STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335649	A. BUILDING _____ B. WING _____	08/21/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NORTH GATE HEALTH CARE FACILITY	**7264 NASH ROAD NORTH TONAWANDA, NY 14120**

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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review conducted during a Focused Infection Control Survey (#NY 626) on 8/21/20, the facility did not establish and 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 two (Unit D and E) of five resident care units reviewed. Specifically, housekeeping staff did not properly don (put on) and doff (remove) PPE (personal protective equipment). Additionally, an Outreach Laboratory Technician (phlebotomist) did not utilize appropriate PPE for residents that were on contact and droplet precautions. The findings are: The facility policy and procedure titled Coronavirus (COVID-19) with a revision date of 8/19/20 documented that all residents within the Yellow Zone (exposed to COVID-19), new admissions and persons under investigation (PUI)) are placed on contact and droplet precautions. Review of an undated facility education packet titled Infection Control Guide provided by Licensed Practical Nurse (LPN) #2 Clinical Instructor included written instructions with diagrams from the CDC (Centers for Disease Control) for donning and doffing PP (personal protective) gowns. A gown should be tied in the back, fully cover the torso from the neck to the knees, wrap around the back and fastened at the back of the neck and waist. To remove a gown, unfasten the ties, pull away from the neck and shoulders, touching inside of the gown only, turn gown inside out and fold or roll into a bundle and discard. 1. During observations on 8/21/20 from 8:09 AM to 8:13 AM on the B Unit (Yellow Zone): - Housekeeper #1 was observed wearing full PPE including gloves, gown, N95 with surgical mask covering, and face shield as she was collecting trash from a trashcan inside the doorway of resident room [ROOM NUMBER]. - Housekeeper #1 exited the room, doffed her gloves, pulled her arms out of the sleeves of gown, and rolled the gown up from the bottom and pulled the gown off over her head while still wearing her face shield. The gown was observed touching and sliding over the face shield. Housekeeper #1 then rolled the gown into a ball and placed the gown on the housekeeping cart on top of a box of gloves and paper towels. - At 8:10 AM Housekeeper #1 retrieved a clean gown from the PPE supply cart in the hall. The neck ties of the gown were tied, and she proceeded to pull the clean gown over her face shield with the gown rubbing against the outside of her face shield as she pulled it over her head, then slipped her arms into the sleeves. She donned clean gloves and entered and retrieved trash from room [ROOM NUMBER]. - When Housekeeper #1 exited the room, she doffed her gloves and attempted to untie the neck ties. She proceeded to remove arms from gown sleeves, rolled up the gown and pulled the gown off over her head while still wearing her face shield. The gown was observed touching and sliding over her face shield. She rolled the gown into a ball and placed it on the top of housekeeping cart, on top of the supplies next to the other soiled gown. - At 8:12 AM Housekeeper #1 retrieved another clean gown from the PPE supply cart in the hall and placed the clean gown on top of her cart next to the two soiled gowns. During an interview on 8/21/20 at 8:14 AM, Housekeeper #1 stated she had been trained on the proper donning/doffing sequence of PPE and pointed to a sign on the wall. She stated her face shield is considered dirty and she could contaminate her clothing by pulling a gown over her face shield. Housekeeper #1 stated she had placed the soiled gowns on top of the cart, but she would usually put them into a bag tied to the cart. During observations on 8/21/20 from 6:45 AM to 7:55 AM on the E Unit (Yellow Zone): - Housekeeper #2 was observed wearing an isolation gown backwards, tied at the neck in the front, exposing her uniform (maroon scrubs) from the neck down when entering to clean resident rooms #125, 126,127, 128 and 129. - Housekeeper #2 did not change her protective gown between each resident's room. When she did remove the protective gown after cleaning a resident's room, she rolled the gown in a bundle and put it in a clear plastic bag attached to the cleaning cart. She then donned the same gown to go into the next resident's room. - During continued observation Housekeeper #2 was cleaning resident room [ROOM NUMBER], there were two residents in the room, and neither were wearing a face mask. Housekeeper #2 was observed to carry cleaning products under her arm which came in contact with her exposed uniform. As she cleaned the room, she picked up wadded tissues off the floor, placed them in a trash can, carried the trash can out of the room, set it on the edge of the cleaning cart, emptied the garbage into the housekeeping cart and reached into her pocket to grab a roll of garbage bags to replace the bag in the can. - Additionally, while in the resident's room Housekeeper #2 attempted to adjust the privacy curtain between the two residents and the curtain came into contact with her exposed uniform (maroon scrubs). During an interview on 8/21/20 at 8:02 AM, Housekeeper #2 stated that she does not always change the precaution gown between cleaning resident rooms, because she prefers the gowns with the long sleeves attached so she does not have to wear the arm protectors as she does with the short sleeved gowns. She added that she does not always have the gowns that she prefers available. Housekeeper #2 stated that she wears the precaution gown backwards because it allows her easier access to reach into her pockets to grab the rolls of garbage bags. During an interview on 8/21/20 at 10:35 AM, Clinical instructor LPN #2 stated housekeepers are to wear precaution gowns with the opening in the back and tied at the back of the neck, so that their clothing is completely covered. They are to wear a gown in every room on a Yellow Zone because of the close contact with the resident's environment and to change the gown between cleaning each resident's room. Precaution gowns should be removed per CDC (Centers for Disease Control and Prevention) guidance: untying from the back of the neck, pulling away from the neck and shoulders, turning inside out, rolling into a bundle and discarding (if disposable) or placing in the appropriate receptacle if reusable; not placed on their cleaning cart for reuse. Gowns should not be shimmied over their heads to remove, as it could lead to contamination and spread of infection. During an observation 8/21/20 at approximately 11:25 AM Housekeeper #2 was observed in the administrative hallway suit wearing the same precaution gown. During an interview on 8/21/20 at 12:15 PM, the Director of Nursing (DON) stated their expectation of staff in the facility is to don/doff PPE as per the signs posted on the wall. The signs are posted everywhere and show the proper sequence. 2. Review of an undated sign titled PPE Directions that was posted throughout the hallway on the E Unit documented any direct contact with residents such as personal care, treatments, collecting of vital signs and assessments the following PPE was required: goggles or face shield, N95 with surgical mask, gown, and gloves. During observations on 8/21/20 between 6:45 AM and 7:25 AM on the E Unit (Yellow Zone): - Outreach Laboratory Technician (phlebotomist) #1 entered and exited resident room #'s 128, 127, 126, 125, and 123 while pushing a wheeled laboratory supply cart used for blood draws. - Lab Technician #1 was wearing a N95 face mask covered with a surgical mask, they did not don or doff a PPE gown or eye protection when entering or exiting any of these rooms. Residents in these rooms were not wearing face masks. - At 7:09 AM the door was closed to resident room [ROOM NUMBER], and there was a sign posted on the door with instructions to see the nurse before entering the room. Lab Technician #1 then walked down the hall to the nurses' station and asked what kind of precautions were needed for room [ROOM NUMBER]. Registered Nurse (RN) #3 stated to the Lab Technician that every resident on the unit was on precautions. Lab Technician #1 walked back down the hall to resident room [ROOM NUMBER], wheeled the laboratory supply cart into room [ROOM NUMBER] without donning a precaution gown or eye protection. - At 7:17 AM Lab Technician #1 exited room [ROOM NUMBER] and entered resident room [ROOM NUMBER] without donning an isolation gown or eye protection. Residents in these rooms were not wearing face masks. During an interview on 8/21/10 at 7:30 AM, Outreach Laboratory Technician #1 stated that she does not work for the facility directly and had not received any education regarding the facility's

