STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335408	A. BUILDING _____ B. WING _____	**05/26/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WEDGEWOOD NURSING REHABILITATION CENTER	**5 CHURCH STREET SPENCERPORT, NY 14559**

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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews conducted during the COVID-19 Infection Control Focus Survey (Case #NY 521), it was determined that the facility did not establish and maintain an infection prevention and control program designed to help prevent the development and transmission of COVID-19. The facility staff did not consistently follow infection control precautions for residents on contact and droplet precautions potentially resulting in cross contamination. Specifically, two staff members were observed exiting the rooms of two residents (Residents #1 and #5) that were positive for COVID-19 without removing (doffing) Personal Protective Equipment. This is evidenced by the following: The facility's COVID-19 policy, dated 5/12/20, included to use Personal Protective Equipment (PPE) appropriately. This includes to don (put on) gowns, gloves, mask, eye/face shield before entering a resident's room with COVID-19; doff (take off) gowns and gloves prior to exiting the resident's room; remove the face shield after exiting the room (for extended use, wear gloves to clean and disinfect by carefully wiping the inside and the outside of the face shield using an EPA-registered N-List product, allowing to air dry, and then remove gloves and perform hand hygiene); doff mask after exiting the room (for extended use, wear the same facemask for multiple residents with suspected or confirmed COVID-19 without removing between residents). 1. Resident #5 had [DIAGNOSES REDACTED]. The Minimum Data Set (MDS) Assessment, dated 5/7/20, revealed that the resident had moderately impaired cognition. In an observation on 5/26/20 at 9:00 a.m., the Certified Nursing Assistant (CNA) exited the resident's room in contaminated PPE (gown, gloves, mask, and face shield). She proceeded walking in her PPE approximately 10 feet down the hallway carrying a red isolation trash bag. She opened the door to the utility room with the same gloves, dropped off the trash, and again opened the utility room door to exit the room with the same gloves. She then proceeded back to the resident's room and removed her gown and gloves in the hallway in front of the resident's room and disposed of the items in a red trash container in the hallway. Without cleaning her hands, the CNA donned gloves, and then took a disinfectant wipe and washed the face shield while it was still on her head. She then removed the face shield and left her facemask in place. When interviewed at that time, the CNA said there was no trash can in the room to dispose of her gown and gloves. She said that she usually puts on a surgical face mask over her N-95 mask and only disposes of the surgical mask. When questioned, she said she did not know if she should remove PPE in the hallway. 2. Resident #1 had [DIAGNOSES REDACTED]. The MDS Assessment, dated 5/9/20, revealed that the resident's cognition was severely impaired. In an observation on 5/26/20 at 9:15 a.m., the Licensed Practical Nurse (LPN) donned PPE and entered Resident #1's room carrying medications. She exited the resident's room in contaminated PPE (gown, gloves, mask, and face shield) and removed her gown and gloves in the hallway outside of the resident's room. She performed hand hygiene, cleaned her shield, and disposed of her N95 mask. When interviewed at that time, the LPN said there was no trash bag in the resident's room. She said that she should have doffed her PPE prior to exiting the resident's room. When interviewed on 5/26/20 at 9:35 a.m., the LPN Manager/Infection Control Nurse said that staff should be removing their gowns and gloves and disposing of them prior to exiting the resident's room. She said that the face shields are being disinfected and sanitized and staff should be changing their mask. She said the facility has plenty of PPE including masks. (10 NYCRR 415.19)

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.