| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 335478 | A. BUILDING _____ B. WING _____ | 08/26/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| ESSEX CENTER FOR REHABILITATION AND HEALTHCARE | PO BOX 127 ELIZABETHTOWN, NY 12932 |

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 0836<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | **Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interview and record review during the COVID-19 Focused Infection Control Survey on [DATE], the facility did not ensure compliance with all applicable Federal, State, and Local Laws, Regulations, and Codes. Specifically, the facility did not comply with New York State Executive Order (EO) 202.18 to ensure resident's family and/or their next of kin were notified of either a single confirmed infection of COVID-19 or COVID-19 death within 24 hours from the date of occurrence for 1 of 1 family interviewed. Additionally, in accordance with the Centers for Medicare and Medicaid Services (CMS) regulation, the facility did not inform residents, their representatives, and families of those residing in facilities by 5 p.m. the next calendar day following the occurrence of either a single confirmed infection of COVID-19, or three or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other for 3 (Resident #s 5, 6 and 7) of 3 residents interviewed and 1 of 1 family interviewed. The findings are: Executive Order 202.18 dated [DATE] documented the following: Any skilled nursing facility, nursing home, or adult care facility licensed and regulated by the Commissioner of Health shall notify family members or next of kin if any resident tests positive for COVID-19, or if any resident suffers a COVID-19 related death, within 24 hours of such positive test result or death. CMS guidance titled, Interim Final Rule Updating Requirements for Notification of Confirmed and Suspected COVID-19 Cases Among Residents and Staff in Nursing Homes (Ref: QSO-,[DATE]-NH), dated [DATE], provided that, as part of a skilled nursing facility's COVID-19 reporting requirements, facilities must Inform residents, their representatives, and families of those residing in facilities by 5:00 p.m. the next calendar day following the occurrence of either a single confirmed infection of COVID-19, or three or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other. Such requirements were made effective [DATE] in regulatory amendments to 42 CFR 483.80 pursuant to 85 Fed. Reg. , . The Policy and Procedure (P&P) titled Covid-19 Notifications/Reporting last revised [DATE], documented the facility was to inform residents and their representative within 12 hours of the occurrence of a single confirmed infection of COVID-19. This notification could be accomplished with robocalls, individual calls, letters, or the facility public website. The P&P documented facilities in New York State should notify family/next of kin of all residents if any resident in the building expired due to COVID-19 related illness with 24 hours. On [DATE], the Hospital Electronic Response Data System (HERDS) report listed the following information: 28 COVID-19 positive residents and 3 COVID-19 related deaths. An undated facility line list (monitoring tool and data collection for influenza-like outbreaks) documented 7 residents tested positive for COVID-19 on [DATE], 15 residents tested positive for COVID-19 on [DATE], and 5 residents tested positive for COVID-19 on [DATE]. An undated facility document titled COVID-19 Positive Staff from [DATE] to current documented 14 staff tested positive for COVID-19 on [DATE]. On [DATE], the facility's public website documented, For the period [DATE] through [DATE] we have had 30 in-house Resident(s) or Staff who have tested positive for COVID-19. The facility's website did not provide information related to COVID-19 related deaths. Resident #5: Resident #5 was admitted to the facility with [DIAGNOSES REDACTED]. The Minimum Data Set (MDS- an assessment tool) dated [DATE] documented the resident had moderately impaired cognition, could understand others and could make him/herself understood. During an interview on [DATE] at 12:02 PM, Resident #5 stated he/she was not aware of any positive cases of COVID-19 within the facility. Additionally, he/she stated staff had not informed him/her of staff or residents testing positive for COVID-19 in the last week. Resident #7: Resident #7 was admitted to the facility with [DIAGNOSES REDACTED]. The MDS dated [DATE] documented the resident was cognitively intact, could understand others and could make him/herself understood. During an interview on [DATE] at 12:17 PM, Resident #7 stated the facility had not informed him/her that there were COVID-19 positive residents in the facility. Resident #6: Resident #6 was admitted to the facility with [DIAGNOSES REDACTED]. The resident had been recently admitted to the facility and did not have MDS information available. During an interview on [DATE] at 12:33 PM, Resident #6 stated he/she had not been told by the facility that there were COVID-19 positive residents in the facility. During a family interview on [DATE] at 10:35 AM, the family member stated the facility left her a voice message that her mother/father had tested positive for COVID-19, but she had not been notified when other residents or staff tested positive for COVID-19. She stated the facility did not notify her of COVID-19 related resident deaths. The family member stated she was not informed by the facility to refer to the facility website for updated COVID-19 information in the facility. During an interview on [DATE] at 10:25 AM, Social Services #5 stated she was the primary person responsible for notifying residents and their families regarding the status of COVID-19 in the facility. All families were called on [DATE] to notify them there had been one resident death related to COVID-19 but stated none of the residents residing in the facility had been notified of any of the resident COVID-19 related deaths. She stated she was not aware of the regulation or Executive Order that residents and their representatives were to be notified within a certain time period when there was a resident death related to COVID-19 or when a staff or resident tested positive for COVID-19. She was given the instruction by the facility to only notify residents and families who tested positive for COVID-19. She notified residents and their families of their specific positive test results on [DATE] and [DATE] but did not notify all residents and all resident representatives of COVID-19 related deaths or of other COVID-19 positive staff and residents. During an interview on [DATE] at 3:00 PM, Administrator #1 stated he was aware of the Executive Order and regulation regarding resident and family notification related to COVID-19 positive cases and COVID-19 related deaths. He stated it was Social Services' responsibility to reach out to the residents and families, but doubted residents and families were notified within 24 hours or by 5:00 PM the next calendar day of a new positive case or COVID-19 related death. He stated over the last week or so, residents and families were not consistently notified in a timely manner. During an interview on [DATE] at 3:05 PM, Administrator #2 stated a letter was sent to all families in [DATE] explaining that COVID-19 updates could be found on the facility's website. He stated the facility's website was one way the facility communicated to both residents, families and staff about COVID-19 positive cases and deaths in the facility. If families did not have access to the internet or website, he did not know how they would receive updated information about COVID-19 in the facility. During an interview on [DATE] at 3:10 PM, the facility's public website was reviewed with the Administrator #1. He stated the website was not accurate, and the facility's total number of in-house residents or staff who tested positive for COVID-19 was no longer 30. He stated the website should have been updated daily but had not been updated to reflect current COVID-19 data for the facility.<br>10NYCRR 400.2 |
| F 0880<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | **Provide and implement an infection prevention and control program.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0880<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | (continued... from page 1)<br>Based on observation, interview and record review during the COVID-19 Focused Infection Control Survey (Complaint #NY 631) conducted on 8/20/2020, the facility did not maintain an infection prevention and control program (IPCP) designed to provide a safe environment, and to help prevent the development and transmission of communicable diseases and infections. Specifically, the facility did not ensure multi-resident use equipment was sanitized and personal protective equipment (PPE) was changed between unknown COVID-19 residents and negative COVID-19 residents on 1 (Unit 1) of 3 units and did not ensure staff performed proper hand hygiene on 3 (Unit #'s 1, 2, and #3) of 3 units. Additionally, the facility did not comply with Department of Health regulations at 10 NYCRR Subpart 66-3, relating to face mask use and social distancing including New York State Executive Order 202.11, New York State Department of Health guidance regarding the use of facemasks and Centers for Disease Control (CDC) guidance for social distancing among staff members who were not wearing masks while congregated less than 3 feet apart outside in common areas on facility grounds. The findings are: On 8/19/2020, the Hospital Electronic Response Data System (HERDS) report listed the following information: Facility census- 88, 24 COVID-19 positive residents, 0 COVID-19 related deaths, and 88 residents on isolation. Finding 1: The facility did not ensure; multi-resident use equipment was sanitized after use, personal protective equipment was changed between unknown COVID-19 residents, and negative COVID-19 residents and that staff performed proper hand hygiene. The Food and Drug Administration (FDA) guidance titled Non-contact Infrared Thermometers dated 04/23/2020, documented the close distance required to properly take a person's temperature represents a risk of spreading disease between the person using the device and the person being evaluated. A subsequent FDA guidance titled Non-contact Temperature Assessment Devices during the COVID-19 Pandemic dated 06/19/2020, documented Non-contact infrared thermometers require minimal cleaning between uses. The Policy and Procedure (P&P) titled Hand Washing last revised 12/2019, documented the facility considered hand hygiene the primary means to prevent the spread of infections and to use an alcohol-based hand rub, or alternatively, soap and water for the following situations that included: After contact with objects (e.g., medical equipment) in the immediate vicinity of the resident and before and after entering isolation precaution settings. The policy also documented hand hygiene was the final step after removing and disposing of personal protective equipment. The P&P titled Standard Precautions last revised 12/2019, documented reusable equipment was not used for the care of more than one resident until it had been appropriately cleaned and reprocessed. The facility line list (monitoring tool and data collection for influenza-like outbreaks) provided to the survey team on 8/20/20, documented: (Note: the facility referred to unknown COVID-19 residents as Person Under Investigation (PUI) or presumed positive residents) -room [ROOM NUMBER]: Negative COVID-19 resident -room [ROOM NUMBER]: PUI resident (unknown) -room [ROOM NUMBER]: Negative COVID-19 resident -room [ROOM NUMBER]: PUI resident<br>(unknown) -room [ROOM NUMBER]: PUI resident (unknown) -room [ROOM NUMBER]: Positive COVID-19 resident -room [ROOM NUMBER]:<br>Positive COVID-19 resident During an observation on 8/20/20 at 10:30 AM, the Licensed Practical Nurse (LPN) #1 on Unit 1 was observed entering and exiting room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], and