STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	D35000	A. BUILDING: _____ B. WING _____	C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALCOEUR GARDENS AT TOMS RIVER	1126 ROUTE 166 TOMS RIVER, NJ 08755

(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) COMPLETE DATE
R 000	Initial Comments Type of Survey: Standard with Complaint #: NJ 00142232 CENSUS: 17 SAMPLE SIZE: 8 THE FACILITY IS IN COMPLIANCE WITH ALL OF THE STANDARDS IN THE NEW JERSEY ADMINISTRATIVE CODE 8:37, STANDARDS FOR LICENSURE OF RESIDENTIAL HEALTH CARE FACILITIES AND DEMENTIA CARE HOMES, BASED ON THIS COMPLAINT VISIT.	R 000		
R 100	8:37-2.3(a) Licensing: Administrator Each dementia care home shall have an administrator who is responsible for the day-to-day operations of the dementia care home. This STANDARD is not met as evidenced by: Based on observation, interview and record review it was determined that the facility failed to ensure its policy's titled, "Infection Control - Medication Administration," and "Infection Control - Hand Hygiene," were implemented when a Licensed Practical Nurse (LPN) failed to perform hand washing and/or hand hygiene during medication administration observation for 4 of 8 residents reviewed, Resident #2, Resident #3, Resident #4 and Resident #5. This deficient practice was evidenced by the following: 1. On 6/16/21 at 9:30 a.m., Surveyor #1 and Surveyor #2 observed a LPN as she stood in front of a medication cart on the [redacted] floor. Surveyor #1 informed the LPN that the surveyors were going to observe her [LPN] administer medications to the residents. The LPN stated	R 100		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 07/01/21

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R 100	Continued From page 1	R 100		

that she had four residents left to administer medications to and that she had never been observed administering medications before by the Department of Health.

At 9:45 a.m., Surveyor #1 and Surveyor #2 observed the LPN as she administered the following medications from "Bingo cards," (a single unit dose method of packaged medication in a blister or bubble), into a medication cup for Resident #2, [redacted] milligram (mg) tablet, [redacted] mg chew tablet, and [redacted] mg tablet. The LPN wore gloves and proceeded to Resident #2's room and administered the medications to him/her. The LPN removed her gloves after she administered the medications to Resident #2 and exited the room and went back to the medication cart. Neither Surveyor #1 nor Surveyor #2 observed the LPN perform any handwashing or hand hygiene using alcohol-based hand sanitizer before or after she administered medications to Resident #2.

2. At 9:55 a.m., the surveyors observed the LPN administer [redacted] mg tablet, [redacted] mg tablet, [redacted] mg tablet, [redacted] mg tablet, and [redacted] mg tablet, from "Bingo cards" into a medication cup for Resident #3. Additionally, the LPN retrieved a bottle of [redacted] drops from the medication cart for the Resident #3. The LPN wore gloves and then proceeded toward Resident #3 and administered the medications, including the [redacted] drops in Resident #3's right eye. Surveyor #1 observed that the LPN removed her gloves but did not observe the LPN wash her hands after she administered the [redacted] drops in the [redacted] Resident #3.

3. At 10:15 a.m., during continued observation, Surveyor #1 and Surveyor #2 observed the LPN

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R 100	Continued From page 2 administer [redacted] mg tablet, [redacted] mg capsule, [redacted] microgram (mcg) tablet, [redacted] tablet, [redacted] mg tablet, [redacted] mg, and [redacted] mg tablet, from "Bingo cards" into a medication cup for Resident #4. The LPN wore gloves and proceeded to Resident #4's room to administer the medications. The LPN observed that the resident was lying flat on the bed, she stated to the surveyors that she was going to get assistance from another staff member to properly reposition Resident #4 in the bed. At 10:20 a.m., the LPN returned to Resident #4's room and with the assistance of another staff member, repositioned the resident in bed, administered the medications to Resident #4, removed the gloves and exited the resident's room. The LPN stated to Surveyor #1 and Surveyor #2 that she was going to the rest room and would return shortly. The surveyors did not observe the LPN perform hand washing or hand hygiene after contact with Resident #4. 4. At 10:30 a.m., the LPN returned to the medication cart and got the following medications ready for administration to Resident #5, [redacted] mg tablet, [redacted] mg tablet, [redacted] mg tablet, [redacted] mg tablet, [redacted] mg capsule, and [redacted] mg tablet from "Bingo cards" and poured them into a medication cup and proceeded to Resident #5 and administered the medications to him/her. Neither Surveyor #1 nor Surveyor #2 observed LPN perform hand washing or hand hygiene before preparing the medications for Resident #5 or after she completed administration of the medication. At 10: 40 a.m., Surveyor #1 interviewed the LPN regarding hand hygiene during medication	R 100		

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R 100	Continued From page 3 administration. The LPN stated that she should have used hand sanitizer and should have washed her hands when there was resident contact, and she acknowledged that she did not. At 12:15 p.m., the surveyor informed the Registered Nurse (RN) and the facility Owner of the above hand washing concern. The RN stated that there was a hand sanitizer dispenser attached to the medication cart, and the Owner acknowledged that the LPN should have performed hand hygiene during the medication administration and explained that an in-service on hand washing was recently provided to the staff. Surveyor review of facility policy titled, "Infection Control - Medication Policy" which indicated, "Hand hygiene is performed prior to handling any medication. Hand hygiene with sanitizer is performed between each resident and hand washing between every third resident. If physical contact is performed during administration of medication hand washing is to be done before and after." Additionally, the facility's policy titled, "Infection Control - Hand Hygiene," indicated "Hand hygiene should be performed : ...b. Before and after performing any invasive procedure (e.g. finger stick, administration of eye drops, ear drops, or any other medication administration causing direct contact with residents)" and "...h. Before and after coming in contact with a resident's intact skin (e.g. when...lifting a resident)."	R 100		
R 365 SS=F	8:37-3.1(a)(12) Resident Rights Every resident of a dementia care home shall have the right to a safe and decent living environment and considerate and respectful care that	R 365		

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R 365	Continued From page 4 recognizes the dignity and individuality of the resident. This STANDARD is not met as evidenced by: Based on observation and record review it was determined that the facility failed to provide a safe environment when facility staff failed to ensure that all potentially toxic and potentially harmful cleaning products were secured in a locked cabinet or locked room, and inaccessible to residents to prevent accidental access and injury to 17 of 17 residents with [redacted] impairment. This deficient practice placed all residents of the facility at risk for harm and was evidenced by the following: On 6/16/21 at 9:25 a.m. during the entrance conference of the survey, the surveyor requested that the Administrator provide a list of the residents of the facility and their room numbers for review. At 9:56 a.m., during the tour of the building Surveyor #3 observed that the door to a storage closet, across from Resident Room #8 was in the open position, the surveyor observed that there was no staff present at that time. Surveyor #3 inspected inside the storage closet and observed the following: 1. One (1) quart of [redacted] bleach, with a warning label which indicated, "Hazards to Humans and Domestic animals. Danger: Corrosive, causes irreversible eye damage and skin burns. Harmful if swallowed. Wear protective eyewear and rubber gloves when handling this product. Keep out of reach of children." The surveyor waited in front of the unlocked storage closet for six (6) minutes until the facility Administrator arrived, at that time Surveyor #3 handed the bleach bottle to	R 365		

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R 365	Continued From page 5 the Administrator and request that the Administrator put the product in a secure location. The Administrator did comply with the request. A review of the facility provided resident roster identified that there were seventeen (17) residents that resided at the facility at the time of the survey.	R 365		