| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 335556 | A. BUILDING _____ B. WING _____ | 04/24/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| CREEKVIEW NURSING AND REHAB CENTER | 525 BEAHAN ROAD ROCHESTER, NY 14624 |

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) |
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| F 0880<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Many | **Provide and implement an infection prevention and control program.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observations, interviews, and record reviews conducted during the COVID-19 Infection Control Focus Survey, complaint #NY 352, it was determined that for three of three residential units, the facility failed to establish and maintain an infection prevention and control program designed to help prevent the development and transmission of COVID-19. The facility staff failed to consistently follow infection control precautions for residents on standard and droplet precautions potentially resulting in cross contamination for 89 residents not identified as having COVID-19. Specifically, two staff members were observed exiting the rooms of two residents (Residents #3 and #4) that had COVID-19 without removing (doffing) Personal Protective Equipment. The staff members either entered the room of a resident that did not have COVID-19 or continued to deliver meal trays without putting on (donning) new Personal Protective Equipment. Additionally, the facility did not protect three residents (Residents #6, #7, and #9) that were asymptomatic and did not have COVID-19. All three residents were residing in rooms with residents that had COVID-19. This resulted in Immediate Jeopardy to resident health and safety that is widespread. This is evidenced by the following: The facility COVID-19 Personal Protective Equipment (PPE) Use policy, revised 4/15/20, included to wear the same gown when interacting with more that one resident known to be infected with the same infectious disease and are housed in the same location (i.e. COVID-19 residents residing in an isolation cohort). The facility Outbreak Management policy, created 3/24/20, revealed that current recommendations are to isolate in place when a private room is not available. Roommates of isolated residents might already be exposed, it is generally not recommended to separate them in this scenario. (Center Disease Control, March 2020) Review of the Center for Medicare and Medicaid Services (CMS) COVID-19 Long-Term Care Facility Guidelines, dated 4/2/20, included full PPE should be worn per Centers of Disease Control (CDC) guidelines for the care of any resident with known or suspected COVID-19 per CDC guidance on conservation of PPE. Long-Term Care facilities should separate residents who have COVID-19 from residents who do not or have unknown status. 1. a. Resident #4 has [DIAGNOSES REDACTED]. The Minimum Data Set (MDS)<br>Assessment, dated 3/24/20, revealed the resident had moderately impaired cognition. Review of Resident #4's medical record revealed the resident was positive for COVID-19 on 4/9/20. During a continuous observation conducted on 4/21/20 at 5:50 p.m., Certified Nursing Assistant (CNA) #1 was observed providing hands-on feeding assistance to Resident #4. CNA #1 was wearing the following PPE: a one-piece yellow protective suit, a surgical mask, a face shield, and two pairs of gloves. There was a sign on Resident #4's door that directed to see the nurse. During the observation, CNA #1 touched the outer surface of the face shield with her gloved hand. After providing feeding assistance, CNA #1 exited Resident #4's room with the meal tray in her gloved hands. CNA #1 emptied the meal tray into a large, red trash bin outside of Resident #4's room. CNA #1 then removed her first pair of gloves, picked up the empty meal tray, walked down the hall, and returned the empty tray to the meal transport cart that was holding other resident meal trays that had not been passed yet. CNA #1 then returned to the red trash bin, removed and discarded her second pair of gloves. CNA #1 proceeded down the hall across from the resident's room, accessed the keypad lock to enter the clean utility room, and washed her hands. At 5:57 p.m., CNA #1 collected another meal tray from the cart and proceeded to the room of Resident #5. CNA #1 was observed in Resident #5's room for ten minutes providing hands on feeding assistance. CNA #1 did not cleanse, disinfect, or doff her yellow protective suit during the observation. Review of Resident #5's medical record revealed the resident was not tested for COVID-19 and was asymptomatic (showing no symptoms). When interviewed on 4/21/20 at 6:10 p.m., CNA #1 stated that staff wear the same yellow protective suit to care for all residents. CNA #1 said she should have wiped her suit down when leaving Resident #4's room but had not done so. b. Resident #3 has [DIAGNOSES REDACTED]. The MDS Assessment, dated 4/2/20,<br>revealed the resident had moderately impaired cognition. Review of Resident #3's medical record revealed that the resident was positive for COVID-19 on 4/15/20. In an observation on 4/21/20 at 5:20 p.m., Resident #3 was in their room. There was a sign on the door that directed to see the nurse and an isolation set up on the door which contained gloves. CNA #2 entered the resident's room wearing a yellow one-piece protective suit and a mask with no gloves to deliver the resident's dinner tray. CNA #2 washed her hands with soap and water prior to leaving the room, and then went to the food cart and picked up another resident's tray and proceeded to pass trays on the unit. When interviewed at that time, CNA #2 said that Resident #3 has COVID-19. She said that staff wear the same yellow protective suits when caring for all residents and staff do not need to change the suits. She said the isolation set-up was for the last resident that was in the A bed. When asked about wearing gloves, she said that she washed her hands with soap and water. CNA #2 did not cleanse, disinfect, or doff her yellow protective suit during the observation. 