

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315442	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2025
NAME OF PROVIDER OR SUPPLIER Trinitas Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE 655 East Jersey Street Elizabeth, NJ 07206	

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>51232</p> <p>Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to provide privacy for a resident during hygienic care. Specifically, the bedroom and bathroom doors were not closed, exposing the resident's upper body. This deficiency was noted for 1 out of 20 residents (Resident # 38) reviewed.</p> <p>This deficient practice was evidenced by the following:</p> <p>On 01/13/2025 at 10:19 AM, the surveyor observed Resident # 38 in the bathroom sitting on the toilet, with the wheelchair positioned in front of the resident while getting dressed. The door was open, exposing the resident's upper body.</p> <p>During an interview with the surveyor on 01/13/2025 at 10:39 AM, the Licensed Practical Nurse #1 (LPN #1) said that she was uncertain whether the bedroom and bathroom doors should remain open during the time the resident was getting dressed.</p> <p>During an interview with the surveyor on 01/15/2025 at 11:40 AM, the Director of Nursing (DON) said that the bedroom and bathroom doors should have been closed while the resident was getting dressed.</p> <p>A review of a facility policy dated 03/2024 titled, Quality of Life -Dignity, revealed, Staff shall promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures.</p> <p>N.J.A.C. 8:39-4.1(a)(16)</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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>51232</p> <p>Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to keep the call device system within reach for a resident who was dependent on staff. This deficiency was identified for 1 out of 1 resident (Resident # 32) reviewed for Accommodation of Needs.</p> <p>This deficient practice was evidenced by the following:</p> <p>On 01/13/2025 at 10:01 AM, the surveyor reviewed the electronic medical records (EMR) for Resident #32. The EMR revealed that he/she had a diagnoses of but not limited to Dementia and Alzheimer's Disease (cognitive disease).</p> <p>A review of the significant change in status Minimum Data Set (MDS), an assessment tool used to facilitate the management of care dated 11/20/2024 indicated that Resident #32 had severe cognitive impairment and was dependent in both self-care and mobility.</p> <p>On 01/13/2025 at 9:59 AM, the surveyor observed the resident in the bedroom, seated in a geriatric recliner chair (a large, padded chair designed to assist those with limited mobility) next to the right side of the bed. The call device was out of reach, hanging from the oxygen system connected to the wall on the left side of the bed.</p> <p>On 01/14/2025 at 10:58 AM, the surveyor observed the resident in the bedroom, seated in a geriatric chair next to the right side of the bed. The call device was out of reach, hanging from the oxygen system connected to the wall on the left side of the bed.</p> <p>During an interview with the surveyor on 01/15/2025 at 11:40 AM, the Director of Nursing (DON) said that the resident needs access to a call device and acknowledged that it is not appropriate for him/her to be without one. The DON indicated that she would reassess the situation and seek an appropriate solution.</p> <p>A review of a facility policy dated 03/2024 titled, Call System, revealed, The facility will provide a call system to enable residents to alert the nursing staff from their beds and toileting/bathing facilities. If a resident is physically incapable of actuating a call system, the resident shall be physically housed in a resident room close enough to the nursing station to allow for line-of-sight supervision at a frequency identified by a through individualized nursing assessment.</p> <p>N.J.A.C. 8:39-27.1 (a)</p>		

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<p>F 0577</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>49712</p> <p>Allow residents to easily view the nursing home's survey results and communicate with advocate agencies.</p> <p>Based on observation and interviews, it was determined that the facility failed to maintain the most recent State of New Jersey inspection results in a place readily accessible to the residents, families, and the public. The deficient practice was identified on 3 of 3 units.</p> <p>This deficient practice was evidenced by the following:</p> <p>During the Resident Council Meeting on 01/15/2025 at 10:00 AM, five of five alert and oriented residents said they were not aware of the location of the State Survey results and that the facility had not spoken to them about the results.