STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335164	A. BUILDING _____ B. WING _____	04/26/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HUMBOLDT HOUSE REHABILITATION AND NURSING CENTER	64 HAGER STREET BUFFALO, NY 14208

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 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review conducted during an COVID-19 Infection Control Focus Survey (Complaint #[ST] 448) completed on 4/26/20, the facility did not immediately inform the resident's representative(s) when a significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications) for one (Resident # 2) of five residents reviewed for notification. Specifically, there was a six-day delay in the notification of the resident's responsible party when the resident experienced a deterioration in health status (fever, lethargy, and altered mental status (AMS). The finding is: Review of facility policy and procedure (P&P) Confirmed or Suspected COVID-19 dated [DATE] revealed symptoms can include fever, cough, and shortness of breath (SOB). If there are suspected cases or positive cases of COVID- 19 in the facility, notify resident's physician, family, Medical Director, and the Infection Preventionist. 1. Resident # 2 had [DIAGNOSES REDACTED]. The Minimum Data Set (MDS, a resident assessment tool) dated [DATE] revealed the resident was usually understood, usually understands, and had severe cognitive impairment. Review of Progress Notes dated 4/8/20 to [DATE]4/20 included the following: - 4/8/20 at 7:10 AM Licensed Practical Nurse (LPN) #3 documented, Resident #2 was noted to have elevated temp (temperature) 101.8 degrees (normal 96.8) Fahrenheit, medicated with [MED] ([MEDICATION NAME], fever reducing medication). Current temp 97.8. - 4/9/20 at 10:39 PM LPN #4 documented, Resident #2 had an elevated (temperature) of 102.2 at 9:45 PM. [MED] given with good effect 100.1 at 10:30 PM. - [DATE]1/20 at 3:28 AM LPN #5 documented elevated temp at 2:00 AM of 104.4. [MED] ([MED]) and ice pack and cool compress given for elevated temp. Supervisor notified. Rechecked temp at 3:30 AM 104. - [DATE]1/20 at 6:00 AM LPN #5 documented at 4:30 AM, temp 101.6. Ice pack and cold compress continue. Per Supervisor, MD (Medical Doctor) called with no new order. - [DATE]2/20 at 2:13 PM Admissions documented, temp 101, [MED] given at 1:30 PM. Review of the MD Acute Visit note dated [DATE]1/20 documented, Resident has been running a fever. He/she does not look well. He/she is currently on comfort measures only. His/her limitations of care includes no labs (laboratory). Assessment: Fever, lethargy, AMS. Review of the interdisciplinary Progress Notes dated 4/7/20 to [DATE]4/20 revealed there was no documented evidence the family was notified of the resident's change in condition. During an interview on 4/26/20 at 11:52 AM, the Assistant Director of Nurses (ADON) stated she did not recall updating the responsible party regarding Resident #2's change in condition. Review of a handwritten nurses note dated 4/26/20 revealed LPN #6 documented the responsible party was notified of the change in resident condition on [DATE]4/20. 415.3(e)(2)(ii)(b)(c)
F 0880 **Level of harm** - Immediate jeopardy **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 conducted during the COVID-19 Infection Control Focus Survey (Complaint #[ST] 448) completed on 4/26/20, it was determined that the facility did not establish and maintain an Infection Control Program to ensure the health and safety of residents to help prevent the transmission of COVID-19. Specifically, facility staff entered and exited the rooms of residents diagnosed with [REDACTED]. The CNAs (certified nursing assistant) did not remove their gowns or gloves after exiting the rooms of residents on Contact and Droplet Precautions and did not complete appropriate hand hygiene. CNA's were unable to identify residents that were on Contact and Droplet Precautions for COVID-19. This was a pattern of no actual harm that is immediate jeopardy to resident health and safety. Additionally, Resident #1 a person under investigation (PUI) for COVID-19 was not placed on Contact and Droplet precautions per the facility's process and staff were observed not wearing facemasks appropriately in resident care areas. Review of a facility policy and procedure (P&P) titled Preventing the spread of COVID-19 dated [DATE] documented infection prevention and control measure must be enhanced at this time and that hand hygiene is of the utmost importance. Employees must clean their hands according to CDC guidelines, including before and after contact with residents, after contact with contaminated surfaces and after removal of PPE. Identify dedicated employees to care for COVID-19 patients. If suspect or confirmed with COVID-19 keep the resident isolated following proper isolation precautions. Review of P&P titled Confirmed of Suspected COVID-19 dated [DATE] documented if there is a suspected or positive case of COVID-19 initiate droplet precautions and place signage on the door. Place resident in their room with the door closed. Implement a PPE tote on the resident's door. Assure that all residents in affected units remain in their rooms, cancel communal dining. Review of an undated P&P titled Handwashing /Hand hygeine documented to wash hands before and after entering isolation precaution settings. The finding is: a) During an interview on [DATE] at 12:00 PM, the Director of Nursing (DON) and the Administrator stated there were five COVID-19 positive residents on the third floor and six COVID-19 positive residents on the fourth floor. The third and fourth floors have positive residents and exposed residents The 4th floor was the dementia unit and all the residents on that unit were on droplet precautions. Additionally, they had no residents currently under investigation for COVID-19. The facilities bed capacity was 173 and the current resident census was 127. COVID-19 positive residents eat meals in their rooms. During an observation on [DATE] at 12:28 PM CNA #3 was on a resident care unit on the fourth floor in the hallway. There were residents, staff and visitors present in the immediate area (with in six feet). CNA #3's mask was below his chin and exposing his nose and mouth. During an observation on [DATE] at 12:30 PM there were six residents in a lounge area across from the nurses' station on the fourth floor, they were not maintaining their face masks or social distancing. Staff members (activities/nursing) were present in the area but did not redirect the residents to replace their masks or to social distance, until the surveyors intervened. The Licensed Practical Nurse (LPN) #1 stated there were both COVID-19 positive and negative residents in the lounge area at this time. During continued observations at 12:38 PM the fire doors were closed to the low-end hall (Rooms #401 to #408) designated as the COVID-19 positive zone by the facility. A stocked linen cart was uncovered, and the majority of the resident room doors were open and had Contact and Droplet precautions signs posted on all of them. During interview on [DATE] at 12:40, CNA #4 was on the designated COVID-19 zone in the hallway and stated they redirect the residents the best they can, and the residents should have their face masks on, but it's hard for the residents to keep them on. Residents on this floor that are able can move and walk freely around the unit. CNA #4 stated he did not know which residents on the fourth floor were COVID-19 positive and did not know how the facility identified resident's that were positive as they treat all the residents as if they were positive on the fourth floor. CNA#4 was wearing two gowns, his facemask was covering his mouth but not his nose. Throughout the interview CNA #4 would lower his facemask below his mouth to speak. The staff keep their same gowns on all shift until they go on break or home. He was educated on the use of PPE and should not have pulled his facemask down to speak and that it slips down at times. During a lunch meal pass observation on [DATE] at 12:45 PM on the fourth floor COVID-19 designated zone, two meal carts were wheeled onto the low-end hall and placed behind the closed fire doors. CNA #1 and CNA #2 were observed to pass the

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 -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 1) lunch meal trays and provide meal set up assist moving from COVID-19 positive resident rooms to COVID-19 negative resident rooms, wearing the same PPE and without completing hand hygiene. The residents in their rooms were not wearing masks. After the trays were passed CNA #1 and CNA #2 left the COVID-19 designated zone and returned to the resident lounge area wearing the same PPE and without performing hand hygiene. During interview on [DATE] at 12:49 PM, CNA #1 stated that he did not know which residents were COVID-19 positive or negative. He did not know how to identify which residents were positive and that he treats every resident as if they were positive, that's just what I do. CNA #1 stated he was educated on PPE use and should have performed hand hygiene between residents. During interview on [DATE] at 12:50 PM, CNA #2 stated she was educated on the use of PPE and should have changed her gown and preformed hand hygiene when exiting a COVID-19 positive room and before entering a non COVID-19 resident room, but sometimes there are not enough gowns. CNA #2 did not know which residents were positive, or negative for COVID-19 and that they treat all residents on the fourth floor as if they were positive. During an interview on [DATE] at 12:50 PM, the Assistant Director of Nursing (ADON) stated they are treating the entire floor with extreme caution. CNA's should not be moving from COVID-19 positive rooms to COVID-19 negative rooms without removing their gowns and performing hand hygiene. During an interview on [DATE] at 2:50 PM, the Director of Nurses stated that they did education on COVID-19, the use of PPE, and handwashing. On the fourth floor there are COVID-19 positive rooms where they were cohorting residents that were both positive and negative. The unit also has dementia residents that independently move and wander throughout the entire fourth floor. If a resident is on precautions for COVID-19 a Contact and Droplet Precautions sign is placed on the door as well as a precaution set up (PPE [MEDICATION NAME]) hung on the room door. With hands on care the expectation would be to change gowns and gloves, but to just do a quick task it was not necessary. During a telephone interview on [DATE] at 3:35 PM, a representative from the [ST] State epidemiology division stated that facility staff should be donning and doffing (putting on and taking off) PPE and performing hand hygiene between COVID-19 positive residents and COVID-19 negative residents. If they cannot maintain the zones or have designated staff for the COVID-19 positive residents, the facility should think about moving the residents to where a red zone could be maintained. During a telephone interview on [DATE] at 5:53 PM, the Medical Director stated that staff should be not moving from COVID-19 positive residents to COVID-19 negative residents without