

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER 315219	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/29/2020
NAME OF PROVIDER OF SUPPLIER VOORHEES CENTER		STREET ADDRESS, CITY, STATE, ZIP 3001 EVESHAM ROAD VOORHEES, NJ 08043	
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 Level of harm - Minimal harm or potential for actual harm Residents Affected - Few	<p>Provide and implement an infection prevention and control program.</p> <p>Based on observation, interview and review of other pertinent facility documents, it was determined that the facility failed to follow appropriate infection control practices and handle soiled personal protective equipment in a safe and sanitary manner during a COVID-19 Focused Survey. This deficient practice was identified on 1 of 5 nursing units (Unit #4), and was evidenced by the following: On 4/29/20 at 11:20 AM, during the initial tour of the facility, the surveyor interviewed the Unit Manager of Unit #4 regarding the availability and storage of Persona Protective Equipment (PPE) (specialized clothing or equipment worn by employees for protection against safety hazards, i.e., gowns, gloves, face masks or face shields). The UM stated that the facility stored gowns for the employees to wear over their uniforms during resident care in the clean utility room. The UM accompanied the surveyor into the clean utility room where both clean linens and supplies were stored. When the UM opened the door to the room there was a blue, cloth gown that was hung from the top shelf of a three-tiered wire rack that was draped over shelving that contained bed linens, sheets, towels, and gowns for both employee and resident use. The UM immediately removed the gown from the rack and stated that it should not have been there. The UM left the clean utility room and spoke with a nurse who was seated at the nurse's station. She returned and stated that the agency nurse (contracted employee) hung the gown in the clean utility room because she thought that she had to wear the same gown. She stated that she told the agency nurse that there were more available and all that she had to do was ask. The UM further stated that she would call Housekeeping to have the clean utility room cleared of it's contents and cleaned. At 11:58 AM, the surveyor interviewed the Agency Registered Nurse (ARN) who stated that she was a travel nurse employed by an outside agency. The ARN further stated that she was assigned to care only for COVID-19 positive residents and wore the same gown over her uniform as she rendered care which included medication administration and vital signs (temperature, heart rate, and pulse oximetry, i.e. probe placed on finger to measure oxygen level in the blood) which required direct resident contact. The ARN stated that she hung the gown that she had previously worn to care for COVID-19 positive residents on the top rack of the linen cart to the left of the cart which was in the same vicinity where clean bed linens and resident gowns were located on the second shelf. She further stated that she thought that she was supposed to hang it up after she exited the corridor dedicated to COVID residents on the unit for later use. The ARN accompanied the surveyor into the clean utility room and identified the area where she hung the gown. The surveyor noted that the contents of the clean utility room had not yet been discarded and the area did not appear to have been cleaned after the UM removed the soiled gown from the three-tiered linen cart. At 12:15 PM, in a later interview with the UM, she stated that all of the supplies and linens stored in the clean utility room had to be removed and laundered because the ARN placed a contaminated gown in there and all of that stuff was contaminated. She stated that she would call Housekeeping again to have the area cleaned. At 1:10 PM, the surveyor interviewed the Center Nurse Executive (CNE) who stated that there shouldn't be any soiled gowns in the clean utility room. She further stated that all nurses were trained to remove their gowns in the doorway of a resident's room, place it in a plastic bag, and place the bag in the dirty utility room to be laundered. At 2:25 PM, in a later interview with the UM, she stated that after the surveyor came to her a second time about the status of the clean utility room she removed the contaminated linens from the three- tiered wired rack and cleaned the shelves herself with bleach cleaner applied to paper towels that she obtained from Housekeeping. She further stated that she cleaned the room herself because she feared that if she waited any longer someone may have utilized contaminated linens for resident use. At 3:50 PM, in a later interview with the ARN, she stated that she made a dumb mistake by hanging the soiled gown used to care for COVID-19 positive residents in the clean utility room. She stated that she was instructed that she could wear the same gown continuously as the residents on her assignment all tested positive for COVID-19. She stated that it was her second day working at the facility and her first day assigned to Unit #4. She explained that she was told that she could not wear a gown behind the nurse's station, so she hung the soiled gown up in the clean utility room because she thought that was the right thing to do. The surveyor reviewed the facility policy, Washable and Disposable Gown Use and Reuse, (dated 4/11/20) which revealed the following: When gown is removed, staff member needs to place in plastic bag and tie bag closed. The bagged gown can then be mixed with other linen or taken to the soiled utility room and placed in soiled laundry hamper. NJAC 8:39-19.4</p>		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE		(X6) DATE

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.