</p> <p>During a tour of each unit, the surveyor had to ask at the nurse's station where the State survey results binder was kept. The surveyor was told by the unit secretary or nurse that was at the desk at each unit that it was located behind the nurse's station. The surveyor was also told at each unit that if the residents asked for it, they could see it. On the 4 South unit the Registered Nurse (RN) could not locate the binder when asked. The RN said, I know it's here somewhere. There were no posted signs to direct resident's, families, and the public to the location of the survey results. These binders were not accessible to residents or visitors without asking staff.</p> <p>During an interview with the surveyor on 01/15/2025 at 10:34 AM, the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON) said that the survey results are located on the unit behind the desk. The DON then said the residents were allowed to go behind the nurse's station and ask or get look at the results if there was someone behind the desk to help them. When asked if they considered if the results binder was readily accessible to the residents or public, the LNHA stated, No.</p> <p>The facility was unable to produce a policy in reference to the State of New Jersey inspection results.</p> <p>NJAC 8:39-9.4(b)</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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51232</p> <p>Based on observation, interview, and review of pertinent facility documentation, it was determined that the facility failed to maintain a clean, safe, and sanitary environment for 2 of 3 units (South and North Units).</p> <p>This deficient practice was evidenced by the following:</p> <p>On 01/12/2025 at 10:28 AM, Surveyor #1 observed the baseboard trim in room [ROOM NUMBER] detached from the wall on the North Unit.</p> <p>On 01/13/2025 at 10:35 AM, Surveyor #1 observed water stains on the ceiling tiles in the shower room on the North Nursing Unit.</p> <p>On 01/13/2025 at 10:43 AM, Surveyor #1 observed the shower room on the North Nursing Unit, which including a portable commode, three commode buckets, a commode lid, and a non-stick food placement mat placed on a chair in the corner.</p> <p>During an interview with Surveyor #1 on 01/15/2025 at 9:58 AM, the Maintenance Director (MD) said that water stains could indicate condensation or a leak and if wet ceiling tiles are observed, an investigation is conducted, followed by the replacement of ceiling tiles as needed.</p> <p>During an interview with Surveyor #1 on 01/15/2025 at 10:14 AM, the Assistant Housekeeping Director (AHD), said that shower rooms are cleaned regularly and as needed. Housekeeping does not handle residents' personal items, emphasizing that they do not touch any private belongings.</p> <p>During an interview with Surveyor #1 on 01/15/2025 at 11:40 AM, the Director of Nursing (DON) said that nursing staff shares the responsibility of cleaning the shower rooms, and while they remove residents ' personal items, housekeeping conducts a thorough cleaning afterward.</p> <p>A review of the dated facility policy 03/2024, titled, Homelike Environment, revealed, The facility staff and management shall maximize to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. Those characteristics include cleanliness and order.</p> <p>43936</p> <p>2.) On 01/12/2025 at 10:04 AM during the initial tour of the fourth floor, Surveyor # 2 observed Resident # 84's room. At that time, the surveyor observed brown stains on the wall near the bed and on a feeding pump located on a pole in the room. The garbage receptacle had no bag in it. The bedside table adjacent to the bed was observed to have dried stains on it.</p> <p>On 01/14/2025 at 10:37 AM, Surveyor # 2 observed Resident # 84's room. At that time, the surveyor observed that the garbage receptacle had no bag in it. The room also emanated a strong odor of fecal matter.</p> <p>(continued on next page)</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>On 01/15/2025 at 11:35 AM during an interview with the surveyor, the Director of Nursing (DON) replied, Daily. Housekeeping is twenty-four seven but lesser on evenings and overnights. when the surveyor asked how often resident rooms are cleaned. The DON explained that cleaning entails the garbage, floors, dusting, bedside tables, and the garbage.</p> <p>45209</p> <p>3.) On 1/14/25 at 9:58 AM while touring the fifth floor, surveyor #3 observed large area of brown splatter residue on the wall to the right of Resident #52's bed behind their intravenous pole and dresser. Surveyor #3 also observed brown residue on the intravenous pole.</p> <p>On 1/14/25 at 10:08 AM, surveyor #3 interviewed Certified Nursing Assistant (CNA #1) who reported that all of nursing is responsible to ensure the resident's rooms are clean. When asked who would make sure that the resident's medical equipment remained clean CNA #1 responded, the nurse.</p> <p>On the same date at 10:48 AM, surveyor #3 interviewed Licensed Practical Nurse (LPN #1) acknowledged the large area of brown residue behind the intravenous pole and dresser. LPN #1 stated that the room is their home and it should not have brown splatter on the wall.