STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335588	A. BUILDING _____ B. WING _____	05/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE GRAND REHABILITATION AND NRSG AT CHITTENANGO	331 RUSSELL STREET CHITTENANGO, NY 13037

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 during the COVID 19 Infection Control Focus Survey (NY 077) the facility did not establish and maintain an Infection Control Program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of COVID 19 for 14 of 65 residents who were COVID 19 positive, including Residents #1, 3, 4, and 5. Specifically, - Staff on Unit A, which housed 14 residents who were positive for COVID 19, were not aware of facility protocols for caring for residents with COVID 19, including Residents #1, 3, 4, and 5. - Staff training on caring for residents with COVID 19 was not consistent with the facility's current intended protocols. - Staff caring for residents with COVID 19 were not knowledgeable of the facility's current protocols for infection prevention. Findings include: The facility's policies Guidance on Coronavirus (2/2020), Infection Prevention and Control for Facilities with residents with suspected or Confirmed COVID 19 in the Facility (3/2020), Droplet Precautions (3/2019), and Contact Precautions (3/2019) were reviewed. The policies did not document the specific practices in place at the facility for prevention of the transmission of COVID 19. 1) Resident #3 had [DIAGNOSES REDACTED]. Resident #4 had [DIAGNOSES REDACTED]. Resident #5 had [DIAGNOSES REDACTED]. Residents #3 and 5 resided in the same room and Resident #4 resided in a room alone. On 5/5/2020 at 1:15 PM, the Director of Nursing (DON) was interviewed and stated any residents who were COVID 19 positive were on Unit A. She stated all staff on Unit A were trained and designated to work on that unit. She stated at the beginning of the shift, Unit A staff were issued a cloth gown, goggles or face shield, an N95 mask, a surgical mask, and one disposable gown. The disposable gown was to be used when caring for residents who were COVID 19 positive. When staff needed to care for residents who were COVID 19 positive, they were to remove the cloth gown, hang it in the resident's room that they were caring for, and apply the disposable gown and gloves. She stated when the care was done, the staff should doff the disposable gown and gloves, practice hand hygiene, and don the cloth gown they were originally wearing. She stated the disposable gown was to be hung in a COVID 19 positive residents' room for the shift and could be used for all COVID 19 positive residents. On 5/5/2020, the following was observed: - At 3 PM, nurse aide trainee #5 entered unit A. She was wearing a cloth gown, an N95 respirator mask, a surgical mask over the N95 respirator mask, and eye protection (goggles). - At 3:05 PM, nurse aide trainee #5 donned a disposable gown over the cloth gown and entered Resident #4's room. The surveyor could not view the care provided as the curtain was pulled. - A few minutes later, nurse aide trainee #5 exited from around the curtain and came into view of the surveyor. She was not wearing gloves and was wearing a cloth and disposable gown, goggles, and an N95 mask and surgical mask. No hand hygiene was performed and nurse aide trainee #5 exited the room. - Nurse aide trainee #5 immediately entered the room of Residents #3 and 5, was in the room for a few seconds and then exited. - In the hallway, outside of Residents #3 and 5's room, nurse aide trainees #5 removed the disposable gown, rolled it up and hung it on the handrail in the hallway. - A few minutes later, nurse aide trainee #5 picked up the disposable gown re-folded it and placed it in a different spot on the handrail in the hall. On 5/5/2020 at 3:20 PM, nurse aide trainee #5 was interviewed and stated she received one disposable gown per shift, and it was to be worn in rooms where the residents were COVID 19 positive. She stated the disposable gown was to be applied over the cloth gown that she wore all shift. She stated she had one disposable gown per shift, she wrote her name on it, and she stored it on the handrail in the hallway so it was easier to locate when she needed it. She stated in addition to the disposable gown over the cloth gown, she wore 2 pairs of gloves when she took care of residents who were COVID 19 positive. She stated she was not told to do this, but she felt more comfortable doing this. On 5/5/2020 at 4:04 PM, the DON was re-interviewed and reiterated the same practice for staff to follow when caring for COVID 19 positive residents as she stated during the 1:15 PM interview. She stated the cloth gown was to be removed and the disposable gown was to be donned prior to caring for residents who were COVID 19 positive. She stated it was never acceptable to hang a used gown on a handrail in the hallway and once the disposable gowns were used, they were to be hung in a room of a resident who was COVID 19 positive. 2) Resident #1 had [DIAGNOSES REDACTED]. On 5/5/2020 at 2:32 PM, certified nurse aide (CNA) #4 was observed wearing a cloth gown, an N95 respirator mask covered by a surgical mask, and goggles. She entered Resident #1's room, did not perform hand hygiene, or apply gloves, and did not apply the disposable gown that hung over the resident's closet door. CNA #4 was observed going through the resident's top dresser drawer and several drawers of a plastic utility cart, and then handed the resident a pen from of the cart. CNA #4 then went into the resident's bathroom to perform hand hygiene and exited the room. When questioned as she was exiting the room, CNA #4 stated she should have performed hand hygiene and applied gloves before entering the room and did not. On 5/5/2020 at 2:35 PM, CNA #4 stated in an interview, there were no COVID 19 positive residents at the facility, they were all in the hospital. The residents on this unit (A unit) were in a 14-day quarantine. She stated if she needed to use a disposable gown there would be a bright orange sign outside the room and she would get a disposable gown from the bin outside of the room. The surveyor asked to see the bright orange sign on a door that required a disposable gown and she was not able to show the surveyor the sign she was talking about. CNA #4 stated she knew she needed a disposable gown for Residents #4's room but there was no orange sign on their door right now. She stated if she went into that room, she would get a disposable gown from the drawer outside of the room, take off the cloth gown and place it in a plastic bag outside of the room and then do resident care. Once care was done, she would remove the disposable gown and don the cloth gown that was in the plastic bag. She stated she was new to the unit, it was her first time working there and she had received no training on the unit. On 5/5/2020 at 4:04 PM, the Director of Nursing (DON), who was also the Infection Control Preventionist was interviewed and stated the unit had designated staff that were trained on the protocols for caring for residents with COVID 19. She stated staff should always wear gloves when touching anything in a room where a resident was COVID positive. She stated the staff only needed a gown if they were providing direct care to a resident. STAFF TRAINING On 5/5/2020 at 1:15 PM, the Director of Nursing (DON), who was also the Infection Control Preventionist, was interviewed and stated any residents who were COVID 19 positive were on the A unit. She stated all staff on the A unit were issued a cloth gown, goggles or face shield, and N95 mask for their shift along with one disposable gown to be used in rooms where residents were COVID 19 positive. When the staff need to care for a COVID 19 positive resident, they were to remove the cloth gown, hang it in the room, and apply the disposable gown and gloves. She stated when care was done, the staff should doff the disposable gown and gloves, practice hand hygiene, and don the cloth gown. She stated the disposable gown was to be hung in a COVID positive residents' room for the shift and could be used for all COVID positive residents. In an interview with certified nurse aide (CNA) #3 she stated she was working light duty right now so she was not really doing direct care but if she did, she would wear a disposable gown when caring for resident's who are COVID 19 positive. She stated she was given one disposable gown per shift and it was hanging in a resident's room right now who was COVID 19 positive. She stated she used the same disposable gown to care for all residents who were COVID 19 positive. On 5/5/2020 at 2:30 PM, registered nurse (RN) #2 stated in an interview, the staff were to wear a cloth gown all day on the unit and when they entered a COVID 19 positive room, they were to wear the disposable gown that was in the room. He stated the gowns were designated for the residents in the rooms and all staff were to wear the same

