STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315178	A. BUILDING _____ B. WING _____	01/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR GARDENS CARE CENTER	**140 PARK AVE EAST ORANGE, NJ 07017**

(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: 1/26/21 Census:140 Sample: 20 (19 Staff + 1 Resident) A COVID-19 Focused Infection Control Survey was conducted by the New Jersey Department of Health. The facility was found not to be 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 conducted according to §483.70(e) and following	F 880		5/11/21

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

Electronically Signed | 02/09/2021

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.

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F 880	Continued From page 1 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 infection.	F 880		

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F 880	Continued From page 2 §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, and record review, it was determined that the facility failed to ensure that staff who provided care to residents were familiar and adhered to infection practice guidelines according to the facility's policy and the Center for Disease Control (CDC). This deficient practice was identified for 1 of 19 facility staff members observed to ensure that staff perform handwashing as per the facility's policy to prevent the spread of infection while rendering care to residents. The Findings are as follows: On 1/26/21 at 11:00 AM, the surveyor observed the Respiratory Therapist (RT) on the [redacted] enter Resident [redacted]'s room. Resident [redacted] was noted receiving [redacted]. The RT was observed removing surgical gloves from his pocket and donning the gloves without washing or sanitizing his hands prior. The RT was then observed caring for Resident [redacted] After completing care for Resident [redacted], the RT removed the surgical gloves and discarded them in the waste receptacle in the resident's room prior to leaving Resident [redacted]'s room without sanitizing or washing hands. On 1/26/21 at 11:05 AM, the surveyor interviewed the RT. The RT stated that he should have washed his hands before donning the surgical gloves but finds it difficult to don the gloves when his hands are damp. The RT also stated that he	F 880	ELEMENT #1 Resident [redacted] was assessed by the RN-Unit Manager on 1/26/2021 to determine if there was any adverse effect related to the Respiratory Therapist□s failure to observe proper handwashing practices; none were observed. Respiratory Therapist was provided 1:1 education and handwashing competency by the Director of Nursing/Infection Preventionist on 1/26/2021. ELEMENT #2 All residents have the potential to be affected by the deficient practice. ELEMENT #3 A Root Cause Analysis was conducted by the Interdisciplinary Care Plan Team and frontline staff representatives and it was determined that the alleged infection control deficiency occurred because the facility did not have consistent audit and observations on how staff are following hand hygiene protocols when providing resident care. A Performance Improvement Project is implemented to re-educate all staff on hand hygiene protocols and to audit frontline staff during care delivery to ensure that they are following facility	

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F 880	Continued From page 3 should have washed his hands after removing the contaminated gloves but forgot. The surveyor reviewed Resident [redacted] Face Sheet (a document that gives a patient's general information), which identified that the resident had a diagnosis that included but were not limited to [redacted] The surveyor reviewed the policy and procedure for "[redacted] Care." Review of the "Guidelines 5" section of the, "[redacted] Care" defines, "The facility will ensure staff responsible for providing [redacted] care including [redacted] are trained and competent according to professional standards of practice and adhere to standard and transmission-based precautions, as needed." The surveyor reviewed the "Hand Hygiene" facility policy, which indicates that, "Staff involved in direct resident contact will perform proper hand hygiene procedures to prevent the spread of infection to other personnel, residents, and visitors." Review of the "Policy Explanation and Compliance Guidelines," section 5. b. indicates, "The use of gloves does not replace hand washing. Wash hands after removing gloves." On 1/26/21 at 3:30 PM, the surveyor discussed the RT infection control breach issue with the Administrator and DON/Infection Control Preventionist, who could not explain why this situation occurred. No additional information was	F 880	policy and procedures. Directed Inservice Training was conducted on the following topics: Module 1 - Infection Prevention and Control Program were completed by Topline staff (Department Heads) and Infection Preventionist CDC COVID-19 Prevention Messages for Frontline Long-Term Care Staff: Keep COVID-19 Out were viewed by all staff Module 6B-Principles of Transmission-Based Precautions completed by Topline staff (Department Heads) and Infection Preventionist CDC COVID-19 Prevention Messages for Frontline Long-Term Care Staff: Use PPE Correctly Out were viewed by all staff CDC COVID-19 Prevention Messages for Frontline Long-Term Care Staff: Clean Hands were viewed by Frontline staff All staff were re-educated by the DON/Designee on facility Hand Hygiene policy on 1/28/2021 and ongoing. All staff will undergo Hand Hygiene Competency to be observed by DON/designee on 1/28/2021 and ongoing. The DON/Designee will audit 25 staff for Hand Hygiene Compliance daily (all shifts) x 2 weeks, weekly x 4 weeks and then monthly x 3 months. ELEMENT #4 The DON/Designees will submit the results of the audits to the QAA Committee during the Monthly Infection Prevention and Control Meetings and the	

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F 880	Continued From page 4 supplied. NJAC 8:39-19.4 (a)	F 880	Quarterly Quality Assurance and Performance Improvement (QAPI) Meeting for trends and recommendations review.	

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
315178 Y1	A. Building B. Wing Y2	6/3/2021 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR GARDENS CARE CENTER	140 PARK AVE EAST ORANGE, NJ 07017

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 05/11/2021	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	
1/26/2021	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO