

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315353	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/14/2024
NAME OF PROVIDER OR SUPPLIER Cranbury Center		STREET ADDRESS, CITY, STATE, ZIP CODE 292 Applegarth Road Monroe Township, NJ 08831	

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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28604</p> <p>Based on observations, interviews, record review, and facility policy review, the facility failed to maintain the residents' dignity when staff stood while assisting residents to eat in the dining room for one of 17 residents (Resident (R) 16) reviewed for meal assistance of 34 sampled residents. This failure had the potential to result in an undignified dining experience.</p> <p>Findings include:</p> <p>Review of R16's Admission Record located in the electronic medical record (EMR) under the Profile tab, revealed she was admitted to the facility on [DATE] with diagnoses to include unspecified dementia with agitation and dysphagia.</p> <p>Review of R16's annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/29/24 located in R16's EMR under the MDS tab, revealed R16 had a Brief Interview for Mental Status (BIMS) score of two out of 15, which indicated the resident was severely cognitively impaired. The MDS revealed R16 required a mechanically altered diet.</p> <p>During an observation on 06/11/24 at 12:02 PM, the meal trays were delivered to 17 residents seated at four tables in the Unit C dining room.</p> <p>During an observation on 06/11/24 at 12:06 PM, R16 was sitting in a wheelchair at the second table in the dining room with the lunch meal placed on the tray in front of her. Continued observation revealed Licensed Practical Nurse (LPN) 3 walked over to R16, picked up a fork then fed her small bites of food from the plate, while standing next to her.</p> <p>During an interview on 06/11/24 at 12:16 PM, LPN3 confirmed she was standing over R16 while assisting her to eat the lunch meal in the dining room. LPN3 stated that by standing while feeding R16 she didn't maintain her dignity. LPN3 also stated she could not find a chair to sit in, so she fed her standing up because she wanted to feed R16 while the meal was warm.</p> <p>During an interview on 06/14/24 at 8:53 AM, the Director of Nursing (DON) and interim Administrator stated they expected nursing staff to sit down next to the resident while feeding them to maintain their dignity.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility's policy titled, Resident Rights Under Federal Law, revised on 02/01/23 and provided by the facility, revealed . Purpose To treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his/her self-esteem and selfworth . 5. Respect and Dignity. The resident has a right to be treated with respect and dignity, including (refer lo Center Operations Policies and Procedures, Treatment: Considerate and Respectful)</p> <p>NJAC 8:39-4.1(a)(12)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>28604</p> <p>Based on observations, interviews, and facility policy review, the facility failed to ensure a homelike environment when staff delivered the lunch meal on a tray from the cart to the table and did not remove the food from the tray in the dining room for 16 of 55 residents that resided on Unit C (Residents (R) 16, R23, R39, R47, R49, R54, R56, R69, R70, R75, R80, R86, R90, R110, R113 and R123. This failure had the potential to result in an institutional dining experience.</p> <p>Findings include:</p> <p>During an observation on 06/11/24 at 12:01 PM, two staff members delivered the lunch meal trays and sat them on the tables in front of R16, R23, R39, R47, R49, R54, R56, R69, R70, R75, R80, R86, R90, R110, R113 and R123. Continued observation revealed nursing staff in the dining room did not remove the food from the tray and place it on the table after the trays were delivered.</p> <p>During an interview on 06/11/24 at 12:13 PM, Certified Nursing Assistant (CNA) 5 verified she had worked at the facility since 2014 and the food was not removed from the tray after it was placed on the table in the dining room on Unit C.</p> <p>During an interview on 06/11/24 at 12:15 PM, CNA6 confirmed she had worked at the facility less than one month and resident's food was always served on trays and not removed from the tray after placed on the table in front of the residents in the dining room.</p> <p>During an interview on 06/11/24 at 12:16 PM, Licensed Practical Nurse (LPN) 3 acknowledged she had worked at the facility over three years, and she had observed staff removing the meal trays from the cart, placing it on the table in front of the residents without removing the plates, bowls, drinks, and utensils from the tray.</p> <p>During an interview on 06/14/24 at 8:53 AM, the Director of Nursing (DON) and Administrator stated leaving food on the trays after being served in the dining room was a cafeteria setting and not a homelike environment.