STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335423	A. BUILDING _____ B. WING _____	**06/08/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PREMIER GENESEE CENTER FOR NRSG AND REHABILITATION	**278 BANK STREET BATAVIA, NY 14020**

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)
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** Based on observation, interview, and record review conducted during a COVID-19 Focus Infection Control Survey (Case #NY 213) completed on 6/8/20 it was determined that the facility did not maintain an Infection Control Program to ensure the health and safety of residents to help prevent the transmission of COVID-19 for two (Units 1 and 5) of five units. Specifically, facility staff did not use the appropriate PPE (personal protective equipment) on a unit where residents were potentially exposed to COVID-19, did not wear face masks when within six feet of others and did not perform proper hand hygiene. The findings are: The Health Advisory from NYSDOH Bureau of Healthcare Associated Infections (BHAI): Memorandum dated March 13, 2020, to all Nursing Homes and Adult Care Facilities, provided: All HCP (health care personnel) and other facility staff shall wear a facemask while within 6 feet of residents. Extended wear of facemasks is allowed; facemasks should be changed when soiled or wet and when HCP go on breaks. The facilities policy and procedure titled COVID-19 Infection Control - New York revised 5/14/20 documented when COVID-19 is identified in the facility, staff are to wear all recommended PPE (gloves, gown, eye protection, and respirator or face mask) for the care of all residents on the unit regardless of symptoms. Employees are educated and reminded to clean their hands according to CDC guidelines, including before and after contact with residents, after contact with contaminated surfaces or equipment, and after removing PPE. 1a.) During an observation on 6/7/20 on Unit 1 at 8:08 AM a sign was posted on the double entry doors to Unit 1 that read: COVID-19 Yellow Zone. - This area of the facility is for residents that have been exposed to COVID-19. - All residents will be provided with a mask that they can don (put on) while staff is providing care, or if they need to come out of room; - Staff will don gown and surgical mask at the beginning of each shift. Gowns and surgical mask can be worn as extended use and do not need to be changed from resident to resident; - Gloves must be worn for all contact with residents, including med pass; changed in between residents and hands sanitized. During an observation on Unit 1 6/7/20 at 8:15 AM Certified Nurse Aide (CNA) #1 was not wearing a gown. During an interview at the time of the observation CNA#1 stated there were no COVID-19 positive residents on the unit but there were two residents on the unit that were on precautions because they were just admitted to the facility. During an observation on Unit 1 6/7/20 at 8:17 AM Licensed Practical Nurse (LPN) #2 was not wearing a gown. During an interview at the time of the observation, LPN #2 stated that Unit 1 was considered a Yellow Zone. A Nursing Supervisor had tested positive for COVID-19 and had contact with the residents. LPN #2 further stated they should wear gowns at all times, but the gowns are plastic and that it was hard to wear the plastic gowns because it gets too hot. During an observation and interview on Unit 1 at 8:22 AM LPN #1 had her face mask below her nose, she was not wearing an isolation gown, and was within six feet of others. LPN #1 stated that face masks should be worn at all times and the mask should cover her nose and mouth. LPN #1 stated there were gowns available, but they were plastic. During an interview on 6/7/20 at 9:08 AM, the Director of Nursing (DON) stated Unit 1 was a Yellow Zone because a Nursing Supervisor tested positive for COVID-19 and the residents were exposed. Staff were expected to wear a face mask, gown, and gloves. b. During an observation on Unit Five (identified by the nursing supervisor as a COVID-19 free Unit) 6/7/20 between 8:12 AM and 8:15 AM revealed LPN #4 was standing at the medication cart near the nurses' station her face mask was below her chin and she was talking to a resident that was within six feet of her. A second LPN #3 walked behind the nurses' station not wearing a face mask and came within six feet of a different resident that was sitting behind the nurses' station. During the same observation CNA #4 was not wearing a face mask, walked past the nurses' station with a breakfast tray, entered Resident #2's room and provided set up assist. Neither CNA #4 nor Resident #2 were wearing a face mask. The observation further revealed two additional CNA's (#6 and #7) walked up to the food delivery cart and they were not wearing face masks. During an observation on Unit Five 6/7/20 at 8:16 AM revealed CNA #5 delivered a breakfast tray to a resident in the day room. CNA #5 positioned the resident's wheelchair at the table, applied a clothing protector to the resident, and set up the resident's meal. CNA #5 left the day room, without completing hand hygiene picked up another breakfast tray from the food delivery cart and entered another resident' room. During an interview on 6/7/20 at 8:42 AM, LPN #3 stated staff should always be wearing a face mask on the unit and within six feet of others. During an interview on 6/7/20 at 9:21 AM, CNA #4 stated staff should always be wearing a face mask when on the unit. CNA #4 stated she could not find her mask to put it on before entering Resident #2's room. During an interview on 6/7/20 at 9:47 AM, CNA #5 stated hand washing should be done before and after resident care and when passing trays. During an interview on 6/7/20 at 11:29 AM, the DON stated staff should always be wearing a face mask on the units that cover their nose and mouth and they should use hand sanitizer or wash their hands between passing resident meal trays. 415.19 (b)(1)

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

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.