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) disposable gowns in those rooms. On 5/5/2020 at 2:35 PM, CNA #4 stated in an interview, there were no COVID positive residents at the facility, they were all in the hospital. The residents on this unit (A unit) were in a 14-day quarantine. She stated if she needed to use a disposable gown there would be a bright orange sign outside the room and she would get a disposable gown from the bin outside of the room. The surveyor asked to see the bright orange sign on a door that required a disposable gown and she was not able to show the surveyor the sign she was talking about. CNA #4 stated she knew she needed a disposable gown for Residents #4's room but there was no orange sign on their door right now. She stated if she went into that room, she would get a disposable gown from the drawer outside of the room, take off the cloth gown and place it in a plastic bag outside of the room, and do care. Once care was done she would remove the disposable gown and don the cloth gown that was in the plastic bag. She stated she was new to the unit, it was her first time working there and she had received no training on the unit. On 5/5/2020 at 3 PM, the day shift staff left the unit and the evening shift arrived. All of the disposable gown that were hanging in rooms with residents who were COVID 19 positive remained hanging in those rooms after the change of shift. On 5/5/2020, from 3:05 PM to 3:15 PM, nurse aide trainee #5 was observed and did not follow the protocols described by the DON in the 1:15 PM interview as she wore a disposable gown over the cloth gown, did not don gloves in a COVID 19 positive room, and stored the disposable gown that was worn in two COVID 19 positive rooms on the handrail in the hallway. On 5/5/20 at 3:10 PM, CNA #8 stated in an interview, staff were issued a disposable gown when they came on duty for use in COVID 19 positive rooms and it was to be left in the resident room. If they needed to go into another resident room who had COVID 19, there should be a gown left hanging from the previous shift who worked with the resident and they can use that gown. On 5/5/2020 at 3:20 PM, nurse aide trainee #5 was interviewed and stated it was her understanding that the disposable gown was to be worn over the cloth gown, she stored her disposable gown on the handrail as it was easier to locate that way. She stated she donned two pairs of gloves when caring for COVID 19 positive residents. On 5/5/2020 at 4:04 PM, the DON, who was also the Infection Control Preventionist, was re-interviewed and reiterated the same practice for staff to follow when caring for COVID 19 positive residents as she stated in the 1:15 PM interview. She stated the cloth gown was to be removed and the disposable gown was to be donned prior to caring for residents who were COVID 19 positive. She stated it was never acceptable to hang a used gown on a handrail in the hallway or to place it in a bag outside of the room. She stated staff also should not be doubling the gowns up, they should remove the cloth gown and don the disposable gown and then change back when they were done caring for a resident with COVID 19. She stated the gown was to be used by one staff member only and if more gowns were needed, they had them on the unit. She stated the gowns were hung in the residents' room through the shift and were thrown out at the end of every shift. She stated she was not aware none of the gowns were thrown out today by the day shift. She stated all staff were trained and she did not know who CNA #4 was or how she ended up on the unit today without training. On 5/5/2020 at 4:25 PM, the DON left the room to obtain training records and returned with the Assistant Director of Nursing (ADON). The DON stated the Educator was out due to illness, so she took the COVID 19 education information off the Educator's desk. The ADON stated that besides the training done by the Educator the new staff were trained in orientation. The ADON stated the process for COVID 19 positive residents included wearing a disposable gown over the cloth gown when caring for those residents and that was what she trained the staff to do. The DON, who was present, stated to the ADON and surveyors that was not accurate and on 4/20/2020 the facility had their first COVID 19 positive resident and the facility had changed the practice to removing the cloth gown and donning a disposable gown. There was no documentation as to who the ADON educated on wearing two gowns. During the 5/5/2020 interview at 4:25 PM, the DON provided an education summary dated 4/20/2020 for precautions to take on Unit A. The education documented when entering a COVID 19 positive room staff were to take off the cloth gown, don a disposable gown, and hang the cloth gown on the door. Upon exiting the room, staff were to remove the disposable gown and save it in the resident's room for the next visit to that room. The protocol did not mention the gown being assigned to staff to take from room to room with them when caring for COVID 19 positive residents. The sign in sheet for the training dated 4/21/2020 documented the ADON and CNA #8 were trained. The sign in sheet did not document RN #2, CNAs #3 and 4, or nurse aide trainee #5 were trained. 10NYCRR415.19 (b)(1)