STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335638	A. BUILDING _____ B. WING _____	04/30/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BUFFALO CENTER FOR REHABILITATION AND NURSING	**1014 DELAWARE AVE BUFFALO, NY 14209**

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 -** Immediate jeopardy **Residents Affected -** Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review conducted during the COVID-19 Infection Control Focus Survey (Complaint #[ST] 778) completed on 4/30/20, it was determined that the facility did not establish and maintain an Infection Control Program to ensure the health and safety of residents to help prevent the transmission of COVID-19. Specifically, facility staff entered and exited the rooms of residents diagnosed with [REDACTED]. CNA #1 (certified nursing assistant) did not remove their disposable gown after exiting a room of a COVID-19 positive resident on Standard and Droplet Precautions and then entered two non COVID-19 resident rooms and assisted with resident care. Housekeeper #1 completed housekeeping tasks in a room of a resident diagnosed with [REDACTED]. CNA #1 and Housekeeper #1 were unable to identify residents that were on isolation precautions for COVID-19. This was a pattern of no actual harm that is immediate jeopardy to resident health and safety. Additionally, staff were observed not appropriately wearing face masks when within six feet of others. Review of an undated facility Best Practice Reference Guide titled Coronavirus (COVID-19) Admission/ Readmission documented all new admissions should be considered as a potential exposure to the COVID-19 virus and should be placed on droplet and isolation precautions for 14 days, use appropriate PPE, and maintain hand hygiene. Prior to entering and exiting a patients' room healthcare personnel must perform hand hygiene with soap and water or alcohol-based hand sanitizer. Review of a facility Best Practice Reference Guide titled Coronavirus (COVID-19) PPE Use Updated March 31, 2020 documented for staff to wear the same gown when interacting with more than one patient known to be infected with the same infectious disease. Review of a facility policy and procedure (P&P) titled Environmental Cleaning and Disinfecting dated 4/29/20 documented PPE was indicated by the resident's type of isolation and will be worn at all times. Housekeeping is instructed to discuss questions regarding PPE with nursing staff. Isolation rooms will be cleaned after other rooms are completed. Use paper towels instead of washcloths to prevent cross contamination. Use a clean mop head and change after cleaning the room. Change the mop bucket and solution after cleaning room. Review of a facility Quick Reference Guide titled Coronavirus (COVID-19) Infection Control/ Environmental Updated April 29, 2020 documented to use PPE according to established guidelines this includes use of non-sterile gowns and eye protection. Healthcare personnel must perform hand hygiene by washing hands with soap and water or applying alcohol-based hand sanitizer. The findings are: a.) During an interview on 4/30/20 at 8:40 AM, the Director of Nursing (DON) stated there were thirty-seven COVID-19 positive residents on the third and fourth floors. The facility had no residents under investigation for COVID-19. The facilities bed capacity was 200 and the census was 170. During an interview on 4/30/20 at 8:54 AM, Licensed Practical Nurse (LPN) #1 Unit Manager stated the Fourth Floor A - hall had one resident diagnosed with [REDACTED].#1 diagnosed with [REDACTED]. I need a sock. A sign was posted on the door to the room that stated, Precautions please see nurse prior to entering room. CNA #1, wearing a disposable gown, held Resident #1's hand and walked the resident to their bed and assisted them into the bed. While wearing the same disposable gown CNA #1 exited the room, walked down the hallway and entered the room of a non COVID-19 Resident #2. As CNA #1 assisted the non COVID-19 Resident #2 with adjusting their under clothing, Resident 2's supported themselves by placing their hand on the arm and shoulder of CNA #1, touching the CNA's gown. Continued observation on 4/30/20 at 9:08 AM, COVID-19 positive Resident #1 was pacing in the hallway between rooms (#409, 411, and 412) while holding the handrail stating they were lost. While wearing the same disposable gown, CNA #1 assisted Resident #1 back to their room, and applied slipper socks to the residents' feet. CNA #1 exited the room and entered the room of a non COVID-19 resident while wearing the same disposable gown. During an interview on 4/30/20 at 9:25 AM, LPN #2 stated report was given to the CNA #1 prior to the beginning of the shift that there was one COVID-19 positive resident on the Fourth floor A - hall. During an interview on 4/30/20 at 9:33 AM, CNA #1 stated report was given to her in the morning and that, it slipped my mind a resident was COVID-19 positive. During an interview on 4/30/20 at 9:37 AM the ADON stated, It's cross contamination to go from a (COVID-19) positive to (COVID-19) negative room. The CNA should have changed the gown. Continued observations on the Fourth Floor A- hall on 4/30/20 at 9:48 AM revealed Housekeeper #1 was in street clothes and entered the room of a resident diagnosed with [REDACTED]. She again exited the room gathered supplies from her cart and reentered the room with a toilet brush, cleaning cloth, and spray bottle. When Housekeeper #1 exited the room, she placed the toilet brush, cleaning cloth, and the spray bottle on the housekeeping cart. She removed her gloves, dried hands and face with brown paper towels and applied new gloves without performing hand hygiene. Housekeeper #1 was then observed entering a non COVID-19 room and bathroom at 9:56 AM with the same toilet brush, cleaning cloth, and spray bottle. Housekeeper #1 exited the non COVID -19 room, placed the toilet brush, cleaning cloth, and spray bottle on housekeeping cart. She removed gloves, and again applied new gloves without performing hand hygiene. Housekeeper #1 then entered a COVID-19 positive room, mopped the floor, exited the room, and placed the mop into a pail of water on the housekeeping cart. While wearing the same gloves, using the same cleaning cloth, and spray bottle as above the housekeeper wiped down the hallway handrails and exterior door knobs of rooms 407, 408, 409, 410, 411, 412, 413, and 414, placed cleaning cloth and spray bottle on housekeeping cart. She again removed her gloves and applied new gloves without performing hand hygiene. The housekeeper then entered a non COVID-19 room and mopped the floor using the same mop and water that was used for the COVID-19 positive room. During an interview on 4/30/20 at 10:05 AM, Housekeeper #1 stated, I don't usually work this floor, but I treat everyone as positive. Additionally, Housekeeper #1 stated there were no residents diagnosed with [REDACTED]. During an interview on 4/30/20 at 10:27 AM, the DON stated all staff should wear the proper PPE for the precautions (gown, gloves, face mask, face shield), properly remove PPE (discard disposable gown or disinfect reusable gown) and perform hand hygiene when moving from a COVID-19 positive room to a COVID-19 negative room because there was, the high potential for cross contamination of positive to negative which can lead to death. During an interview on 4/30/20 at 11:10 AM, Registered Nurse (RN) #1 Infection Preventionist (IP) stated staff should wear full PPE (gown, gloves, face mask, face shield) when entering the room of a COVID-19 positive person, remove PPE (discard disposable gown or disinfect reusable gown) when exiting the room, and perform hand hygiene. Staff should not move from COVID-19 positive room to COVID-19 negative rooms because, they could easily cross contaminate at that point. During a telephone interview on 4/30/20 at 12:04 PM, the Medical Director stated the outcomes of COVID-19 are unknown at this time. COVID-19 is very contagious and staff should be following the facility protocols that were put into place. The expectation is not to go from a COVID-19 positive room to a COVID-19 negative room without changing their gowns or disinfecting the reusable yellow suits, and they should be performing hand hygiene when removing their gloves. During an interview on 4/30/20 at 12:18 PM, the Administrator stated staff should be wearing a disposable gown or a reusable jump suit, gloves, N95 and a surgical mask and a face shield when going into a room where a resident has been diagnosed with [REDACTED]. The disposable gowns should be disposed of after exiting a COVID-19 positive room and cannot be disinfected. If they are wearing a reusable jump suit, it should be disinfected when coming out of a COVID-19 positive room and before entering a non COVID-19 positive room. Staff should wear the provided PPE and wash their hands after removing their gloves. During an interview on 4/30/20 at 12:39 PM, the Director of Housekeeping and Laundry stated, the housekeepers in a COVID-19 positive room should wear a face mask, face shield, gown, and gloves. The expectation is to perform hand hygiene between