removing PPE and performing hand hygiene. The residents are vulnerable population and there is an increased risk of transmission with this disease and he would expect the staff to be removing the PPE and performing hand hygiene. If possible, the facility should dedicate staff, put COVID-19 positive residents in rooms together, and if there was enough room within the facility to put the positive residents all in the same area and remove from them from COVID-19 negative resident areas. During an observation on 4/24/20 at 12:59 PM in the fourth- floor lounge area across from the nurses station revealed three male residents sitting at a table eating lunch within a foot of each other. At the time of the observation the DON was standing by the nurses' station, and was asked does the facility allow communal dining at this time? The DON stated no, and the residents should not have been seated at the same table. After surveyor intervention the DON attempted to redirect the residents. During an observation 4/25/2020 at 12:19 PM LPN #2 was observed at the second- floor nurses' station on with their face mask below their chin exposing nose and mouth within six feet of the DON and surveyor. The LPN stated she should not have the facemask off at the desk, but I knew when I got up and walked away, I would pull it up. Additionally stated, the face mask was to be worn anytime within six feet of anyone else, due to the COVID-19 crisis. During an observation 4/25/2020 at 12:33 PM CNA #4 was observed at the fourth-floor service elevator with facemask below his nose exposing the nose and within six feet of two employees and the surveyor. CNA #4 stated, It gets real hot in here. During an observation on 4/25/2020 at 12:50 PM, the fourth-floor Housekeeper (#1) was observed with a healthcare particulate respirator surgical mask (mask that helps provide respiratory protection against certain airborne particles) below her chin and a disposable facemask that was ripped horizontally exposing the nose. The housekeeper was observed wearing a cover gown, gloves, and ripped facemask entering the room of a COVID-19 positive resident. The housekeeper then exited the room, removed gloves, applied new gloves without performing hand hygiene, and while wearing the same gown and ripped facemask entered the room of a non-COVID-19 positive resident. The housekeeper then exited that room, removed gloves, applied new gloves without performing hand hygiene, and while wearing the same gown and ripped facemask then entered the room of another non-COVID-19 resident. During an interview on 4/25/2020 at 1:20 PM, Housekeeper #1 stated she only changes gloves between resident rooms. I change the gown when I leave the unit. I don't change the gown between precaution (level of infection control) and non-precaution rooms, we only get one gown per shift because there aren't enough gowns to go around. In addition, the housekeeper stated the healthcare particulate respirator surgical mask slips down to her chin which exposes her nose in resident rooms. During further observation on 4/25/2020 at 1:29 PM LPN #2 was again observed at the second- floor nurses' station with her facemask below her chin exposing her nose and mouth and within six feet of two CNA's. b.) Resident #1 had [DIAGNOSES REDACTED]. The Minimum Data Set (MDS, a resident assessment tool) dated 2/6/20 documented Resident #1 was moderately cognitively impaired, was understood and understands. Review of Resident #1 care plan revised on 3/5/20 and identified as current revealed there was no care plan developed to address respiratory precautions, measurable goals or interventions. During an interview on 4/24/20 at 11:46 AM with the facility DON, Corporate RN and Administrator present the Administrator stated there was one COVID-19 related death overnight from the fourth floor and there was one resident (Resident #1) under investigation for COVID-19 on the third floor. The results of the swab test were still pending. The DON stated the PUI (Resident #1) was not reported to the surveyors on 4/24/20. During an observation 4/24/20 at 12:49 PM Resident #1 was in lying in bed in their room with the door open. There were no identifiers (precaution signs or precaution totes per facility process) to indicate to staff and visitors that the resident was on Contact and droplet precautions. During an interview on 4/24/20 at 12:50 PM, the ADON stated the resident was moved to their current room on 4/9/20 and was swabbed for COVID-19 on 4/21/20 and the results were still pending. There should have been a Contact and Droplet precaution sign and tote placed on the door to the resident's room to alert staff and visitors the resident was on airborne/droplet precautions. Review of Resident #1's Progress Note dated 4/21/20 at 8:10 AM revealed the resident was lethargic, skin was cool to touch with increased weakness and had a temperature of 99.3 (normal 96.8). At 9:06 AM the ADON assessed the resident and noted the resident to have an occasional loose nonproductive cough, lung sounds were diminished in the bilateral bases and the Swab pending. Continued review of the progress notes revealed on 4/24/20 at 12:40 PM the laboratory (lab) was contacted, and the COVID-19 swab was still pending. Review of Resident #1's Medication Review Reports (physician's orders) dated [DATE]/20 through 4/30/20 revealed there was no physician's order to obtain a COVID-19 swab. Review of Resident #1's laboratory Infectious Disease report for with a print date of 4/26/20 at 8:58 AM revealed that [DIAGNOSES REDACTED] CoV 2 RNA was detected (infected with COVID-19 virus). 415.19 (b)(1)