STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335565	A. BUILDING _____ B. WING _____	05/21/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE GRAND REHABILITATION AND NURSING AT BARNWELL	3230 CHURCH STREET VALATIE, NY 12184

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 observation, interview and record review, 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. Specifically, the facility did not follow the cohorting requirements documented in the Dear Administrator Letter (DAL) dated April 29, 2020 for 4 (Resident #'s 4, 8, 9, and #10) of 10 residents reviewed. Persons Under Investigation for COVID-19 (Resident #s 4 and 8) were cohorted with asymptomatic Residents #9 and #10. Additionally, the facility did not ensure there were transmission-based precautions signs on the doors of Resident #'s 4 and #8. Also, the facility did not ensure a glucometer was cleaned and disinfected after being used on Resident #4. This is evidenced by: 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 New York State Department of Health Dear Administrator Letter (DAL) dated April 29, 2020 documents the following: As care pertains specifically to COVID-19, state and federal rules and regulations require nursing homes must adhere to appropriate safety measures including, but not limited to: Having protocols to separate residents into cohorts of positive, negative, and unknown as well as separate staffing teams to deal with COVID-positive residents and non-positive residents. In order to effectuate this policy, nursing home facilities should transfer residents within a facility, to another long-term care facility, or to another non-certified location if they are unable to successful separate outpatients in individual facilities. Finding 1: The facility did not ensure residents were separated into cohorts of COVID-19 infection status of positive, negative, and unknown. The Policy and Procedure (P&P) for Infection Control: Guidance on COVID-19 (formerly Coronavirus) dated 4/2020 documented staff were to ensure residents with symptoms of suspected COVID-19 or other respiratory infection (such as fever, cough) were to be placed on Droplet and Contact precautions. Residents were also to be placed in a private room with a dedicated bathroom when possible and if not, the facility was to cohort residents with same presentations or confirmed diagnosis. During an observation on 5/20/20 at 11:30 AM, Resident #s 4 and 10 were residing in the same room. The facility's Resident Roster documented Resident #s 4 and 10 were residing in the same room. During an observation on 5/20/20 at 11:30 AM, Resident #s 8 and 9 were residing in the same room. The facility's Resident Roster documented Resident #s 8 and 9 resided in the same room. Resident #4: Resident #4 was admitted to the facility with [DIAGNOSES REDACTED]. The Minimum Data Set (MDS- an assessment tool) dated 5/20/20 documented the resident was cognitively intact and able to make needs known. A progress note dated 5/17/20 at 8:41 AM, documented oxygen saturation of 91-93% on room air and a temperature of 103.1 degrees. A progress note dated 5/17/20 at 6:34 PM, documented a physician's orders [REDACTED]. Resident #10: Resident #10 was admitted to the facility with [DIAGNOSES REDACTED]. The MDS dated [DATE] documented the resident was cognitively intact and able to make needs known. A progress note dated 5/6/20 at 12:05 PM, documented the resident tested negative for COVID-19. Resident #8: Resident #8 was admitted to the facility with [DIAGNOSES REDACTED]. The MDS dated [DATE] documented the resident had severe cognitive impairment. A progress note dated 5/17/20 at 1:40 PM, documented the resident had chills, a fever of 101.6 degrees. A progress note dated 5/17/20 at 6:58 PM, documented a physician's orders [REDACTED]. Resident #9: Resident #9 was admitted to the facility with [DIAGNOSES REDACTED]. The MDS dated [DATE] documented the resident was cognitively intact and able to make needs known. A progress note dated 5/6/20 at 12:10 PM, documented the resident tested negative for COVID-19. During an interview on 5/20/20 at 4:54 PM, the Regional Administrator stated residents with different COVID statuses should not have been residing in the same room. During an interview on 5/20/20 at 5:13 PM, the Director of Nursing (DON) #1 stated residents who had an unknown or suspected COVID-19 status should not have been assigned to live in the same room with residents who were asymptomatic and have tested negative for COVID-19. During an interview on 5/20/20 at 5:20 PM, the Administrator stated that cohorting residents was supposed to be done in 3 categories: positives, negatives, and unknowns or suspected together. During an interview on 5/21/20 at 11:00 AM, The DON #2 stated residents should have been cohorted according to their COVID-19 status, positives together, negatives together, and unknowns or suspected. DON #2 also stated residents should have been in private rooms if possible and if private rooms were not possible, then residents with statuses of unknown or suspected COVID-19 should be placed together. Finding 2: The facility did not ensure there were signs on the room doors of symptomatic residents pending test results for COVID-19. The P&P for Droplet Precautions dated 3/2019 documented droplet precautions were to be used for specified residents known or suspected to be infected by microorganisms transmitted directly from the respiratory tract of the susceptible mucosal surfaces of another resident. As soon as precautions were implemented, a Stop Report to Nurse sign was to be placed on the resident's door and remain in place until precautions were discontinued. During an observation on 5/20/20 at 11:30 AM, there was not a Stop Report to Nurse sign placed on the doors for Resident #s 4 and 8's doors. Resident #4: A progress note dated 5/17/20 at 8:41 AM, documented oxygen saturation of 91-93% on room air and a temperature of 103.1 degrees. Resident #8: A progress note dated 5/17/20 at 1:40 PM, documented the resident had chills and a fever of 101.6 degrees. A progress note dated 5/17/20 at 6:58 PM, documented a physician's orders [REDACTED]. During an interview on 5/20/20 at 11:40 AM, Licensed Practical Nurse (LPN) #2 stated Residents #s 4 and 8 were not placed on droplet precautions because their test results were pending, so they were not yet identified as being positive. During an interview on 5/20/20 at 12:05 PM, Health Assistant (HA) #2 stated the sign on the door and the isolation carts indicated which residents were COVID-19 positive and Residents #s 4 and 8 were considered negative. During an interview on 5/20/20 at 12:20 PM, Registered Nurse (RN) #1 stated that, if there was no sign on the door or an isolation cart outside the room, then that resident was considered negative. During an interview on 5/20/20 at 5:13 PM, DON #1 stated the expectation was for staff to treat all unknown or suspected residents as COVID-19 positive, and that signs and isolation carts should have been placed on Resident #s 4 and 8's rooms to alert and instruct all staff prior to entering the room. Finding 3: The facility did not ensure a glucometer was clean and disinfected after each use. A P&P titled Cleaning/Disinfecting of Glucometer dated 3/2020 documented durable medical equipment (DME) must be cleaned and disinfected before reuse by another resident. Glucometer cleaning should take place prior to, and immediately after each use to prevent the spread of pathogens from blood or body fluids. Resident #4: A progress note dated 5/20/20 at 12:07 PM, documented Resident #4 was to receive insulin per sliding scale with no coverage needed. During an observation on 5/20/20 at 12:51 PM, LPN #2 performed a blood glucose test on Resident #4. LPN #2 removed her gloves and exited the resident's room, placed the glucometer on the medication cart prior to disinfecting the glucometer, and left the medication cart to perform other tasks. During an interview on 5/20/20 at 12:54 PM, LPN #2 stated the glucometer used on Resident #4 was not specific to that resident and was used on other residents on the unit. LPN #2 stated all multi-use devices were supposed to be disinfected before and after resident use and prior to returning it to the medication cart and did not know why she did not disinfect the device. During an interview on 5/21/20 at 11:00 AM, the DON #2 stated staff were supposed to

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) wipe down the glucometers per manufactures instructions after each use and before it was returned to the medication cart. 10 NYCRR 415.19(b)(1)