</p> <p>Review of the facility's policy titled, Resident Rights Under Federal Law, revised on 02/01/23 and provided by the facility, revealed . 9. Safe Environment. The resident has the right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safety</p> <p>NJAC 8:39-31.4(a)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 25490</p> <p>Based on observation, interviews, record review, and facility policy review, the facility failed to follow a physician's order for a right-hand splint device for one of one resident (Resident (R) 74) reviewed for range of motion of 34 sample residents. This failure could potentially cause worsening contractures and a decline in range of motion.</p> <p>Findings include:</p> <p>Review of R74's Admission Record tab located in the electronic medical record (EMR), indicated R74 was admitted to the facility on [DATE] with diagnoses to include but not limited to, hypertension, hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, and unspecified lack of coordination.</p> <p>Review of R74's quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 03/15/24 revealed a Brief Interview for Mental Status (BIMS) score of 11 out of 15 which indicated R74 had moderately impaired cognition.</p> <p>Review of R74's Care Plan, dated 05/12/24 and located in the EMR under the Care Plan tab, revealed [R74] to use RUE (Right Upper Extremity) hand splint during daytime for 6-8 hours .</p> <p>Review of the Physician Orders, dated 05/10/24 and located in the EMR under the Orders tab, revealed R74 to wear a RUE resting hand splint daily for 6-8 hours (hrs.) during daytime .Assistance for application/removal was required every day and evening shift.</p> <p>During an observation and interview on 06/11/24 at 2:29 PM, R74 had a right-hand splint device, which was light and dark blue, lying on his dresser across the room. an interview, R74 was asked about the hand splint observation. R74 stated he was to wear the splint every day and proceeded to remove his right hand from under his bed sheets and showed me his right hand, which was contracted. R74 was asked why he was not wearing his hand splint and R74 stated, No one has put it on me.</p> <p>During an observation on 06/12/24 at 9:12 AM, R74 was lying in his bed resting and observation of the light and dark blue hand splint was still lying on the dresser in the same position as observed on the previous day on 06/11/23.</p> <p>During an interview on 06/12/24 at 9:12 AM, Licensed Practical Nurse (LPN) 2 stated R74 RUE splint should have been worn daily, she placed the splint on R74's right hand. LPN2 was asked the importance of wearing a hand splint and the LPN2 stated, Splints should be worn as ordered and if not worn regularly R74 could lose what range of motion he has. LPN2 further stated that R74 was not able to apply the splint on his own.</p> <p>During an interview on 06/12/24 at 2:19 PM, the Director of Nursing (DON) revealed her expectation of staff was that all physician orders were followed.</p> <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 06/12/24 at 3:17 PM, the facility Administrator revealed her expectation of staff was that physician orders were followed.</p> <p>Review of the facility's policy titled, Activities of Daily Living (ADL), dated 05/01/23, revealed Based on the comprehensive assessment of a patient and consistent with the patient's needs and choices, the Center must provide the necessary care and services to ensure that a patient's activities of daily living (ADL) abilities are maintained or improved and do not diminish unless circumstances of the patient's clinical condition demonstrate that a change was unavoidable .assistive devices and adaptive equipment are provided as needed.</p> <p>NJAC 8:39-27.1(a)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>46592</p> <p>Based upon observation, interview, and facility policy review the facility failed to allow cooking vessels to completely air dry before being placed for storage in one of one kitchen. This failure has the potential to create an environment that would enable bacteria growth between the vessels which could cause illness among 127 of 128 residents.</p> <p>Findings include:</p> <p>During an observation and interview on 06/11/24 at 10:10 AM with the Chef Manager (CM), buffet pans and other pans were stacked to be stored without reaching complete dryness. The CM was shown the multiple stacked pans, and the CM stated all the washed items should have been completely dried before stacking and storing. The CM then proceeded to take the stacks of wet items to the dishwasher room.</p> <p>During an observation and interview on 06/12/24 at 2:34 PM, with the CM and Food Services Director (FSD), buffet pans and other pans were stacked to be stored without reaching complete dryness. The CM and FSD were shown the multiple stacks, and the CM stated all the washed items should have been completely dried before stacking and storing, and that the staff were educated on 06/11/24, the day before. The CM then proceeded to take the stacks of wet items to the dishwasher room to be recleaned.</p> <p>During an interview on 06/14/24 at 11:20 AM, the Administrator verified nesting pans stored for future use in the kitchen should have been completely dried before being stacked together.</p> <p>Review of the facility's policy titled, Warewashing, revised 02/23 and provided by the facility, revealed all dishware, service ware, and utensils will be cleaned and sanitized after each use. The policy continued to indicate, all dishware will be air dried and properly stored.</p> <p>NJAC 8:39-17.2(g)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 28604</p> <p>Based on observation, interview, record review, and facility policy review, the facility failed to follow infection control and prevention guidelines to prevent cross-contamination when they did not follow Enhanced Barrier Precautions (EBP) while performing catheter care for one of one resident (Resident (R) 103) reviewed for catheters of 34 sampled residents. This failure had the potential to spread multidrug resistant organisms (MDROs) to the residents.</p> <p>Findings include:</p> <p>Review of R103's Admission Record, located in the electronic medical record (EMR) under the Profile tab, revealed R103 was admitted to the facility on [DATE] with diagnoses that included quadriplegia, C5-C7 incomplete, colostomy status, pressure ulcer of sacral region stage three, and suprapubic catheter status.</p> <p>Review of R103's comprehensive Care Plan located in the EMR under the Care Plan tab, revealed the following focus areas: I, [R103] have a PICC [peripherally inserted central catheter] line measuring 36cm [centimeters] in my RUE [right upper extremity] r/t [related to] use of ABX [antibiotic] therapy secondary to Multi-Organism Wound Infection [a germ that is resistant to treatment with many antibiotics] , dated 03/01/24, with no EBP interventions; I, [R103] have actual skin breakdown present on admission r/t impaired gait and mobility, deconditioning s/p [status post] hospitalization Wounds Present on Admission: actual pressure ulcer, sacrum, Rt [right] buttock, Lt [left] hip: B/L [bilateral] heels, Rt foot, dated 09/20/23, with no EBP interventions; and I, [R103] have a supra-pubic catheter placed d/t [due to] neurogenic bladder, dated 09/20/23, with no EBP interventions.</p> <p>Review of R103's Physician's Orders, dated 06/01/24, located in the EMR under the Orders tab, revealed orders as follows: Perform Indwelling Catheter Care (Suprapubic catheter 18F [French] with 10 ml [milliliters] balloon) every day and evening shift, Observe right arm double lumen PICC every shift and Dakins (1/4 strength) External Solution (Sodium Hypochlorite) Apply to coccyx topically every day and evening shift for wound***Cleanse wound with Dakin's Solution, apply Silvadene Cream to wound bed, apply wet to dry packing and cover with Silicone bordered foam and apply to coccyx topically as needed for Wound ***Change dressing if loose or soiled.</p> <p>Observation on 06/11/24 at 10:18 AM revealed R103 lying in bed with the indwelling urinary catheter tubing not kinked, the catheter bag was not covered, and was attached to the bottom bed rail. There was no EBP sign on the resident's door and no cart with personal protective equipment (PPE) near or outside of the resident's room. Interview with R103 at this time revealed staff were not wearing a gown when performing catheter or wound care.</p> <p>Observations on 06/11/24 at 10:39 AM, 12:32 PM, and 2:50 PM, revealed there was no EBP sign on R103's door and no PPE cart outside of the room.</p> <p>During an interview and observation on 06/11/24 at 12:34 PM, Licensed Practical Nurse (LPN) 2 confirmed R103 did not have an EBP sign on the door and there was no PPE cart outside of the room or in the hallway.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 06/11/24 at 12:34 PM, LPN3 verified R103 did not have an EBP sign on the door and there was no PPE cart outside of R103's room. LPN3 stated nursing staff were trained by the former Infection Preventionist (IP) on EBP a few months ago and the EBP was used for residents with open wounds, indwelling urinary catheters, PICC lines, and MDROs (multidrug resistant organisms). LPN3 stated EBP were extra precautions that you took when providing wound and catheter care and should wear a gown and gloves when performing wound and catheter care.</p> <p>During an interview on 06/11/24 at 12:40 PM, Certified Nursing Assistant (CNA) 4 stated she was trained by the former IP on EBP a few months ago and should wear a gown and gloves when providing care to residents but she didn't know which residents should be on EBP. CNA4 also stated residents on EBP would have an EBP sign on the outside of the door and a PPE cart would be placed outside of the door. CNA4 verified R103 did not have an EBP sign on the door or PPE cart in the hallway. CNA4 also stated she was assigned to R103 and had provided catheter care using gloves but not a gown.