STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	335565	A. BUILDING _____ B. WING _____	05/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE GRAND REHABILITATION AND NURSING AT BARNWELL	3230 CHURCH STREET VALATIE, NY 12184

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.** Based on observation, interview and record review conducted during the COVID-19 Infection Control Focused Abbreviated Survey completed on 5/12/20, the facility did not establish and maintain an Infection Control Program to ensure the health and safety of residents to help prevent the transmission of COVID-19. Specifically, on 2 (Units 4 and 6) of 6 units, staff were observed entering rooms of COVID-19 positive residents, then entering COVID-19 negative residents' rooms without changing PPE or performing hand hygiene in between. This is evidenced by: The policy and procedure (P&P) titled Guidance on COVID-19 (formerly Coronavirus) dated 2/11/20, documented Health Care Providers (HCP) must receive training on, and demonstrate an understanding of, when to use Personal Protective Equipment (PPE). The P&P documented gloves were to be put on upon entry into the patient room or care area and removed and discarded when leaving the patient room or care area, and a clean isolation gown was put on upon entry into the patient room or area and removed and discarded in a dedicated container for waste or linen before leaving the patient room or care area. UNIT 4 During an observation on Unit 4 on 5/11/20 at 2:45 PM, Resident Assistant (RA) #2, who wore a gown, face mask, and gloves, entered and exited resident rooms with and without signs on or next to the door that stated PPE Gowns, Gloves, Face Mask, and Goggles must be worn beyond this point. RA #2 was observed within 6 feet of residents without changing PPE. During an observation on Unit 4 on 5/11/20 from 2:45 PM to 2:55 PM, an Activities Aid (AA) #1 was observed exited a resident room with a sign on the door PPE Gowns, Gloves, Face Mask, and Goggles must be worn beyond this point and entered another resident room that did not have a sign on the door. AA #1 spoke with the resident and stood within 6 feet of the resident, and the resident was not wearing a mask. AA #1 exited the room and entered another resident room with a sign next to the door PPE Gowns, Gloves, Face Mask, and Goggles must be worn beyond this point. AA #1 sat on the resident's bed within 6 feet of the resident and read to the resident. The resident was in a wheelchair next to the bed and was not wearing a mask. Throughout the observation period, AA #1 was wearing a gown and face mask, was without gloves and did not change any portion of the PPE or perform hand hygiene before entering or exiting resident rooms. During an interview on 5/11/20 at 2:50 PM, RA #2 stated that, before entering a resident's room she put on a gown and followed the signs on or next to the resident's door, and she was aware she was entering and exiting COVID positive rooms and COVID negative rooms. She stated she was not sure what she was supposed to do regarding changing PPE because she had been given different instructions over the last couple weeks. She stated there should be more instruction given from the facility to staff about going from COVID positive rooms to COVID negative rooms. During an interview on 5/11/20 at 2:55 PM, AA #1 stated she had not received training on PPE or COVID-19 procedures in the facility. She was not sure if she should wear gloves or if she should change PPE upon entering or exiting COVID positive and COVID negative resident rooms. She stated a nurse on another unit told her she did not have to change PPE when going in and out of resident rooms. She stated she was sitting on the resident's bed that had signage next to the door that PPE was required and that probably was not a good idea. She stated she should probably have had gloves on in resident rooms. During an observation on 5/11/20 RA #4, while delivering meal trays, exited a COVID positive resident's room, then entered a COVID negative resident's room, then entered another COVID positive resident's room, and then entered another COVID negative resident's room, The RA did not perform hand hygiene or change PPE during this observation. During an interview on 5/11/20 Registered Nurse (RN) #1 stated the PPE sign on or near the resident's door was to inform staff that the resident in the room was COVID positive and they needed the PPE listed on the sign to enter the room. RN #1 also stated, any staff exiting a COVID positive room should change PPE and wash hands. UNIT 6 During an observation of Unit 6 on 5/11/20 at 1:14 PM, Certified Nurse Aide (CNA) #1 entered and exited resident rooms with and without signs on or next to the door that stated PPE Gowns, Gloves, Face Mask, and Goggles must be worn beyond this point to pass lunch trays without changing PPE. CNA #1 was wearing a gown, face mask, face shield, and gloves. During an interview on 5/11/20 at 1:05 PM, CNA #1 stated she was told she did not need to change PPE while passing meal trays and could not recall what was taught in the infection control or PPE training. During an interview on 5/11/20 at 1:18 PM, Licensed Practical Nurse (LPN) #1 stated she was not sure what the staff were supposed to do regarding PPE when going from COVID-19 (COVID) positive rooms to COVID negative rooms. She had not worked in the last 5 days, so was not aware if there had been any changes regarding PPE use during that time. She stated she wore the same PPE throughout the shift, unless she did a treatment on a resident, then she changed her PPE. She stated staff wore the same PPE throughout the shift and should probably change their PPE but did not. During an interview on 5/11/20 the facility Administrator stated all staff were provided COVID training that included appropriate use of PPE and when to change. Upon exiting a COVID positive room staff should change their gown, remove gloves and wash their hands. 10 NYCRR 415.19 (b)(1)
F 0885 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review conducted during the COVID-19 Infection Control Focus Survey completed on 5/11/20, the facility did not inform residents by 5:00 PM the next calendar day following the occurrence of either a single confirmed infection of COVID-19, or three or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other. Specifically, for 2 (Resident #s 5 and 6) of 2 residents interviewed, the facility did not provide verbal or written notification when a resident at the facility tested positive for COVID-19 or a resident suffered a COVID-19 related death. This is evidenced by: Resident #5: Resident #5 was admitted to the facility with [DIAGNOSES REDACTED]. The Minimum Data Set (MDS - an assessment tool) dated 3/28/20 documented the resident was cognitively intact. During an interview on 5/11/20 at 3:05 PM, Resident #5 stated he/she knew there were COVID positive residents on the unit because he/she saw the PPE signs that hung on or next to those resident's bedroom doors. He/She had never received written or verbal notification from the facility about COVID positive cases or COVID related deaths in the facility. Resident #6: Resident #6 was admitted to the facility with [DIAGNOSES REDACTED]. The MDS dated [DATE] documented the resident was cognitively intact. During an interview on 5/11/20 at 2:15 PM, Resident #6 stated he/she noticed yellow signs were placed on a resident's room, and that is how he/she was made aware of a newly diagnosed COVID-19 positive resident. Resident #6 stated he/she was his/her own representative and did not have a family member that would be made aware of newly diagnosed residents or deaths from COVID-19 at the facility. He/She had never received written or verbal notification from the facility about COVID positive cases or COVID related deaths in the facility. During an interview on 5/11/20 at 6:22 PM, the Administrator stated residents with cognitive capacity were informed by nursing when a resident is diagnosed with [REDACTED]. The facility had no formal record or tracking system in place for resident/family notification of COVID-19 information, but family or next of kin were notified daily by robocall. Additionally, a letter was sent using a mailing list to the resident directly or their representative if the resident was not their own representative. 10 NYCRR 483.70(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.