</p> <p>On the same date at 11:06 AM, surveyor #3 interviewed Unit Manager Registered Nurse (UMRN# 1) who stated that the brown residue appeared to be enteral formula. UMRN #1 confirmed that the wall should not be that condition and it should have been identified by nursing or housekeeping. When asked why the wall should not look like that UMRN# 1 responded, because this is their home and we should keep it clean.</p> <p>On 1/16/25 at 9:59 AM, surveyor #3, interviewed the Assistant Director of Facilities who acknowledged the brown residue on Resident #52's wall and that it should have been identified by housekeeping.</p> <p>On 1/16/25 at 10:04 AM, surveyor #3, interviewed the Assistant Director of Environmental Services, in the presence of the Operations Manager, who confirmed that the brown residue on Resident #52's wall should have identified and should not present in that condition.</p> <p>On 1/16/25 at 11:35 AM, surveyor #3, interviewed the Director of Nursing, in the presence of the Licensed Nursing Home Administrator (LNHA) acknowledged brown residue on Resident #52's wall should have been cleaned to ensure homelike environment.</p> <p>N.J.A.C. 8:39-31.3(a)</p> <p>N.J.A.C. 8:39-31.4 (a)</p>		

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<p>F 0640</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38680</p> <p>Based on interview and record review, it was determined that the facility failed to complete and transmit a Minimum Data Set death in facility tracking record in accordance with federal guidelines. This deficient practice was identified for 1 of 2 residents reviewed for resident assessment (Resident #58). This deficient practice was evidenced by:</p> <p>On [DATE] at 12:07 PM, the surveyor reviewed the facility assessment task that included the Resident's MDS Assessments.</p> <p>On [DATE] at 12:07 PM, the surveyor reviewed Resident #58's electronic medical record. The record revealed that the resident expired on [DATE]. The electronic health record reflected that there was no death in facility tracking record completed for the resident's death date of [DATE].</p> <p>On [DATE] at 12:13 PM, the surveyor interviewed the MDS Coordinator. The MDS Coordinator confirmed that the death in facility tracking record was not completed or transmitted for Resident #58. She stated it should have been completed by [DATE].</p> <p>A MDS is a comprehensive tool that is a federal mandated process for clinical assessment of all residents that must be completed and transmitted to the Quality Measure System. The facility must electronically transmit the MDS within 14 days of the assessment being completed.</p> <p>The surveyor reviewed the facility's policy entitled MDS Completion and Submission Timeframes with a revised date of [DATE]. The policy revealed that the facility will conduct and submit resident assessments in accordance with current federal and state submission timeframes.</p> <p>NJAC 8;.d+[DATE].2</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>38680</p> <p>Based on observation, interview, and record review, it was determined that the facility failed to develop a comprehensive care plan to address an elopement alarm for 1 of 23 residents (Resident #59) reviewed.</p> <p>The deficient practice was evidenced by the following:</p> <p>On 01/12/25 at 10:00 AM, the surveyor observed Resident #59 in the room with an elopement alarm on the left ankle.</p> <p>The surveyor reviewed Resident #59's medical record which reflected that the resident had diagnoses which included muscle weakness and anxiety.</p> <p>A review of the physician orders for Resident # 59 reflected an order dated 09/10/21 for the resident to have a wanderguard. The minimum data set, an assessment tool, dated 11/8/24 Q MDS reflected that Resident #59 used an elopement alarm used daily.</p> <p>The surveyor reviewed the resident's care plans which revealed there was no care plan developed to address the elopement alarm which was initiated on 09/10/2021.</p> <p>On 01/15/25 at 10:53 AM, the surveyor interviewed the Nurse Manager who said the elopement alarm should be included in the care plan. The nurse manager and surveyor reviewed the care plans of Resident #59 together. She confirmed that there was no care plan addressing the elopement alarm.</p> <p>A review of the policy titled, Care Plans-Comprehensive, with a revised date of January 1, 2025 reflected 2. The comprehensive care plan is based on a thorough assessment that includes, but is not limited to, the MDS. It further reflected 8. Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change.</p> <p>NJAC 8:39-27.1(a)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>45209</p> <p>Based on observation, interview, record review, and review of pertinent facility documents it was determined that the facility failed to use appropriate infection control practices, such as hand hygiene and Personal Protective Equipment (PPE) when providing care and other high-contact care activities to 3 of 3 residents (Resident #23, #52, #84) reviewed under the Infection Control Task.</p> <p>The deficient practices were evidenced by the following:</p> <p>1. On 1/14/2025 at 10:24 AM, surveyor #1 observed Licensed Practical Nurse (LPN#1) perform tracheostomy (a small surgical opening that is made through the front of the neck into the windpipe) care, which was identified as requiring aseptic techniques (a set of practices that prevent the spread of infection) on Resident #52 and observed the following:</p> <p>At 10:31 AM, following Resident #52's assessment by LPN #1 it was determined that that deep suctioning was required to clear their airway due to excessive secretions. LPN #1 removed her disposable gloves and applied sterile gloves without performing hand sanitation. Upon completion of suctioning, LPN #1 removed the sterile gloves and washed their hands with soap and water lathering under the flow of running water for fifteen seconds.</p> <p>At 10:39 AM, LPN #1 proceeded to apply sterile gloves in order to change Resident #52's tracheostomy inner cannula (the inner portion of the tracheostomy tube which can help prevent airway obstruction). While applying the right glove, LPN#1 grabbed the thumb of the glove with the ungloved left hand which broke the sterility of the right glove.</p> <p>During the inner cannula change at 10:41 AM, LPN #1 recognized that she did not have the correct cannula. With sterile gloves applied, LPN #1 retrieved the proper supplies, opened the package, and continued with the change which resulted in a break of aseptic techniques.</p> <p>At 10:46 AM, following the inner cannula change, LPN #1 removed the sterile gloves and changed to disposable gloves without hand sanitization.</p> <p>At 10:51 AM, surveyor #1 interviewed LPN #1 who confirmed that handwashing was not completed for the required 15-20 seconds that there should have been hand sanitizing between glove changes. LPN #1 also acknowledged that she broke aseptic techniques and the sterility of the gloves when she touched the thumb of the right glove and when she gathered supplies in the room with the gloves on.</p> <p>During an interview with another surveyor on 1/15/2025 at 10:00 AM , the Infection Preventionist (IP) confirmed that hand hygiene is essential between glove changes to prevent cross contamination.</p> <p>During an interview with surveyor #1 on 1/16/2025 at 11:35 AM, the Director of Nursing (DON), in the presence of the Licensed Nursing Home Administrator (LNHA) acknowledged that hand sanitation should be completed between glove changes, the hand washing length, and break in sterile technique.</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 - Some</p>	<p>A review of facility policy titled, Tracheostomy Care, Revised 12/24, under section General Guidelines included: 1. Aseptic technique must be used: c. during tracheostomy tube changes, either reusable or disposable [.] 2. [.] Sterile Gloves must be used during aseptic procedures .</p> <p>A review of facility policy titled, Handwashing/Hand Hygiene, Revised 3/24, under section Policy Interpretation and Implementation included: 5. Employees must wash their hands for at least 20 seconds using antimicrobial or non-microbial soap and water (.) 6. In most situations, the preferred method of hand hygiene is with and alcohol-based hand rub. If hands are not visibly soiled use and alcohol based rub containing 60-95% ethanol or isopropanol for the following situations (.)b. before donning sterile gloves; (.) j. after removing gloves.</p> <p>43936</p> <p>2.) On 01/13/2025 at 11:28 AM while outside of Resident # 84's room, Surveyor # 2 observed Registered Nurse (RN) # 1 in the room. RN # 1 was disconnecting the feeding tube (External tube inserted into the stomach to provide nutritional formula) that was connected to Resident # 84 from the nutritional formula hanging on a pole. RN # 1 was wearing gloves but not a disposable gown.</p> <p>At that time, Surveyor # 1 also observed a sign outside the doorway that was titled, Enhanced Barrier Precautions Everyone Must: The sign revealed that providers and staff must wear gloves and a gown for the following High-Contact Resident Care Activities. The sign revealed a list including Device care or use: central line, urinary catheter, feeding tube .</p> <p>A review of Resident # 84's Active Orders revealed an order for, Formula hang flush bag of 150,L [milliliter] ever 6 hours X 20 hours to run with feeding. Special Instructions: [Brand name redacted] at 50 mL/hour X 20 hours. Up at 2 PM and Down at 10 AM or when total volume of 1000 mL infused. Hang flush bag at 150 mL every 6 hours X 20 hours to run with feeding. Twice a day start feeing at 02:00 PM, Remove feeing 10:00 AM.</p> <p>A review of Resident # 84's Electronic Medical Record (EMR) revealed an order to clean a wound to left foot with normal saline solution and apply aquacel, wrap with gauze daily.</p> <p>A review of Resident # 84's Care Plan revealed a focus for, Impaired skin integrity, presence of: wounds : Stage III wound to sacral area. 9/11/2024 ulcer to left dorsal foot.