STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335548	A. BUILDING _____ B. WING _____	08/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ONONDAGA CENTER FOR REHABILITATION AND NURSING	217 EAST AVENUE MINOA, NY 13116

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** - Few	**Provide and implement an infection prevention and control program.** Based on observation, record review, and interview during the COVID-19 Focus Infection Control survey (NY 108) completed on 8/12/2020, the facility did not 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 4 residents (Residents #6, 7, 8, and 10) observed during lunch service on 1 of 2 units (South Unit). Specifically, certified nurse aides (CNAs) were observed touching their face masks, and other areas of their face/head, a dirty linen cart, a personal cell phone and other residents prior to handling resident food items without performing hand hygiene. Additionally, one CNA touched a resident's food with bare hands. This is evidenced by: The 12/2019 Hand Washing Policy documents: - The facility considers hand hygiene the primary means to prevent the spread of infections and provide high quality of care to its residents. - Guidance for hand washing includes use of soap and water before and after eating or handling food, before and after assisting residents with meals, and before and after conducting your own personal hygiene. - Guidance for use of alcohol-based hand rub or soap and water includes before and after direct contact with residents and after contact with objects in the resident's vicinity On 8/12/20 the following was observed during the lunch meal in the hall of the South Unit: - At 12:37 PM, CNA #4 opened the lid to the dirty linen cart and placed an item in it, took a meal tray from the tray cart, set up the tray for Resident #6, touching lids and utensils, and sat in chair nearby. She then touched her head, face, eyes, used her cell phone, adjusted a wireless earphone in her right ear, and adjusted the fabric mask on her face, which was positioned below her nose. - At 12:46 PM, CNA #10 was seated in a chair in the hall, she faced an unidentified resident who was seated in a wheelchair, ran her hands through the resident's hair, adjusted the resident's shirt, scratched her own head and adjusted her hair. - At 12:49 PM, an unidentified CNA orientee cleared a tray, held onto an unidentified resident's hands as she spoke to her, and then sat near Resident #6. She adjusted her face mask that had fallen below her nose, adjusted her hair, and remained seated between residents in the hall. She pushed a resident in their wheelchair and adjusted their clothing protector. - At 12:59 PM CNA #10 was touching an unidentified resident's hands and legs. CNA #4 continued holding her cell phone with both hands. - At 1:00 PM, a second tray cart arrived on the unit, the unidentified CNA orientee, CNA #4 and CNA #10 got up and began serving trays to the residents in the hall. - At 1:04 PM, the unidentified CNA orientee assisted a resident with the meal, and then fed Resident #9. She repeatedly moved her cloth face mask on/off her nose and mouth, touched her head, eyes, and ear. - At 1:05 PM, CNA #10 fed bites of food to Resident #8, then handed the resident the spoon. - At 1:07 PM until 1:19 PM, CNA #4 fed Resident #7. While feeding the resident, she took her cell phone out of her pants pocket, held it as she used it, touched her face and head, adjusted her mask back up to her nose, dropped her cell phone onto the floor, picked it up, put it her pocket and continued to feed the resident. - At 1:22 PM, CNA #4 approached Resident #10, picked up half of the resident's sandwich with her bare hand, encouraged the resident to eat it, scooped some food onto the resident's plate near the sandwich with a spoon, and again encouraged the resident to eat. - At 1:34 PM, the unidentified CNA orientee remained seated directly next to residents in the hall, was speaking to staff in the hall with her mask completely off her nose and mouth. There was no hand hygiene performed by any of the CNAs observed from 12:37 PM to 1:34 PM. Alcohol based hand rub (ABHR) and single use gloves were positioned in multiple areas along the hall where the meals were served. When interviewed on 8/12/20 at 1:55 PM, CNA #4 stated hand hygiene was to be performed before and after all resident contact. Contact included touching, assisting, feeding, and setting up meal trays. If the CNA touched her own face mask, personal items, or other areas of her body, hand hygiene was to be performed prior to resident contact. When trays were passed, CNA #4 stated hand hygiene should be performed in between residents but it was sometimes difficult when they were busy and in and out rooms. When feeding, gloves should be worn, especially if any food was touched and hand hygiene should be performed. The CNA could not recall if she performed hand hygiene before she passed trays, fed Resident #7, or assisted resident #10. She stated she should have put on gloves before directly touching food. CNA #4 stated it was important for infection control and to reduce the possible spread of COVID-19. CNA #4 stated she did not realize the various ways she continued to touch her face, head, mask, and cell phone without performing hand hygiene. When interviewed on 8/12/20 at 3:22 PM, the Assistant Director of Nursing (ADON) and acting Infection Control RN stated staff were educated on hand hygiene, when to utilize alcohol-based hand rub (ABHR, hand sanitizer) and when to wash with soap and water. Staff were expected to perform hand hygiene in between all types of resident contact, including touching a resident, providing meal trays, feeding, and any other form of contact. Anytime staff contacted personal objects, touched their faces, masks, or other areas of their bodies, they were expected to perform hand hygiene. Masks were to be worn at all times and if the masks were repeatedly touched, staff were to perform hand hygiene. Any contact with resident food was to be done with gloved hands. Staff were educated on the heightened importance of proper infection control due COVID-19 as well as general good practice. Staff had been provided a great deal of education and information regarding the spread of COVID-19 and how to reduce risks through proper infection control practice. 10NYCRR 415.19(a),(b)

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.