room [ROOM NUMBER]. She<br>was wearing a face shield, face mask, and gown. She was observed taking the temperatures of the 5 residents and did not sanitize the thermometer between resident use, did not change her PPE between unknown COVID-19 residents and negative COVID-19 residents, and did not perform hand hygiene before entering or exiting each resident room. During an observation on 8/20/20 at 11:00 AM, Nurse Practitioner (NP) #9 on Unit 3 was observed exiting room [ROOM NUMBER] and entered room [ROOM NUMBER]. The NP did not change her gloves or wash her hands when she exited room [ROOM NUMBER] and before entering room<br>[ROOM NUMBER]. During an observation on 8/20/20 at 11:15 AM, Certified Nurse Assistant (CNA) #3 on Unit 2 walked down the hallway to the soiled work room. Unit 2 had COVID-19 positive, negative and unknown residents. CNA #3 entered the soiled work room, removed her face shield and placed it on a hook on the wall. Then she removed and discarded an isolation gown and exited the soiled work room. CNA #3 did not wash her hands or use hand sanitizer after removing personal protective equipment (PPE). During an interview on 8/20/20 at 10:43 AM, LPN #1 stated she went from resident to resident in rooms 1, 3, 4, and 5, taking the residents' temperatures with the same thermometer. She stated she did not sanitize the thermometer between use for each resident and did not change her PPE going in and out of resident rooms. She stated she did not touch the residents' foreheads with the thermometer and did not know she was supposed to sanitize the thermometer between each use. She stated she was not aware that she was supposed to change her PPE between unknown residents and negative residents and stated she did not know she had to change her PPE since there were no confirmed positive COVID-19 residents on Unit 1. The LPN stated she was supposed to wash her hands or use hand sanitizer when going in and out of resident rooms. During an interview on 8/20/20 at 11:15 AM, CNA #3 stated she had cared for a resident down the hall and when she was done, she removed her gown upon exiting the resident's room and put a new gown on to walk down the hall. She stated she performed hand hygiene before she entered the soiled work room to remove her face shield and gown and did not need to wash her hands again. During an interview on 8/20/20 at 2:45 PM, the Assistant Director of Nursing (ADON) stated LPN should have doffed (removed) PPE coming out of rooms [ROOM NUMBER], but did not necessarily have to doff coming out of room [ROOM NUMBER]<br>because the resident in room [ROOM NUMBER] was negative for COVID-19. She stated staff should perform hand hygiene between each resident and upon exiting each resident room. She stated the LPN should have sanitized the thermometer after each use. The ADON stated hand hygiene and cleaning the thermometer were standard infection control precautions that should be followed regardless of COVID-19 in the facility. During an interview on 8/20/20 at 4:25 PM, the Director of Nursing (DON) LPN #1 should have changed her PPE when she exited each resident room and should have performed hand hygiene between residents when taking their temperatures. She stated the LPN should have cleaned the thermometer after each use. The DON stated hand hygiene and cleaning equipment, such as the thermometer, between residents were universal infection control precautions that should always be followed by staff. Finding 2: The Health Advisory from New York State Department of Health (NYSDOH) Bureau of Healthcare Associated Infections (BHAI) Memorandum dated March 13, 2020 to all Nursing Homes and<br>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 Executive Order 202.11 dated March 27, 2020 documented the following: Any guidance issued by the New York State Department of Health related to prevention and infection control of COVID-19 shall be effective immediately and shall supersede any prior conflicting guidance issued by the New York State Department of Health and any guidance issued by any local board of health, any local department of health, or any other political subdivision of the State related to the same subject. The CDC guidance titled Preparing for COVID-19 in Nursing Homes dated 6/25/2020, documented facilities should implement aggressive social distancing measures, which included healthcare personnel (HCP) to practice social distancing (at least 6 feet apart) and wear a facemask (for source control) when in break rooms or common areas. The Policy and Procedure titled Staff Screening last revised 6/12/20, documented the 2019-nCov (COVID-19) was [MEDICAL CONDITION] thought<br>to be spread mainly from person-to-person; between people who were in close contact with one another (within about 6 feet) and through respiratory droplets produced when an infected person coughs or sneezes. During an observation on 8/20/20 at 10:35 AM, 5 staff members were observed within 3 feet of each other outside on facility grounds. Four of the 5 staff members were not wearing masks and were smoking cigarettes. During an observation on 8/20/20 at 11:20 AM, 4 staff members were observed outside on a covered patio in front of the entrance doors to the facility. The 4 staff members were less than 3 feet from each other. Two of the 4 staff members were not wearing masks correctly. Their masks were below their chin, not covering their nose or mouth. During an observation on 8/20/20 at 11:25 AM, 4 staff members were outside of the facility's loading dock without masks and were less than 3 feet from each other having a conversation. During an interview on 8/20/20 at 4:30 PM, the Director of Nursing stated staff should not be standing in groups on the loading dock without masks and stated staff should be social distancing. During an interview on 8/20/20 at 4:35 PM, a Corporate Registered Nurse stated staff absolutely should not be smoking on facility property and the staff should know not to congregate, especially without wearing face masks. 10NYCRR415.19(a)(1-3),(b)(4) |