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335638	A. BUILDING _____ B. WING _____	**04/30/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BUFFALO CENTER FOR REHABILITATION AND NURSING	**1014 DELAWARE AVE BUFFALO, NY 14209**

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 -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 1) glove changes, and to not wear street clothes because they cannot be disinfected. COVID-19 is a highly infectious disease and moving from a COVID-19 positive room to a COVID-19 negative room could infect the other room. b.) During an observation on 4/30/20 at 7:53 AM revealed Housekeeper #2 was speaking to another staff member near the lobby elevators, within six feet of each other. Housekeeper #1's face mask was at their chin, exposing their mouth and nose. Housekeeper #1 stated she pulled the face mask down to talk to the other staff member. During an observation on 4/30/20 at 8:23 AM revealed the Assistant Director of Nursing (ADON) was walking in the main lobby hallway within six feet of others, entered the elevator with three surveyors and her face mask was below her nose and mouth. The ADON stated she was just in the Administrative area and should have covered her nose and mouth when she was within six feet of others. During an observation in the therapy clinic on 4/30/20 at 8:26 AM there were four employees sitting behind the clinic desk. Two employees, a Speech Therapist and a Physical Therapist (PT) were sitting side by side within two feet of each other. Neither were wearing a face mask or a face covering. During an interview at the time of the observation Speech Therapist #1 and PT #1 both stated they were educated to wear a face mask if they were within six feet of each other and should have had a mask on. During an observation on 4/30/20 at 8:47 AM, Dietary Aide #1 stepped off the elevator and into the elevator lobby of the Third Floor, there were two employees (maintenance worker and an environmental worker) in the area preparing to go on to the COVID-19 unit. Dietary Aide #1 came within two feet of them while handing the maintenance worker a resident's meal tray. Dietary Aide #1 was not wearing a face covering or a mask. During an interview at the time of the observation Dietary Aide #1 stated, he knew he was supposed to wear a mask and he forgot his mask in the kitchen. During an interview on 4/30/20 at 10:27 AM, the DON stated all staff should wear face mask if social distancing cannot be maintained. 415.19(b)(1)