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.

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) specific precaution protocols for COVID-19. The Lab Technician stated that she obtained blood samples on 10 different residents (room #'s 128, 127,126,125, and 123) on the E Unit and that drawing blood was considered direct hands on care. The technician stated they did not don or doff an isolation gown or eye protection prior to entering or while in any of the resident's rooms and added that she was not aware that she was supposed to. Additionally, the Lab Technician stated that none of the residents were wearing face masks when she obtained their blood. During an interview on 8/21/20 at 7:35 AM, Registered Nurse RN #2 stated that 10 residents had their blood drawn this morning and that drawing blood was considered direct care and the lab technician should have donned and doffed a different isolation gown for each resident and wore eye protection. Review of the Specimen log sheet dated 8/21/20 revealed Lab Technician #1 initialed that eight residents from E Unit had their blood drawn, as some residents were documented that they refused. During an interview on 8/21/20 at 9:15 AM, the DON stated that drawing blood would be a direct care activity. The Lab Technician should have worn the appropriate PPE for a Yellow Zone (N95 with a surgical mask covering, gowns, eye protection and gloves) for each resident that they had contact with and gowns and gloves should be changed between each resident. The DON stated there was no specific education provided to lab technicians related to the facility's precaution protocols but would have expected the nurses on the unit to explain them, and for the Lab Technician to follow the signs and directions posted throughout the unit for PPE use. During a telephone interview on 8/21/20 at 10:15 AM, the Outreach Laboratory Manager #1 and Lab Technician #1 stated the technician drew blood samples for residents throughout the facility this morning (approximately twelve residents total). The Outreach Manager stated that all Outreach Technicians are required to wear a face mask, goggles or face shield, a gown, gloves and to wash and sanitize their hands between every resident. 415.19 (a)