STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335265	A. BUILDING _____ B. WING _____	07/27/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
VAN RENSSELAER MANOR	85 BLOOMINGROVE DRIVE TROY, NY 12180

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 Focused Infection Control Survey (Complaint #NY 938) conducted on 7/23/2020, the facility did not maintain an infection prevention and control program designed to provide a safe environment, and to help prevent the development and transmission of communicable diseases and infections. Specifically, the facility: did not comply with Centers for Disease Control (CDC), Centers for Medicare and Medicaid Services (CMS), and New York State Department of Health (NYSDOH) guidance for visitation, mask usage and social distancing, This is evidenced by: Finding 1: The facility did not comply with Centers for Medicare and Medicaid Services (CMS) and New York State Department of Health (NYSDOH) visitation guidelines. The CMS Quality, Safety & Oversight Group (QSO-20-14-NH) Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in Nursing Homes (REVISED), dated 3/13/2020, documented that all facilities nationwide should, restrict visitation of all visitors and non-essential health care personnel, except for certain [MEDICATION NAME] care situations, such as an end-of-life situation. The NYSDOH Health Advisory: COVID-19 Cases in Nursing Homes and Adult Care Facilities, dated 3/13/2020 documented facilities should suspend all visitation except when medically necessary. An email dated 7/1/2020 at 3:28 PM, from the Assistant Administrator to facility staff and resident families, documented the facility was putting the finishing touches on a new visitation plan that would take place on the facility's front patio that was in compliance with Centers for Disease Control (CDC) guidelines and NYSDOH Advisories. The email also documented patio visitation would commence on 7/6/2020 and included instructions for making visitation appointments, and the required protocol that would need to be followed by visitors during the visitation. The instructions included all visitors and residents would be required to wear a mask. The Patio Visitor Screening Form dated 7/6/20, documented a total of 56 visitors had been screened that day. Fifty-five of the visitors screened were allowed to visit residents. During an interview on 7/23/20 at 10:08 AM, Registered Nurse (RN) #1 stated the outdoor patio visits started around the time local news stations had reported on it, probably around July 4th or so. During an interview on 7/23/20 at 1:17 PM, the Director of Nursing (DON) reviewed the Patio Visitor Screening Form dated 7/6/20 and stated patio visitation began on 7/6/2020. During an interview on 7/23/20 at 1:15 PM, the Administrator stated the facility started outdoor visitation on 7/6/2020. Finding 2: The facility did not ensure 2 of 5 visitors, and 2 of 3 residents wore face masks at all times during an outdoor patio visit. The Health Advisory from NYSDOH titled Health Advisory: Skilled Nursing Facility Visitation: dated 7/10/2020 to Nursing Home (NH) Operators and Administrators, documented that when a facility has met the metrics to reopen to visitation, visitors must wear a face mask or face covering which covers both the nose and mouth at all times when on the premises of the NH. The undated facility document titled Outdoor Visitation Guidelines documented the following: visitors must wear their face mask correctly, and staff would be available to instruct and ensure visitors adhered to proper procedures; visitors who failed to wear a face mask and follow proper guidelines would be asked to leave the facility. Pursuant to the facility's Outdoor Visitation Guidelines, residents were also to wear a face mask during visits, and not leave their designated area behind their partition on the patio. During an observation on 7/23/2020 from 1:38 PM to 1:43 PM, there were a total of 5 visitors and 3 residents visiting on the facility's outdoor patio. There were 4 visiting stations each separated by partitions. Each of the 4 stations was then divided using a clear plastic curtain. The residents were seated on one side of the clear plastic curtain, and the visitors seated on the other side, maintaining a 6-foot distance. Two visitors sitting in the visiting station closest to the screener's table attended by Clerk #4 in the front vestibule did not properly wear their face masks. One of the visitors had a face mask with her but was talking on a cellphone without the mask covering her nose and mouth. The other visitor wore her mask below her chin. The resident visiting with those 2 visitors was also talking on a cellphone, had a face mask, but was not wearing it. The resident in the second visiting station from the screener's table in the front vestibule, wore the mask below the chin, not covering the nose or mouth. During an interview on 7/23/20 at 10:08 AM, Register Nurse (RN) #1 stated the residents and visitors were supposed to be 6 feet apart, with a clear shower curtain that divided the tables as a barrier. She stated residents and visitors both had to wear masks during the visit. During an interview on 7/23/20 at 1:40 PM, Clerk #4 state he was filling in as the visitor screener for the first time that afternoon. He stated, at the time of the interview, there were 5 family members visiting on the patio, and 3 residents. He stated visitors agreed to the Outdoor Patio Guidelines and had to wear a mask while visiting. He stated he had not been instructed to ensure visitors and residents were properly wearing their masks and that the masks were kept on throughout the visit. During an interview on 07/24/20 at 4:05 PM, the DON stated masks were to be worn at all times by both visitors and residents, unless a resident was having a difficult time wearing the mask. The screener was supposed to ensure visitors were wearing their masks, and the housekeeper on the patio also made rounds to ensure masks were being worn properly. During an interview on 7/23/20 at 1:52 PM, the Administrator stated there was always a nurse or another employee at the visitor screening table to screen visitors. The screeners were supposed to monitor the visitors and resident to ensure masks were being worn properly. Finding 3: On 3 of 9 units reviewed, the facility did not ensure residents were positioned at a distance of at least 6 feet apart. The CDC guidance titled Preparing for COVID-19 in Nursing Homes dated 6/25/2020, documented facilities should implement aggressive social distancing measures, which included residents remaining at least 6 feet apart from others. During an observation on 7/23/20 at 9:48 AM, in the left common area on Unit B-2, 5 residents were sitting in a half circle facing a television. All residents were within 3 feet of each other. None of the residents were wearing face masks. During an observation on 7/23/20 at 10:00 AM, in the right common area on Unit B-2, 4 residents were sitting and facing the television. Three of the 4 residents were seated were seated within 2 feet of each other. None of the residents were wearing a face mask. During an observation on 7/23/20 at 10:02 AM, in the right common area on Unit C-2, 3 residents were sitting in a common area, facing a television, and 2 of the 3 residents were seated were seated within 3 feet of each other. None of the residents were wearing a face mask. Two staff members were seated with the residents. During an observation on 7/23/20 at 10:40 AM, in a common area on Unit A-2, 4 residents were sitting facing a television, all were seated were seated within 3 feet of each other. None of the residents were wearing a face mask. During an interview on 7/23/20 at 10:10 AM, CNA #3 stated she did not realize the residents in the common area on Unit C2 were not spaced 6 feet apart, and that it was a mistake to not identify this. During an interview on 7/23/20 at 10:32 AM, Licensed Practical Nurse (LPN) #4 stated staff brought residents out of their rooms and placed them in front of the television during the day. LPN #4 stated some of the residents identified were unable to move themselves, and the staff had placed the residents less than 6 feet apart in the common area. LPN #4 stated there was not enough space to appropriately social distance the residents. During an interview on 7/23/20 at 1:20 PM, the Director of Nursing stated staff were supposed to space residents at least six feet apart in common areas and attempt to ensure the residents maintained a social distance. 10 NYCRR 415.19(a) (1-3)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE