3rd floor was considered an Orange Recovery Zone and the 4th Floor contained both an Orange Zone and a Green zone. On 6/29/20 at 11:19 AM the surveyor donned a gown, gloves, a N-95 mask with a surgical mask over the N-95 mask and a face shield and toured the Yellow Zone on the second floor. The surveyor observed rooms 201 to 209 each had a yellow colored sign attached to the wall outside their room which indicated that staff is to wear a N-95 mask, a surgical mask over the N-95 mask, goggles or face shield and gloves. The surveyor observed 3 tier plastic bins containing PPE located outside the residents' rooms in the Yellow Zone. At 11:28 AM, while observed meal delivery, the surveyor observed CNA #1 wearing an N-95 mask with a surgical mask over the N-95 mask without goggles during meal delivery to the residents in the Yellow Zone. At 11:45 AM, the surveyor interviewed CNA #1 who stated that she wasn't wearing a face shield or goggles in the Yellow Zone because she was not given goggles or a face shield upon entering the facility. CNA #1 stated that sometimes the facility does not have all the PPE that is needed and further stated it's like pulling teeth to get the PPE we need. At 11:50 AM, CNA #1's coworker (CNA #2) gave CNA #1 a pair of goggles. CNA#1 then stated, See it's almost 12 noon and I just got goggles to wear. At 11:05 AM, the surveyor interviewed LPN #1 who stated she was the dedicated nurse in the Yellow Zone. During observations of the yellow zone from 11:05 AM to 12:00 PM, the surveyor observed LPN #1 not wearing goggles while entering and exiting resident's rooms in the Yellow Zone. At 12:00 PM, the surveyor interviewed LPN #1 who stated that goggles were not needed in the Yellow Zone. LPN #1 stated that originally goggles were worn in the Yellow Zone but since there was a lack of supplies, the Yellow Zone changed to not wearing goggles or face shields. LPN #1 could not recall when the policy was changed but stated she was informed verbally. On 6/29/20 at 11:28 AM, during lunch tray delivery in the Yellow Zone, the surveyor observed CNA#1 entering and exiting resident's rooms without performing hand hygiene between residents. The surveyor observed CNA#1 enter and exit rooms 206, 205, 203 and 202 and delivered lunch trays to the residents performing hand hygiene between residents. During an interview with CNA #1 at 11:45 AM, CNA#1 stated that during lunch meal delivery there was not time to wash hands or use hand gel between residents because the food will get cold. The CNA #1 stated that there was not hand sanitizer in each resident's room, but each resident's room has a bathroom with a sink. At 1:05 PM the surveyor interviewed CNA#1 who stated that the Yellow Zone is considered the caution zone and the residents in the Yellow Zone may or may not be positive for Covid-19. CNA #1 stated she was taught to wear goggles in the Yellow Zone and that when she arrived for work on this day, she was only given a N-95 mask and not goggles. The CNA#1 further stated that she was supposed to receive all PPE that is needed for the unit when entering the facility. At that time, CNA #1 stated that hand hygiene was to be performed before entering a resident's room and after exiting a resident's room and after removing gloves. CNA#1 confirmed that she did not wash her hands or use hand gel between resident's room when delivering the lunch trays. CNA #1 stated I didn't wash my hands. I should have washed my hands between residents. During an interview with the Administrator, DON, ADON and IP on 6/29/20 at 1:58 PM, the ADON stated that residents in the Yellow Zone are on Standard and Droplet Precautions and staff are to wear a N-95 mask with a surgical mask over top of the N-95 mask, a face shield or goggles and gloves upon entering a residents' room. The ADON stated that each room in the Yellow Zone is considered an isolation room and PPE is to be put on prior to entering the room and removed prior to exiting a room. The IP stated that PPE was stored in her office and the administrator's office and all supervisors have access to obtain supplies. The IP further stated the if the staff did not have the appropriate PPE, the staff should have informed the supervisor and PPE would have been given to staff. The ADON stated that the goggles are reusable and were to be cleaned with germicidal wipes and stored in a brown paper bag in the unit managers office. The ADON stated that the same goggles could be worn from room to room in the yellow zone if the staff stayed in the yellow zone. During the interview, the IP confirmed that staff was to perform hand hygiene, either washed their hands or used hand sanitizer, between residents when delivering lunch trays and entering and exiting a residents' room. The surveyor reviewed in-services with sign-in sheets and competencies provided by the facility which included the following: CNA #1 attended the following in-services and competency: 3/18/20- Training on Coronavirus- which included hand hygiene and isolation 3/24/20 -Donning and Doffing of PPE and N-95 Usage 5/13/20- PPE Policy Addendum Covid-19 which included a policy that staff is to wear the N-95 mask covered with an isolation face mask, goggles and or face shield while on the yellow admission zone. 6/3/20- Covid-19 updated Zones and PPE- which included PPE reminders that Yellow Zone requires Standard and Droplet Precautions. Staff is required to wear gloves, N95 mask with isolation/surgical mask over N95, face shields and goggles 3/28/20 -Hand Hygiene competency LPN #1 attended the following in-services: 5/28/20- Covid -19 Symptom and PPE addendum for Covid-19 6/3/20-Covid-19 updated Zones and PPE- which included PPE reminders that Yellow Zone requires Standard and Droplet Precautions. Staff is required to wear gloves, N95 mask with isolation/surgical mask over N95, face shields and goggles A review of the facility's policy titled Handwashing/Hand Hygiene, revealed to use an alcohol based hand rub containing at least 62% alcohol: or alternately, soap (antimicrobial or non-antimicrobial) and water for situations that included before and after entering isolation precaution settings: and before and after assisting a resident with meals. A review of the facility's policy titled, Personal protective Equipment policy addendum Covid-19, with a revised date of 5/12/20, revealed that the presumptive Yellow Zone are for Persons Under Investigation for COVID-19 and residents newly admitted to the facility that require the resident to be on a 14 day monitoring and droplet precautions. The policy further reflected that staff caring for residents in the yellow admission zone will wear the N95 mask, covered with an isolation face mask, goggles or face shield. The policy also included that handwashing/gel sanitizer will be completed prior to exiting a resident's room. NJAC 8:39-19.4(a)1,2</p>		

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