STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	315213	A. BUILDING _____ B. WING _____	08/26/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW SPRINGS REHABILITATION AND HEALTHCARE CTR	1049 BURNT TAVERN ROAD BRICK, NJ 08724

(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: 08/26/21 Census: 138 Sample: 5 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=E	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		11/18/21

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

Electronically Signed | 09/03/2021

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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 documents, it was determined that the facility failed to ensure that infection control practices were followed in accordance with the Center for Disease Control Guidance for donning and doffing personal protective equipment (PPE) for multiple observations of one (1) of two (2) units (the unit housing residents who were persons under investigation (PUI) for COVID-19 on Transmission Based Precautions (TBP). This deficient practice was identified during the COVID-19 Focused Infection Control survey conducted on 8/26/21 and was evidenced by the following: According to the U.S. Centers for Disease Control and Prevention (CDC) guidelines, Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic updated Feb. 23, 2021, includes under the "Personal Protective Equipment (PPE)," that healthcare personnel (HCP) who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions and use a NIOSH-approved N95 or equivalent or higher-level respirator, gown, gloves, and eye protection. In addition, under "Hand Hygiene," the HCP should perform hand hygiene before and after all patient contact, contact with potentially	F 880	F000 Preparation and/or execution of this plan of correction does not constitute an admission or agreement by the Provider of the truth or the facts alleged, or conclusion set forth in the Statement of Deficiencies. This plan of correction is prepared and/or executed because the provisions of Federal and State Laws that require it. F880 SS E 483.80 Infection Control 1. The Housekeeper was removed from the floor and immediately educated on the requirement of donning and doffing appropriately with a new gown in each room that has transmission-based precautions. She was also educated on appropriate hand hygiene. 2. All residents can be affected by this practice. Residents were monitored for signs and symptoms of infection with nothing remarkable noted. In accordance with Federal regulations at 42 CFR §488.424, a Directed Plan of Correction was imposed on the facility. As part of the Directed Plan of Correction a Root Cause Analysis (RCA) was	

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F 880	Continued From page 3 infectious material, and before putting on and after removing PPE, including gloves. Hand hygiene after removing PPE is particularly important to remove any pathogens that might have been transferred to bare hands during the removal process. In addition, under "Gloves," the HCP should remove and discard gloves before leaving the patient room or care area and immediately perform hand hygiene. And under "Gowns," the HCP should put on a clean isolation gown upon entry into the patient room or area. Remove and discard the gown in a dedicated container for waste or linen before leaving the patient room or care area. On 8/26/21, at approximately 9:40 AM to 10:25 AM, during the entrance conference, the surveyor, in the presence of another surveyor, interviewed the Licensed Nursing Home Administrator (LNHA) and the Director of Nursing (DON). The LNHA stated that all the residents on the [redacted] unit were placed on TBP due to possible exposure to COVID-19. The LNHA explained that three (3) residents cohorted in the Executive Order 26, 4.b. section indicated by a plastic barrier at the end of the [redacted] unit. The LNHA stated that all staff were required to wear an N95 mask and a face shield at all times on the [redacted] unit. The LNHA added that upon entering a resident's room, the staff member must don (put on) a gown and gloves and doff (take off) the gown and gloves prior to exiting the resident's room. The DON agreed with the LNHA regarding the required PPE instructions for the staff working on the [redacted] unit. At 10:36 AM, the surveyor observed two (2) signs to "STOP Special Droplet/Contact Precautions" posted on the closed double doors to the	F 880	completed. As part of the Directed Plan of Correction (DPOC) a Root Cause Analysis (RCA) was completed. The SOD identified that a Housekeeper failed to perform proper hand hygiene as well as Don (put on) and Doff (take off) appropriate personal protective equipment (PPE) upon entrance/exiting into resident rooms. The RCA identified that the housekeeper misunderstood education regarding proper use of PPE and appropriate hand hygiene, not requesting clarification when needed. The housekeeper was also experiencing PPE fatigue. 3. As part of the DPOC all topline staff and Infection Preventionist were educated on Module 1, Infection Prevention & Control Program. All frontline staff were educated on the following trainings, Keeping Covid-19 Out and Use PPE correctly for Coivd-19. All staff from all departments including infection preventionist completed Module 7- Hand Hygiene and Module 6B – Principles of Transmission Based Precautions. The Director of Nursing and Infection Preventionist completed competencies with all staff on the above education. The following additional education was completed: a. Education on the necessity of appropriate hand hygiene and appropriate use of PPE. b. Education to staff on strategies to	

