STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335817	A. BUILDING _____ B. WING _____	05/07/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GARDEN CARE CENTER	**135 FRANKLIN AVENUE FRANKLIN SQUARE, NY 11010**

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 0836 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review during the COVID-19 Focused Infection Control Survey (Complaint # 362) the facility did not ensure that it was in 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, and ensure that resident families and their next of kin were notified of either a single confirmed infection of COVID19 or COVID19 death within 24 hours from the date of occurrence for two of five residents reviewed for Infection Control. The findings are: The Executive Order #202.18 dated April 16, 2020 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. The facility's undated Policy and Procedure titled Notification During FOR COVID-19 documents that families or designated representative will be kept informed through phone conversations, emails or ROBO calling. During the staff shortage families who call will speak to the Unit Nurse or leave a call back number from the Director of Nursing or the Supervisor. Administration will continue to take family/designated representative calls as well as utilize ROBO call system to update the status of the facility with positive COVID-19. A family member of Resident # 4 was interviewed on 5/7/20 at 5:45 PM. The family member stated that the facility had not notified him initially when his family member was diagnosed with [REDACTED]. During an interview with the Director of Nursing (DNS) on 5/6/2020 at 2:20 PM, the DNS stated that all the families and representatives were not being notified on a daily basis regarding the newly admitted or diagnosed positive COVID-19 residents or staff. The Administrator was interviewed on 5/6/20 at 3:00 PM and stated that the facility was attempting to set up the ROBO calls after an attempt at emailing families was unsuccessful. During a subsequent interview with the Administrator on 5/7/20 at 10:03 AM, the Administrator stated that she sent out one mass mailing to the families and then put an email system in place to communicate the facility status related to COVID-19. She stated that many of the emails were not successfully forwarded. She stated that a ROBO call system would be set up this week. The administrator stated that some of the residents get information from the nurses. The Administrator was interviewed on 5/18/20 at 10:00 AM. She stated that the facility's ROBO call system went into effect on 5/7/20. Review of correspondence received from the Administrator on 5/18/20 at 11:49 AM revealed that there were two COVID-19 positive deaths in the facility between 4/19/20-5/7/20 and that there were three COVID-19 positive admissions to the facility between 4/19/20-5/7/20. 400.2
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 interviews during the COVID-19 Infection Control Focus Survey (Complaint # NY 362), the facility did not ensure an effective Infection Control Program was maintained to prevent development and transmission of communicable disease This was evident for four (Residents #2, #4, #1, #3 respectively) of four resident room observations. Specifically, a Housekeeper (#1) was observed entering positive COVID-19 rooms (#223 and #225) with the Personal Protective Equipment (PPE) including a gown, face shield, gloves and an N95 mask. After exiting the positive COVID-19 rooms Housekeeper #1 went into the Staff restroom with the same PPE and then entered two negative COVID-19 rooms (# 219 and #221) without changing the gown, N95 mask and the face shield. The finding is: The facility undated Policy and Procedure titled Housekeeping Department-COVID-19 Pandemic Policy and Procedure-Daily Room Cleaning-Occupied Room- Personnel entering isolation room will adhere to isolation dress codes and procedures.the protective clothing is to be removed and put in an isolation bag at the completion of the cleaning procedures. All cleaning equipment used in isolation rooms will be considered contaminated. Resident # 2 has [DIAGNOSES REDACTED]. Laboratory result dated 4/26/20 documented that the resident was positive COVID-19. A Physician's (MD) order dated 4/29/20 documented Isolation/Droplet Precautions related to positive COVID-19. The resident resides in Room # 223. Resident # 4 has [DIAGNOSES REDACTED]. The laboratory results dated [DATE] documented that the resident was positive COVID-19. The MD order dated 4/30/20 documented Droplet Precautions for [DIAGNOSES REDACTED]. The resident resides in room [ROOM NUMBER]. Resident # 1 resides in Room # 219. The Nursing Progress Note dated 4/21/20 documented that the resident was hospitalized with the [DIAGNOSES REDACTED]. The physician's orders [REDACTED]. Resident # 3 resides in Room # 221. A Laboratory result dated 4/10/20 documented that the resident was positive COVID-19. The MD order dated 4/30/20 documented discontinuation of Isolation Precautions. On 5/7/20 at 11:40 am Housekeeper # 1 was observed in full PPE, which included gown, face mask, face shield and gloves, entering room [ROOM NUMBER] (Resident # 2), emptying the trash and replacing the lining. The Housekeeper (#1) proceeded to Room # 225 (Resident #4) with the same PPE and emptied the trash and replaced the liner. Both rooms # 223 and # 225 were positive COVID-19 Isolation rooms. The Housekeeper (# 1) proceeded to enter the staff rest room with the PPE on, followed by entrance into Resident # 1's Room, documented as negative COVID-19, followed by entrance into Resident # 3's Room, documented as negative COVID-19, wearing full, unchanged PPE. Both rooms (#219 and #221) did not have the isolation precaution sign outside the doors. Housekeeper # 1 was interviewed on 5/7/20 at 12:00 PM. The Housekeeper stated that she was going to remove the gown and face shield before going to lunch. During a subsequent interview at 1:5 PM, the housekeeper stated that she thought that Rooms # 219 and # 221 were still on droplet precautions and that was why the face shield and gown were not changed. Housekeeper #1 stated that she was in a rush and the PPEs were to be removed after taking care of the positive COVID-19 rooms and changed before entering the negative COVID-19 rooms. The Unit Manager/Registered Nurse (RN) was interviewed on 5/7/20 at 1:20 PM. The RN stated that Resident #3 (room [ROOM NUMBER]) was discontinued from Droplet/Isolation Precautions for positive COVID-19, Resident #1 (room [ROOM NUMBER]) was monitored for fourteen days following hospitalization for COVID from 4/21/20 and was now off the droplet precautions. The RN confirmed that both rooms (#219 and #221) did not have Precaution signs. The Housekeeping Director was interviewed on 5/7/20 at 1:50 PM. He stated that the housekeepers know what rooms are positive COVID-19 by the Droplet Precautions sign on the door. He stated that the housekeeping staff were directed to clean negative COVID-19 rooms first and that the signs on the doors would indicate the Droplet Precautions. The Housekeeping Director stated that Housekeeper # 1 should have removed the PPEs before proceeding to the negative COVID-19 rooms from the positive COVID-19 rooms. The Director of Nursing Services (DNS) was interviewed on 5/7/20 at 2:30 PM. The DNS stated that the resident (#1) was to be to be removed from Isolation following the 14 days of monitoring and the unit Nurse was responsible to review the case with the Physician to discontinue the Isolation, as appropriate. 415.19(a)(1-3)

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

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