STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335250	A. BUILDING _____ B. WING _____	**09/15/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HIGHFIELD GARDENS CARE CENTER OF GREAT NECK	**199 COMMUNITY DRIVE GREAT NECK, NY 11021**

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 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observations and interviews during the Recertification Survey, the facility did not ensure that food was served in accordance with professional standards for foodservice safety on two of 5 nursing units. Specifically, during observations of meal service for two residents (Resident #14 and Resident #78), two Certified Nursing Assistants (CNA #1 and #2) were observed handling the resident food with their bare hands. The finding is: The facility's policy dated 3/26/2020, titled Dining and Meal Service, documented that nursing staff will wash or sanitize hands between assisting residents with meals. On 9/10/20 at 8:47 AM during breakfast observation on the 2 North unit hallway, CNA #1 was observed spreading margarine on a bagel that he was preparing for Resident #14. CNA#1 was handling the bagel with bare hands. After the CNA completed preparing the bagel, he placed it on the tray for consumption. On 9/10/20 at 8:50 AM CNA #1 was interviewed. He stated his hands were clean. CNA #1 was not sure how to handle the food without touching it with his bare hands and did not realize that handling the food with his bare hands was a problem. On 9/10/20 at 10:50 AM the Registered Nurse (RN) unit supervisor was interviewed. She stated CNA #1 was not supposed to touch the food with bare hands. She stated staff do not wear gloves when preparing food. She stated the CNA should have just used a fork and knife or a plastic wrapper that the bagel came in. On 9/14/20 at 12:35 PM during lunch observation on the 3 South unit hallway, CNA #2 was observed prepping the lunch meal for Resident #78. A slice of bread fell out of the plastic wrapper and into the dish tray cover. CNA #2 picked up the bread with bare hands and placed it on the resident's tray. The resident then picked up the bread and started eating it. On 9/14/20 at 12:38 PM CNA #2 was interviewed. She stated she made a mistake and should not have handled the bread with her bare hands. On 9/14/20 at 1:02 PM the Director of Nursing Services (DNS) was interviewed. He stated the CNAs are supposed to use a barrier when handling food, like a napkin, and their bare hands are not supposed to come in contact with the food. 415.14(h)
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** Based on observations, and interviews during the Recertification Survey, completed on 9/15/2020, the facility did not ensure that an infection prevention and control program was maintained to help prevent the development and transmission of communicable diseases and infections on 1 of 5 nursing units. Specifically, a Licensed Practical Nurse (LPN #1) on the 3 South nursing unit was observed wearing a facial mask below his nose and was less than 6 feet apart with Resident #78 who did not have a mask on. The finding is: Review of the Health Advisory from NYSDOH Bureau of Healthcare Associated Infections (BHAI): Memorandum dated March 13, 2020, to all Nursing Homes and Adult Care Facilities, provided: All HCP (health care personnel) and other facility staff shall wear a face mask while within six feet of residents. Extended wear of face masks is allowed; face masks should be changed when soiled or wet and when HCP go on breaks. The facility's policy, dated 5/6/2020, titled Personal Protective Equipment, documented that employees/health care personnel should receive job-specific training on personal protective equipment (PPE) and demonstrate competency with selection and proper use. On 9/14/20 at 2:45 PM LPN #1 was observed in unit 3 South hallway. The LPN's mask was below his nose while he was handing a nutritional supplement to Resident #78. LPN #1 was speaking to the resident while handing the nutritional supplement to the resident who was not wearing a mask or facial covering. On 9/14/20 at 2:47 PM LPN #1 was interviewed. He stated he keeps forgetting to pull his mask above his nose. LPN #1 stated that the mask should cover his mouth and nose. On 9/15/20 at 2:49 PM the Director of Nursing Services (DNS) was interviewed. He stated that the LPN should be cognizant of the proper way to wear a face mask and should cover his nose and mouth with the face mask. On 9/15/20 at 2:58 PM the Infection Control Registered Nurse (RN) was interviewed. She stated the mask should have been covering the LPN's nose and mouth which is the correct way to wearing a mask. 10NYCRR 415.19(a)(1),(2)

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.