</p> <p>On 1/13/2025 at 11:30 AM, Surveyor # 2 observed the sign outside the doorway of Resident # 84's room that was titled, Enhanced Barrier Precautions Everyone Must: The sign revealed that providers and staff must wear gloves and a gown for the following High-Contact Resident Care Activities. The sign revealed a list including Wound Care: any skin opening requiring a dressing.</p> <p>On the same date at 11:33 AM, Surveyor # 2 observed Registered Nurse (RN) # 1 with assistance from Certified Nurses Aide (CNA) # 1 perform wound care on Resident # 84. At that time, CNA # 1 did not don a gown while in the room.</p> <p>During the wound care at approximately 11:43 AM, RN # 1 removed the soiled dressing from Resident # 84's left foot. At that time, RN # 1 removed the disposable gloves and applied a new pair of gloves. RN # 1 did not perform any hand hygiene between changing gloves.</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 - Some</p>	<p>At approximately 11:46 AM, after irrigating the wound, RN # 1 removed the disposable gloves and applied a new pair of gloves. RN # 1 did not perform any hand hygiene between changing gloves.</p> <p>Lastly, RN # 1 applied a gauze wrap to Resident # 84's left foot. At that time, RN # 1 removed the disposable gloves. RN # 1 did not perform and hand hygiene after removing the gloves. RN # 1 and CNA # 1 then proceeded to lift and position Resident # 84 in their bed. CNA # 1 did not wear a gown throughout the entire observation of wound care.</p> <p>At approximately 11:50 AM during an interview with Surveyor # 2, RN # 1 said CNA # 1 should have worn a gown in the room. RN # 1 said that he washed his hands before wound care and didn't use alcohol-based hand rub between glove changes.</p> <p>On 1/15/2025 at 10:20 AM during an interview with Surveyor # 2, the Infection Preventionist confirmed that staff should be performing hand hygiene between glove changes clarifying it is important to prevent transmission.</p> <p>On 1/15/2025 at 11:35 AM during an interview with the Director of Nursing (DON), Surveyor # 1 asked when a nurse is disconnecting a completed formula feeding for a resident with a feeding tube, should the nurse be wearing a gown if they are on Enhanced Barrier Precautions? The DON replied, yes. The surveyor then asked why would that be important. The DON replied, Because there is an opening an it could possibly transfer possible infection. During the same interview with Surveyor # 2, the Director of Nursing (DON) replied, Yes when the surveyor asked should a nurse perform hand hygiene between glove changes during wound care. The DON said it is important for infection control.</p> <p>A review of the facility policy titled, Handwashing/hang hygiene with a revised date of 3/24 revealed, Employees must wash their hands for at least 20 seconds using antimicrobial or non-antimicrobial soap and water under the following conditions: k. Before and after changing a dressing .e. Before handling clean or soiled dressing, gauze pad, etc., j. After removing gloves.</p> <p>38680</p> <p>3.) Surveyor #3 observed a sign for enhanced barrier precautions (EBP) to the right of the door outside Resident #23's room. The sign reflected that everyone must clean hands, including before and when leaving room. Providers and staff must also wear gloves and gown for the following high contact resident care activities: dressing, bathing, providing hygiene, changing linens, changing briefs and device care.</p> <p>On 01/12/2025 at 10:21 AM, Surveyor #3 observed Resident #23 receiving care. Certified Nurses Aide (CNA) #2 was observed performing direct care on this resident wearing a mask and gloves. CNA #2 was not wearing a gown. When asked if she should be wearing a gown the CNA responded, oh yeah.</p> <p>On 01/14/2025 at 11:18 AM, Surveyor #3 observed Registered Nurse #2 at Resident #23's bedside adjusting the oxygen tubing. RN #2 was observed wearing gloves and no gown. When asked at that time if she should be wearing a gown, RN #2 responded yes.</p> <p>A review of the medical record reflected that Resident #23 had diagnosis which included dysphagia (a problem swallowing).</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 315442	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2025
NAME OF PROVIDER OR SUPPLIER Trinitas Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE 655 East Jersey Street Elizabeth, NJ 07206	
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the quarterly minimum data set, an assessment tool, dated 11/12/2024 reflected that Resident # 23 had long and short-term memory deficits. It reflected that Resident # 23 utilized a feeding tube for nutrition.</p> <p>During an interview on 01/15/2025 at 10:22 AM, the infection preventionist said that when a resident is on EBP a gown should be utilized when providing care and adjusting Oxygen tubing.</p> <p>A review of the policy titled Enhanced Barrier Precautions with an effective date of 04/05/2024 reflected that all residents with medical devices including feeding tubes require gloves and gowns to be worn during high contact resident care.</p> <p>NJAC 8:39 19.4(a)</p>		