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F 880	Continued From page 4 Executive Order 26, 4 unit. Both signs contained the same information that included instructions for everyone, including visitors, doctors, and staff, to follow. The instructions outlined included that in addition to standard precautions, everyone must clean hands when entering and leaving the room and to gown and glove at the door. At 10:46 AM, the surveyor observed the Housekeeper (HK) on the Executive Order 26, 4 unit enter a resident's room wearing an N95, face shield, and gloves. The HK had not donned a gown. From the hallway, the surveyor observed the HK remove a full plastic bag from the covered red bin (in the room), come out of the room, and place the full plastic bag into a large, covered receptacle on wheels. The HK then took an empty plastic bag from a supply roll on top of the covered receptacle and returned to the resident ' s room, placed the empty plastic bag into the same red garbage bin in the room. The HK then took her gloves off, put them in a garbage bin in the room, walked out of the resident's room, and proceeded to the next resident's room. At approximately 10:46 AM to 10:53 AM, the surveyor observed the HK continue down the hallway performing the same procedure for each room. At 10:53 AM, the surveyor interviewed the HK, who stated that she was picking up the plastic bags that were full of used linens. The HK added that it was her responsibility to take the used linens in the plastic bag in the covered red bins in each room, put them in the large receptacle she was pushing, and then replace the bin in the room with an empty plastic bag. The HK stated that the linens from the second floor were already	F 880	combat PPE fatigue. c. Education to staff to never assume but to ask for clarification when required 4. As part of the RCA the facility will measure the success of our systemic actions and changes weekly for the next 5 months, results will be reviewed by the QAPI team to determine if further action is necessary based on the results. We will collect data by auditing/observing the use of PPE and hand hygiene, for three employees per day for two weeks and then weekly for 6 weeks and then monthly for three months throughout the facility to ensure compliance with all staff. These observations will provide the QAPI team with answers to the following questions: 1. Did the recommended corrective actions get done? 2. Are people complying with the recommended changes/action? 3. Have the changes made a difference? The Administrator, Director of Nursing or their designee will review the findings of the audits as well as assure the continuation of education and competencies. The Administrator, Director of Nursing, or their designee will report on these findings at the quarterly Quality Assurance meetings.	

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F 880	Continued From page 5	F 880		

collected, and on the first-floor unit, she had to go into each room to get the linens. The HK stated that she was wearing a lab coat, so she did not have to put on a gown. The HK was unaware that she needed to don a new gown prior to entering each resident's room. The HK added that she put on a new pair of gloves before entering each room, and when she was finished replacing the empty plastic bag, she removed her gloves and placed them in the garbage bin in the room before exiting. The HK also stated that she was not touching anything else in the room and was not going by a resident. The HK stated that she could not use an alcohol-based hand rub (ABHR) that was provided in the hallway in between changing gloves because the ABHR dried out her hands. The HK added that she only touched the plastic bags with gloves on. The HK acknowledged that her routine was to start at the beginning of the first-floor unit hallway and proceed down the hallway picking up the linen bags from each room. The HK also acknowledged that she completed all the rooms on the first-floor unit before entering the COVID-19 section (separated by the plastic barrier and receptacle) to finish the additional rooms behind the barrier and then continued directly to a laundry room entry. The HK acknowledged that she would not reenter the first-floor unit after going through the COVID-19 barrier.

