STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335590	A. BUILDING _____ B. WING _____	**06/01/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PONTIAC NURSING HOME	**303 EAST RIVER ROAD OSWEGO, NY 13126**

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 -** Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview during the COVID-19 Focus Infection Control survey (NY 876), the facility did not 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 for 4 of 7 residents reviewed (Residents #5, 6, 7, and 8). Specifically, a certified nurse aide (CNA) and unit clerk were observed not wearing face masks appropriately when within 6 feet of Residents #5, 6, 7 and 8. In addition, CNA #3 used resident care equipment between Residents #5, 6, 7 and 8's rooms without cleaning the equipment between residents. Findings include: Review of 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 3/18/20 Mitigation Activities to Prevent Spread of Infection policy documented when known outbreak is occurring the facility shall implement strategies to mitigate spread. Consider all staff to wear a mask when in the facility depending on supply, re-educate all staff to proper infection control measures. The undated Infection Prevention and Control Standard Precautions policy documented all reusable resident care equipment was to be disinfected and appropriately cleaned before using on another resident. As of 6/1/2020, the facility was free of any positive COVID-19 cases. On 6/1/20 the following was observed on the 2nd floor nursing unit: - at 10:42 AM, certified nurse aide (CNA) #3 was observed wearing a surgical mask. The top edge of the mask was resting on her chin and her nose and mouth were exposed. She entered a resident's room and was within 6 feet of Residents #5 and #6 who were in the room. She picked up a walker that was in the room and carried it to Resident #7's room and handed the walker to Resident #7. CNA #3 did not disinfect the walker prior to giving it to Resident #7. - At 10:45 AM, CNA #3 entered Resident #8's room. Her mask was resting on her chin, and her nose and mouth were exposed. She was within 6 feet to Resident #8 (who was in the room) and stated that the walker in this room was not Resident #8's walker and she knew whose walker it was. Without disinfecting the walker, she carried it from Resident #8's room, and placed it next to Resident #6 in a different room. CNA #3 then positioned her mask over her nose and mouth and went to the nursing station and used hand sanitizer. - At 12:54 PM, CNA #3 was observed sitting next to Resident #5 who was in a Geri-chair (a reclining positional chair). CNA #3's surgical mask was resting on her lower lip exposing her top lip and nose. She was within 6 feet of the resident, talking, and feeding the resident lunch. On 6/1/20 the following was observed on the 1st floor nursing unit: At 11:48 AM, unit clerk #11 was observed standing at the 1st floor nursing station. She was within 6 feet of two other staff seated at the desk and her surgical mask was resting under her chin, exposing her mouth and nose. When interviewed on 6/1/20 at 12:58 PM, CNA #3 stated she had received tons of in-services about COVID-19, how to keep herself and the residents safe, and on the use of personal protective equipment (PPE). She stated the mask was important because [MEDICAL CONDITION] was airborne. It could also be spread by touching things if they were not cleaned properly. She stated her mask kept falling off her face and it was supposed to be crimped above her nose. She had not said anything to her Manager about the mask not fitting and did not ask if there was another type of mask she could wear. She stated the facility had masks that tied but she had not tried one. She stated equipment was to be wiped down every time a resident used it and she should have cleaned the walkers. When interviewed on 6/1/20 at 12:29 PM, unit clerk #11 stated if she was on the nursing unit, she was to wear a mask but as the unit clerk, she really did not get that close to the residents. She stated she was always supposed to have her mask on unless eating or on break. The proper way to wear the mask was on her nose, around, and under her chin. It was important to help stop the spread of germs. If the mask was down below the chin, it was not stopping the spread of germs and was not the correct way to wear her mask. She was responsible for wearing her mask correctly. When interviewed on 6/1/20 at 1:11 PM, Licensed Practical Nurse (LPN) Manager #1 stated staff received education about COVID-19 and how to prevent the spread. Staff were to wear a mask when at work. They could take the mask off to eat or if they were in the bathroom. The mask had to cover their mouth and nose and the facility had plenty of masks. She stated CNA #3 never mentioned that her mask did not fit properly nor ask for a new one. Staff were to clean resident equipment with disinfecting wipes. The wipes were not kept out in the open for fear that the residents with dementia would take them, but they were located on the medication cart and other storage areas. She expected staff to wear their mask over their nose and mouth and clean resident equipment. When interviewed on 6/1/20 at 2:11 PM, the Director of Nursing (DON) stated the facility had plenty of masks and cleaning wipes. She expected staff to wear their mask covering their nose and mouth and to clean the resident equipment. 10NYCRR 415.19(a)(2)(b)(2)

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