</p> <p>During an interview on 06/12/24 at 8:31 AM, the Nurse Manager stated the IP would place an EBP sign on the door and PPE cart outside of the room if the resident had an open wound, indwelling catheter, PICC line, and MDRO. The Nurse Manager also stated R103 should have been placed on EBP when he was readmitted on [DATE] but someone missed it. The Nurse Manager indicated a gown, and gloves should be worn when the nursing staff were providing high touch activities for residents on EBP and that these precautions were implemented to protect residents and staff from spreading MDROs.</p> <p>During an interview on 06/12/24 at 4:22 PM, CNA7 acknowledged R103 was not on EBP on 06/11/24 and did not know why the resident was on the precautions today because he had not received report yet.</p> <p>During an interview on 06/14/24 at 12:32 PM, the Administrator stated the former IP resigned two months ago and trained the staff on EBP prior to her departure. The Administrator also stated the interim IP was at the facility most days of the week but not on the weekends and expected the admitting nurse to implement EBP and update the care plan when R103 was readmitted to the facility from the hospital on 06/01/24.</p> <p>During an interview on 06/14/24 at 1:16 PM, the interim IP acknowledged EBP was not implemented for R103 until 06/12/24 and she expected the admitting nurse to implement EBP and document EBP on the care plan after his readmission to the facility on [DATE] per the EBP policy. The interim IP stated the EBP signs were available on the floor at the nurses' station and nursing staff had access to the PPE carts during the week and on weekends. The interim IP also stated that the facility must implement EBP for residents with MDROs but could use their discretion for residents with devices such as PICC lines, indwelling urinary catheters, and open wounds.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility's policy titled, Enhanced Barrier Precautions (EBP), revised 04/01/24 and provided by the facility, revealed . 1. Prompt recognition of need: . c. The facility will have the discretion on how to communicate to staff which residents require the use of EBP, as long as staff are aware of which residents require the use of EBP prior to providing high-contact care activities. 2. Initiation of Enhanced Barrier Precautions: a. The facility will have the discretion in using EBP for residents who do not have a chronic wound or indwelling medical device and are infected or colonized with an MDRO that is not currently targeted by Center for Disease Control (CDC). b. An order for enhanced barrier precautions will be obtained for residents with any of the following: i. Wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices (e.g., central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes) even if the resident is not known to be infected or colonized with a Multi- Drug Resistant Organisms MDRO) . 4. High-contact resident care activities include: . g. Device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes .</p> <p>Review of the facility's policy titled, Enhanced Barrier Precautions, revised 01/08/24 and provided by the facility, revealed Policy In addition to Standard Precautions, Enhanced Barrier Precautions (EBP) will be used for novel or targeted multi-drug resistant organisms (MDROs) . Purpose to reduce the risk of transmission of epidemiologically important microorganisms by direct or indirect contact. Refer to: Enhanced Barrier Precautions procedure</p> <p>Review of the facility's document titled, Procedure: Enhanced Barrier Precautions, revised 05/01/24 and provided by the facility, revealed 1. Post the appropriate Enhanced Barrier Precautions (EBP) sign on the patient's room door . 1.1 Enhanced Barrier Precautions (EBP) are to be utilized for the duration of the patient's stay . 3. Follow the CDC [Centers for Disease Prevention and Control] guidance per table below . Enhanced barrier applies to chronic wounds and/or indwelling medical devices (e.g., central line, urinary catheter, enteral feeding tube, tracheostomy, ventilator) regardless of MDRO colonization status. PPE used for these situations during high contact patient care activities: Dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use, central line, urinary catheter, enteral feeding tube, tracheostomy, ventilator, wound care, any skin opening requiring a dressing . Required PPE gown, gloves prior to high contact care activity (change PPE before caring for another patient) . 4. PPE should be accessible and located outside of the patient's room . 12. document: 12.1 type of precautions in care plan</p> <p>Review of the facility's staff in-service titled New EBP Policy, dated 03/20/24 and provided by the facility, revealed nursing staff were trained on the new EBP guidelines.</p> <p>NJAC 8:39-19.4</p>		