At 11:00 AM, the surveyor interviewed the Registered Nurse (RN) regarding PPE use for the first-floor unit. The RN stated that all staff were to wear an N95 and face shield at all times, wear a gown and gloves when entering any resident's room, and remove the gown and gloves upon exiting the resident's room. The RN added that it

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F 880	Continued From page 6	F 880		

did not matter the reason for entering a resident's room, the donning and doffing of gown and gloves as required.

At 11:08 AM, the surveyor interviewed the Account Manager/Director of Housekeeping (DHK), who stated that the housekeeping staff on the first-floor unit were required to wear an N95 mask and face shield at all times. The DHK added that if the staff had to go into the resident's room, they were required to put on a gown and gloves upon entry and remove the gown and gloves upon exit and perform hand hygiene. The DHK was unaware that the HK was not properly donning and doffing and was not performing hand hygiene. The DHK acknowledged that the HK had a routine of collecting the second-floor unit linens first, then proceeded to the first-floor unit, and then the COVID-19 linens were collected last. The DHK stated that when the HK went into the COVID-19 positive section with the receptacle, she could then go directly to the laundry room. The DHK acknowledged that the HK was supposed to don and doff proper PPE and perform hand hygiene even with no resident contact. The DHK stated that infection control inservices were completed by himself and nursing and thought the HK had recently received inservicing on proper PPE and hand hygiene. The DHK stated that he was going to speak with the HK immediately.

At 11:47 AM, the surveyor interviewed the Assistant Director of Nursing (ADON) in the presence of another surveyor, who stated that she was helping as an interim Infection Preventionist (IP) because the previous IP had just recently resigned. The ADON stated that she does perform daily rounds to make sure staff are

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F 880	Continued From page 7	F 880		

wearing the proper PPE and performing the proper procedures for infection control. The ADON acknowledged that all staff must don a gown and gloves prior to entering any room on the first-floor unit and doff the gown and gloves before exiting the room and perform hand hygiene. The ADON also stated that a competency for proper hand hygiene and PPE use was completed for all staff on 8/11/21 before the IP ' s resignation. The ADON also stated that staff were being designated to units as much as possible.

At 1:00 PM, the surveyor, in the presence of another surveyor, met with
the LNHA, DON, Regional Director of Operations, and Regional Nurse. The LNHA and DON acknowledged that the PPE requirement for the first-floor residents was to wear a gown and gloves prior to entry of a resident ' s room and remove upon exiting the resident's room and perform hand hygiene. In addition, the LNHA and DON acknowledged that all staff were to follow proper PPE and hand hygiene which included housekeeping. The LNHA stated that the HK was being inserviced again by the DHK.

The surveyor reviewed the facility policy, dated as adopted 3/2020, provided by the DON titled, "Transmission Precautions for Residents and Donning and Doffing PPE When Caring for Residents with Confirmed or Suspected COVID-19," which reflected that PPE must be donned correctly before entering the resident isolation room and doffed prior to exiting and performing hand hygiene. The policy included "Special Droplet/Contact Precautions" that reflected linen be bagged in the resident ' s room.

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F 880	Continued From page 8 The surveyor reviewed the facility undated policy provided by the DON titled, "Handwashing/Hand Hygiene" which reflected that the facility considers hand hygiene the primary means to prevent the spread of infections, and an ABHR or soap and water is required after removing gloves and before and after entering isolation precaution settings. In addition, hand hygiene is the final step after removing and disposing of PPE, and the use of gloves does not replace hand hygiene. N.J.A.C. 8:39-19.4(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
315213 Y1	A. Building B. Wing Y2	11/24/2021 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW SPRINGS REHABILITATION AND HEALTHCARE CTR	1049 BURNT TAVERN ROAD BRICK, NJ 08724

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 11/18/2021	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	
8/26/2021	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO