STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315351	A. BUILDING _____ B. WING _____	11/19/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF EDISON	**1801 OAKTREE ROAD EDISON, NJ 08820**

(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) COMPLETION DATE
F 000	INITIAL COMMENTS Survey Date: 11/19/2020 Census: 20 Sample: 5 A COVID-19 Focused Infection Control Survey was conducted by the New Jersey Department of Health. The facility was found to be not in compliance with 42 CFR §483.80 infection control regulations as it relates to the implementation of the CMS and Centers for Disease Control and Prevention (CDC) recommended practices for COVID-19.	F 000		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment	F 880		12/22/20

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

Electronically Signed | 12/04/2020

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F 880	Continued From page 1 conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of	F 880		

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F 880	Continued From page 2 infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of pertinent facility documentation, it was identified that the facility failed to implement appropriate infection control practices for performing hand hygiene prior to donning (putting on) and doffing (taking off) Personal Protective Equipment (PPE); donning and doffing PPE; and cleaning multi-use equipment between resident use. This deficient practice was identified during a focused COVID-19 survey for 2 of 5 residents reviewed, (Resident #4 and Resident #5) and was evidenced by the following: On 11/19/2020 at 1:25 PM, the surveyor observed a Stop Sign outside of Resident #4's bedroom door. The sign indicated the resident was on standard, droplet, and contact precautions and only enter the resident's room if wearing PPE. Underneath the Stop Sign, there were instructions on how to appropriately don and doff PPE in accordance with Center for Disease Control (CDC) guidelines. Outside of the resident's room, the surveyor observed two plastic bins stocked with alcohol-based hand rub (ABHR), gloves, face shields, disposable gowns, and KN95 masks. At this time, the surveyor observed the radiographer put on a pair of gloves, open the plastic bin with his gloved hands, take out a KN95	F 880	A. 1.All residents have the potential to be affected by this deficient practice On 11/20/20 the radiographer returned to the facility and was provided education by a 7-3 RN on the following: - The requirements required within F Tag 880 Infection Prevention and Control along with potential for citation of non-compliance due to the actions on 11/19/20. -Hand hygiene -Proper donning and doffing of PPE -The disinfection of multi-use equipment -Informational posters that are located outside of each isolated resident's room. 2. The radiology company that the facility uses was contacted by the Director of Nursing and informed of the receipt of this F tag and its specifics on 11/30/20. B. Vendors who provide services that require direct resident contact will be provided with an educational packet by the facility, and will be required to provide documentation of their employees	

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F 880	Continued From page 3 mask and place the KN95 mask over top the KN95 mask he was wearing. The radiographer then donned a gown and a face shield and entered the resident's room. The surveyor observed that the radiographer donned his PPE without first performing hand hygiene. After the radiographer entered the resident's room with his x-ray machine, the surveyor observed the radiographer reposition Resident #4 in his/her wheelchair by touching the resident's back with his gloved hands and then take a chest x-ray of the resident. After the x-ray was obtained, the radiographer removed the outmost KN95 mask with his gloved hands and throw it away in the garbage can positioned by the entrance to the resident's room. The radiographer then removed his gown and gloves, lifted the lid of the garbage can with his bare hands to dispose of the gown and gloves, and then exited the resident's room without performing hand hygiene. The radiographer entered the hallway and was observed still wearing the same face shield that he wore inside of Resident #4's room. The surveyor did not observe the radiographer wipe down or clean the x-ray machine. The surveyor then followed the radiographer down the hallway to Resident #5's room. Outside of Resident #5's room, the surveyor observed a Stop Sign which indicated the resident was on standard, droplet, and contact precautions. The sign further indicated to only enter the resident's room if wearing PPE. Underneath the Stop Sign were instructions on how to appropriately don and doff PPE per CDC guidelines. Outside of the resident's room the surveyor observed two plastic bins stocked with ABHR, gloves, face shields, disposable gowns, and KN95 masks.	F 880	receiving that education prior to providing services. C. In order to ensure that the cited deficient practice does not recur: 1.The Director of Nursing/Designee will obtain proof of the above required training from a vendor prior to them providing services. 2.The Director of Nursing/Designated RN will randomly observe 2 vendors providing direct services to residents a minimum of 2x/week for 3 months to assure that the following protocols are adhered to: -Proper hand hygiene -Proper donning and doffing of PPE -Disinfection of multi-use resident equipment 2. In addition to the above, The Director of Nursing/Designated RN will observe the radiographer s minimum of a total of 2 times to assure the above requirements are met 3. On the spot education will be provided as needed D. In order to confirm that the processes outlined above are sustained, the Director of Nursing will report the findings of the above at the monthly QAPI meeting for 3 months. During, and at the conclusion of the 3 month period, the Committee will reevaluate and initiate any necessary action or extend the review period.	

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F 880	Continued From page 4 The surveyor observed the radiographer push the x-ray machine into the threshold of the resident's room. The surveyor further observed the radiographer remove his face shield and place it face down so that the front of the face shield was directly touching the top of the plastic bin. The surveyor observed the radiographer don a KN95 mask over the KN95 mask he wore into the facility, don gloves and a gown, and then put on the face shield that he had placed on top of the PPE bin. The surveyor never observed the radiographer perform hand hygiene prior to donning the PPE. At 1:37 AM, the surveyor stopped the radiographer prior to entering Resident #5's room and conducted an interview. The surveyor asked the radiographer why he needed to wear PPE prior to the entry of the resident's rooms? The radiographer stated that the residents were both Executive Order 26, 4.b.. The radiographer stated that hand hygiene was supposed to be performed prior to donning and doffing PPE and admitted to the surveyor that he had never performed hand hygiene. The surveyor asked the radiographer when he cleaned the x-ray machine? The radiographer stated that every facility had different rules and he usually would wipe down the x-ray machine with a sanitizer wipe before he entered another facility. The radiographer stated that he had not wiped down the x-ray machine with a sanitizer wipe because he did not see any. The surveyor had observed that the facility had sanitizer wipes throughout the facility while touring the facility earlier that day. These wipes were available and accessible. At 2:21 PM, the surveyor interviewed the Director of Nursing/Infection Preventionist (DON/IP) who	F 880	The Executive Director(LNHA) is responsible for ensuring implementation and ongoing compliance of this POC and addressing and resolving any variances that may occur	

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F 880	Continued From page 5 stated that hand hygiene was to be performed prior to the application of and after the removal of PPE. The DON/IP stated that hand hygiene was to be performed by washing hands with soap and water for 20 seconds or by utilizing an ABHR. The DON/IP stated that all PPE should be removed and thrown away prior to exiting a resident's room and should not be used for multiple residents. The DON/IP stated that multi-use equipment needed to be sanitized and cleaned between residents per the manufacturer guidelines and specifications for that product. The DON/IP stated that specific instructions on how to apply PPE were posted outside of all the resident's room who required contact and droplet precautions and the expectation was that those directions would be followed by all people who entered the resident's rooms. The DON/IP stated that she had not performed direct observations of vendors coming into the facility on their infection control practices and further stated that she would have to call the company the vendor worked for to find out what infection control education the radiographer had received. At 2:26 PM, the surveyor interviewed the Administrator who stated that the expectation was that all vendors that entered the facility were required to perform appropriate infection control practices while in the facility. The surveyor reviewed the medical record for Resident #4. Review of the resident's Admission Record reflected that the resident was a Executive Order 26, 4.b. to the facility and had diagnoses which included Executive Order 26, 4.b.	F 880		

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F 880	Continued From page 6 Review of the resident's admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, reflected that the MDS assessment was still in progress as the resident had been Executive Order 26, 4.b. [redacted] Review of the resident's final laboratory report dated 11/18/20 indicated that Executive Order 26, 4.b. Executive Order 26, 4.b.Executive Order 26, 4.b. [redacted] Review of the resident's Care Plan (CP) updated 11/18/20 revealed a focus area that the resident had a Executive Order 26, 4.b. diagnosis. The goals of the resident's CP were to minimize risk of transmission to others through the next review date and the resident's symptoms would be managed through the next review date. Interventions for the resident's CP reflected to isolate the resident and implement full standard, contact and droplet/airborne precautions in room with door closed and use PPE which included a face mask, face shield, gown, and gloves. Further CP interventions reflected to monitor the resident for compliance with isolation precautions, screen and limit visitors to only essential visitors for medical needs and end of life support, and wipe down high-touch surfaces within the resident suite. The surveyor reviewed the medical record for Resident #5. Review of the resident's Admission Record reflected that the resident was a recent Executive Order 26, 4.b. [redacted]	F 880		

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F 880	Continued From page 7	F 880		

Executive Order 26, 4.b.

Review of the resident's admission Minimum Data Set (MDS), an assessment tool used to facilitate the management of care, reflected that the MDS assessment was still in progress as the resident had been Executive Order 26, 4.b.

Review of the resident's Executive Order 26, 4.b.

Review of Resident #5's CP updated Executive Order 26, 4.b. . The goals of the resident's CP were to minimize risk of transmission to others through the next review date and the resident's symptoms would be managed through the next review date. Interventions for the resident's CP reflected to isolate the resident and implement full standard, contact and droplet/airborne precautions in room with door closed and use PPE which included a face mask, face shield, gown, and gloves. Further CP interventions reflected to monitor the resident for compliance with isolation precautions, screen and limit visitors to only essential visitors for medical needs and end of life support, and wipe down high-touch surfaces within the resident suite.

Review of the facility's COVID-19 Mitigation and Response Plan revised on 6/12/20 indicated, "Essential medical visitors coming from an outside healthcare agency will be asked to supply their own personal protective equipment for moving through the community (mask) or for the care of residents on isolation precautions (mask,

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F 880	Continued From page 8 gown, gloves, goggles/face shield). Visitors who do not have personal protective equipment will be provided it as indicated by the condition of the resident they are visiting. In regard to hand hygiene practices the facility's Mitigation and Response Plan indicated, "Team members perform hand hygiene before and after all resident contact, contact with potentially infectious material, before putting on and after removing PPE, including gloves and after petting any community pets. Note: Hand hygiene after removing PPE is important to remove any germs or virus that might have been transferred to bare hands during the removal process. Team members perform hand hygiene by using alcohol based hand rub (ABHR) with 60-95% alcohol or washing hands with soap and water for at least 20 seconds." The facility's COVID-19 Mitigation and Response Plan further indicated that PPE the facility utilized for COVID-19 resident's included N95 respirator or face mask, eye protection, gloves, and gowns. The COVID-19 Mitigation Response Plan indicated that all of the non-reusable PPE needed to be discarded after use and, "reusable eye protection (e.g. goggles) must be cleaned and disinfected according to manufacturer's reprocessing instructions prior to re-use. Clean with an EPA registered disinfecting wipe." Further review of the facility's COVID-19 Mitigation and Response Plan indicated, "Dedicated or disposable resident care equipment (blood pressure cuffs, thermometers, mechanical lifts etc.) with an EPA registered disinfectant wipe in between each resident use." NJAC 8:39 19.4(l),(n);27.1(a)	F 880		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
315351 (Y1)	A. Building B. Wing (Y2)	12/17/2020 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF EDISON	1801 OAKTREE ROAD EDISON, NJ 08820

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0880 Reg. # 483.80(a)(1)(2)(4)(e)(f) LSC	Correction Completed 12/17/2020	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
11/19/2020	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO