**A. BUILDING**

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**B. WING**

**NAME OF PROVIDER OR SUPPLIER**

**WINDSOR POINT CONTINUING CARE**

**STREET ADDRESS, CITY, STATE, ZIP CODE**

1221 BROAD STREET
FUQUAY VARINA, NC  27526

<table>
<thead>
<tr>
<th>(X4) ID PREFIX</th>
<th>ID PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
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<tbody>
<tr>
<td>E 000 Initial Comments E 000</td>
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<tr>
<td>F 880 Infection Prevention &amp; Control</td>
<td>F 880</td>
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<td>SS=F CFR(s): 483.80(a)(1)(2)(4)(e)(f)</td>
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<tr>
<td>§483.80 Infection Control</td>
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<tr>
<td>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.</td>
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<td>§483.80(a) Infection prevention and control program.</td>
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<td>The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:</td>
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<td>§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 accepted national standards;</td>
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<td>§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</td>
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**LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE**

Electronically Signed

07/02/2020

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.
<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES</th>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
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<tr>
<td>F 880</td>
<td>Continued From page 1</td>
<td>F 880</td>
<td>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.</td>
<td>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</td>
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<td>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</td>
<td>§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 staff interviews and observations, the facility failed to protect residents from COVID-19 when they did not restrict visitors and follow</td>
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This Plan of Correction constitutes Windsor Point's written allegation of compliance for the deficiency cited.
F 880 Continued From page 2
guidance issued by the Centers for Medicare and Medicaid Services (CMS). This failure occurred
during a COVID-19 pandemic.
Findings included:
The Center for Medicare and Medicaid Services
issued a memorandum on Guidance for Infection
Control and Prevention of Coronavirus Disease
2019 on March 13, 2020 (Reference
QSO-20-14-NH). The memorandum stated
facilities should restrict visitation of all visitors and
non-essential health care personnel except for
certain compassionate care situations, such as
an end-of-life situation.
A tour of the skilled nursing side of the facility was
conducted on 6/17/20 at 11:00 AM. A wall was
observed which consisted of dry wall on the lower
portion of the wall, plexiglass in the center of the
wall and plastic reaching to the ceiling. The wall
was sectioned off by wood beams to create a
3-section sitting area. A table and chair were
placed at 2 of the sections. Chairs had been
placed on the other side of the wall. Baby
monitors were placed on both sides which were
used for communication between visitor and
resident.
An interview was conducted with the Director of
Nursing on 6/17/20 at 11:30 AM, and she stated
staff could take a resident to the constructed wall,
place the resident facing the visitor, and they are
instructed on how to use the baby monitor.
An interview was conducted with the owner of the
facility on 6/17/19 at 12:43, and she stated she
had the wall erected for the main purpose of
facilitating visitations. She also stated she had it
built late April early May and it had been used in
the last week for visitation.
An interview was conducted with the
administrator on 6/19/20 at 10:00 AM, and she
stated the owner wanted the wall up, and it was
However, submission of this Plan of
Correction is not an admission that a
violation exists or that it was cited
correctly. This Plan of Correction is
submitted to meet the requirements
established by state and federal law.

(F 880) Infection Prevention and Control

On June 13, 2020, the area described in
the survey findings, which had previously
been inspected on May 20, 2020 as part
of a COVID-19 survey and determined to
be in compliance with all applicable State
and Federal guidelines, was closed. This
area consisted of a closed, secure room
which included a wall with the lower
portion being dry wall, the middle portion
of which was plexiglass and with 5 mm
plastic reaching the ceiling of (the "area").
Residents did not access the area as of

The residents who had utilized the secure
area were tested for COVID-19 on June

Completed 6/14/2020

The area will remain closed until specific
authorization is provided by the North
Department of Health and Human
Services and the Centers for Medicare &
Medicaid Services that would permit the
utilization of such a secured area.

From June 13, 2020 through June 19,
2020, all residents and staff members in
<table>
<thead>
<tr>
<th>(X4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETION DATE</th>
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<td>F 880</td>
<td>Continued From page 3 used for visitation.</td>
<td>F 880</td>
<td>this community were tested for COVID-19. Contact tracing for the test results indicated that 4 employees who cared for our residents tested positive for COVID-19 and were determined to be the source of COVID-19 through the community in mid June 2020. Completed June 19, 2020</td>
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<td>The Administrator and the Director of Nursing have reviewed the North Carolina Executive Orders along with CMS guidance and directives related to visitation at the nursing home and have established that Windsor Point current standards of practice and procedures are consistent with the same. Random inspections of the physical community will be performed by the Administrator or designee to establish that the N.C. Executive Orders and the CMS directives are adhered to until specific authorization is provided by the N.C. DHHS and the CMS that would permit utilization of the area. The Administrator or designee monitoring reports will be discussed at the scheduled Quality Assurance and Process Improvement meeting. Completed June 13, 2020</td>
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<td>This plan of correction will be reviewed in the next Quality Assurance and Process Improvement meeting and the dates to determine the continuation of monitoring</td>
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### Statement of Deficiencies and Plan of Correction

<table>
<thead>
<tr>
<th>(X1) Provider/Supplier/CLIA Identification Number:</th>
<th>(X2) Multiple Construction</th>
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<tbody>
<tr>
<td>A. Building _____________________________</td>
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<tr>
<td>B. Wing _____________________________</td>
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<td>345500</td>
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**Name of Provider or Supplier**

**Windsor Point Continuing Care**

**Street Address, City, State, Zip Code**

1221 Broad Street, Windsor Point Continuing Care, Fuquay Varina, NC 27526

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<thead>
<tr>
<th>ID Prefix Tag</th>
<th>Summary Statement of Deficiencies (Each deficiency must be preceded by full regulatory or LSC identifying information)</th>
<th>ID Prefix Tag</th>
<th>Provider's Plan of Correction (Each corrective action should be cross-referenced to the appropriate deficiency)</th>
<th>(X5) Completion Date</th>
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<td>F 880</td>
<td>Continued From page 4</td>
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<td>reports are subject to the vote of this interdisciplinary committee.</td>
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**Event ID:** SZSA11

**Facility ID:** 956929

**If continuation sheet Page:** 5 of 5