2. a. Resident #1 has [DIAGNOSES REDACTED]. The MDS Assessment, dated 3/20/20, revealed that the resident was cognitively intact. Review of Resident #1's medical record revealed that the resident was positive for COVID-19 on 4/18/20. In an observation on 4/21/20 at 4:15 p.m., Resident #1 was observed in a semi-private room with the door open. Resident #1 was in bed with their mouth wide open, snoring, and was not wearing a mask. The resident's roommate (Resident #7) was in their bed with no mask. The curtain between the beds was pulled partially covering about 3/4 of the length of the beds. The sign on the door directed to see the nurse. Review of Resident #7's medical record revealed that the resident was not tested for COVID-19 and was asymptomatic. When interviewed by telephone on 4/22/20 at 12:20 p.m., the Registered Nurse (RN) Regional Director of Clinical Services said that the facility was moving Resident #1 to another room on the second floor that day. In an observation on 4/23/20 at 11:27 a.m., Resident #1 and Resident #7 remained in the same room together. b. Review of the facility's Infection Surveillance Sheet revealed that Resident #8 tested positive for COVID-19 on 4/13/20. In an observation on 4/23/20 at 12:09 p.m., the door to Residents #8 and #9's room had a droplet precaution sign. Both Resident #8 and Resident #9 were in their beds, and neither resident was wearing a mask. Review of the medical record for Resident #9 revealed that the resident was not tested for COVID-19 and was asymptomatic. 3. Resident #2 has [DIAGNOSES REDACTED]. The MDS Assessment, dated 4/1/20, revealed the<br>resident had moderately impaired cognition. Review of Resident #2's medical record revealed that the resident was positive for COVID-19 on 4/20/20. In an observation on 4/23/20 at 12:27 p.m., the door to Resident #2's room had a droplet precaution sign. Both Resident #2 and Resident #6 were in their beds, and neither resident was wearing a mask. Review of Resident #6's medical record revealed that the resident was not tested for COVID-19 and was asymptomatic. When interviewed on 4/21/20 at 5:50 p.m., Licensed Practical Nurse (LPN) #1 said that resident's that are positive for COVID-19 have signs on their door that directs to see the nurse. She said that staff should put a blue gown over the yellow one-piece protective suits before entering resident's rooms that are COVID-19 positive. She said the blue gown should be removed before leaving the resident's room. In an interview on 4/24/20 at 9:23 a.m., the RN Regional Director of Clinical Services said that Residents #6, #7, and #9 had not been tested for COVID-19 and were asymptomatic and presumed negative. She said the facility was following CDC guidelines which recommended no movement of residents who had likely had an exposure to COVID-19. She said the privacy curtain should be pulled when a resident that is positive for COVID-19 rooms with a resident that is negative for COVID-19. She said the rooms allow for a 6-foot distance between the residents. She said both residents should wear masks, and the entire room should be placed on droplet precautions. She said she was not |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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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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| | **335556** | A. BUILDING _____ B. WING _____ | **04/24/2020** |

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| F 0880<br><br>**Level of harm -** Immediate jeopardy<br><br>**Residents Affected -** Many | (continued... from page 1)<br>aware if the guidance for cohorting residents had changed. The facility's allegation of compliance to remove the Immediate Jeopardy, dated 4/24/20, included the following: a. Staff would be educated on infection control practices including, but not limited to, preventing cross contamination with an emphasis on factors that can lead to cross contamination, infection control practices, importance of appropriate PPE, implementing proper PPE with return demonstrations, and policies related to COVID-19. Proper signage on COVID-19 rooms doors that direct staff on the type of PPE needed and procedure for donning and doffing. b. Move residents that are not positive for COVID-19 so that they are no longer residing with residents that are positive for COVID-19. The Immediate Jeopardy was removed on 4/25/20 based upon surveyor observations and verifications which included the following: a. Observations revealed that Residents #6, #7, and #9 no longer reside in rooms with COVID-19 residents. b. Observations revealed that all COVID-19 residents had an isolation set up hanging on the door that was stocked with PPE and appropriate signage that directed staff on type of PPE needed and procedure for donning and doffing. Staff were removing all PPE prior to exiting a COVID-19 room (exception cleaning face shield with Clorox wipes) and performing hand hygiene. c. Staff were educated on infection control policies and procedures related to COVID-19 including PPE requirements, preventing cross contamination, donning and doffing PPE, and hand hygiene. The facility provided a copy of the power point used for education and signature sheets for those that completed the education. As of 4/25/20, 60 percent of the staff had been educated with a plan to educate all staff prior to working their next scheduled shift. On 4/27/20, greater than 90 percent of the staff had been educated with a plan to continue to educate all staff and new hires. (10 NYCRR 415.19) |