

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 395592	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/17/2024
NAME OF PROVIDER OR SUPPLIER Haida Nursing and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 397 Third Avenue Extension Hastings, PA 16646	
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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>48941</p> <p>Based on review of established infection control guidelines, facility policies, and clinical records, as well as observations and staff interviews, it was determined that the facility failed to follow infection control guidelines from the Centers for Medicare/Medicaid Services (CMS) and the Centers for Disease Control (CDC) to reduce the spread of infections and prevent cross-contamination during a COVID-19 outbreak and failed to follow infection control guidelines from CMS and the CDC for residents requiring Enhanced Barrier Precautions (EBP) for six of seven residents reviewed (Residents 1, 2, 3, 5, 6, 7).</p> <p>Findings include:</p> <p>The facility's policy regarding COVID-19 management, dated August 27, 2024, indicated that the facility follows current guidelines and recommendations for managing COVID-19 in the facility. This included ensuring the facility has all the necessary supplies, including personal protective equipment (PPE). The CDC recommends a 10-day isolation period for residents with suspected or confirmed COVID infection, and the door should be kept closed if safe to do so.</p> <p>CDC guidance on isolation precautions and Implementation of Personal Protective Equipment (PPE) use in Nursing Homes to Prevent Spread of Multidrug-Resistant Organisms (MDRO's - bacteria that have become resistant to certain antibiotics, and these antibiotics can no longer be used to control or kill the bacteria), dated July 12, 2022, indicates that MDRO transmission is common in skilled nursing facilities, contributing to substantial resident morbidity and mortality and increased healthcare costs. Enhanced Barrier Precautions are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities. CMS updated its infection prevention and control guidance effective April 1, 2024. The recommendations now include the use of EBP during high-contact care activities for residents with chronic wounds or indwelling medical devices, regardless of their MDRO status, in addition to residents who have an infection or colonization (germs living on/within a persons body that can be spread to others) with a CDC-targeted or other epidemiologically important MDRO when contact precautions do not apply.</p> <p>(continued on next page)</p>		

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The facility's policy regarding EBP, dated August 27, 2024, indicated that the facility will use EBPs to prevent the spread of multidrug-resistant organisms (MDROs). EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. Examples of high contact resident care activities requiring the use of gown and gloves for EBPs include: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use (central line, urinary catheter, feeding tube, tracheostomy, or ventilator) and wound care. EBPs are indicated when a resident is infected or colonized with a MDRO.</p> <p>Review of electronic event reports submitted by the facility to the Department of Health, dated August 14, 20, 28, 30, and September 3, 5, 9, 10, 11, 13, and 15, 2024, revealed that a total of 10 staff members and 21 residents developed COVID infection between these dates. Record review revealed that two residents in the facility had active COVID at the time of the on-site visit on September 17, 2024.</p> <p>An admission nurse's note for Resident 1, dated September 12, 2024, at 1:35 p.m. indicated that the resident was incontinent due to catheterization (presence of an indwelling catheter- a thin, flexible tube inserted into the bladder to drain urine from the bladder) and EBP were initiated due to the resident having a dialysis port. A nurse's note, dated September 12, 2024, at 9:49 p.m. indicated that the medical director was notified of the resident's COVID-positive results.</p> <p>A physician's order for Resident 1, dated September 12, 2024, included an order for the resident to be placed on contact and droplet precautions, which included wearing masks (N95), gloves, gowns, and eye shields every shift due to COVID-positive results. A physician's order, dated September 14, 2024, included an order for the resident to receive a therapy pack of 150 milligram (mg) of Nirnatrelvir and 100 mg of Ritonavir two tablets twice daily for five days.</p> <p>Observations during the facility tour on September 17, 2024, at 9:15 a.m. revealed that Resident 1 was in his room lying in bed, and the door to his room was open. There was a red biohazard container in hallway outside of his room and an isolation station was in the hallway outside his room with Personal Protective Equipment (PPE) stocked in it with gowns, surgical masks, and N95 masks. The isolation station did not contain eye shields. Signage on door indicated that the resident was on droplet precautions.</p> <p>Observations on September 17, 2024, at 12:43 p.m. revealed that Nurse Aide 1 exiting Resident 1's room wearing a surgical mask and gloves. Nurse Aide 1 was not wearing a gown or eye shields. While wearing the soiled gloves, she walked to the supply room, got bed sheets, and went back into his room with the same pair of gloves and surgical mask and without a gown or eye shields.</p> <p>Observations on September 17, 2024, at 12:46 p.m. revealed that Nurse Aide 1 and Nurse Aide 2 exited Resident 1's room with surgical masks and gloves on. They were not wearing N95 masks, gowns, or eye shields. They removed their gloves and used hand sanitizer. Interview with Nurse Aide 1 and Nurse Aide 2 at that time confirmed that they should have had gowns on but did not think it was necessary to have N95 masks or eye shields on. Nurse Aide 1 indicated that they only gave the resident his food and had to change his sheets. Nurse Aide 2 indicated that she was unsure what she was supposed to be doing as things were always changing.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An admission nurse's note for Resident 2, dated September 10, 2024, at 10:57 a.m. revealed that EBP were initiated due to the resident having a dialysis port. A nurse's note, dated September 14, 2024, at 1:59 p.m. indicated that during day five testing per admission orders, the resident tested positive for COVID.</p> <p>A physician's order for Resident 2, dated September 14, 2024, included an order for the resident to be placed on contact and droplet precautions, which included wearing masks (N95), gloves, gowns, and eye shields every shift for 10 days due to COVID-positive results.</p> <p>Observations during the facility tour on September 17, 2024, at 9:02 a.m. revealed that Resident 2 was in his room in a bed by the window. There was a red biohazard container in hallway outside of his room and an isolation station was in the hallway outside his room with PPE stocked in it, including gowns and N95 masks. The isolation station did not contain protective eye shields. Signage on door indicated that the resident was on droplet precautions.</p> <p>Observations on September 17, 2024, at 9:10 a.m. revealed that Nurse Aide 3 and Nurse Aide 4 exited Resident 2's room with surgical masks and gloves on and no gowns. Interview with Nurse Aide 3 at that time indicated that they would wear full PPE including gowns, N95 mask, and eye shields if they had direct contact with a resident who was positive with COVID. She indicated that they were working with the resident in the other bed by the door who did not have COVID. She indicated that she had just returned after having COVID herself. Nurse aide 4 was present during the interview with Nurse Aide 3 and had no input at the time.</p> <p>Observations on September 17, 2024, at 12:14 p.m. revealed staff in the room giving care to Resident 2 wearing gloves, gowns, surgical masks, and no protective eye shields. Observations at 12:21 p.m. revealed that Nurse Aide 4 and Nurse Aide 5 exited Resident 2's room and took their gowns and gloves off outside the room and disposed of them in the red biohazard container. Observations revealed that as they exited the resident's room, they had surgical masks on and no protective eye shields. Interview with Nurse aide 4 and Nurse Aide 5 at that time confirmed they should have had N95 masks on and eye shields when caring for Resident 2, who was still on droplet precautions for COVID. The N95 masks were available in the isolation station outside of the resident's room, but eye shields were not stocked in the isolation station.</p> <p>Interview with the Assistant Director of Nursing/Infection Preventionist on September 17, 2024, at 2:00 p.m. confirmed that the staff should have been wearing full PPE when caring for Resident 1 and Resident 2, including protective eye shields, N95 masks, gowns, and gloves as per the facility protocol and as per physician's orders. She confirmed that PPE should be accessible for staff when caring for residents positive with COVID and that the isolation stations should be stocked with the appropriate PPE, including protective eye shields. She indicated that staff were educated on COVID precautions and that the outbreak began with a staff member.</p> <p>A quarterly Minimum Data Set (MDS) assessment (a mandated assessment of a resident's abilities and care needs) for Resident 3, dated July 24, 2024, revealed that the resident was cognitively intact, required assistance with care needs, had an indwelling catheter, and had diagnoses that included neurogenic bladder (bladder lacks control due to nerve or muscle problems) and quadriplegia (paralysis of both arms and legs).</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A physician's order for Resident 3, dated December 14, 2023, revealed that the resident had an indwelling catheter related to his diagnosis of neuromuscular dysfunction of bladder and quadriplegia. A physician's order, dated May 15, 2024, included an order for EBP related to his indwelling catheter.</p> <p>Observations on September 17, 2024, at 9:38 a.m. revealed that two staff had transferred Resident 3 from his bed to his chair via the mechanical lift. They had no gloves or gowns on. Nurse Aide 6 was observed handling the indwelling catheter tube ungloved while positioning it on his chair. Interview with Nurse Aide 6 at that time indicated that she would wear gloves and gowns if doing direct care but that was already done. She indicated that all they had to do was transfer the resident out of the bed with the lift and into his chair. Observations revealed there was an isolation station in the resident's room by the sink in his room, but it was empty. Nurse Aide 6 acknowledged that it should be stocked with the appropriate PPE and indicated that she would need to restock it.</p> <p>Interview with the Assistant Director of Nursing/Infection Preventionist on September 17, 2024, at 2:00 p.m. confirmed that the staff should have had gloves and gowns on when transferring Resident 3 and handling his indwelling catheter. She confirmed that PPE should be accessible for staff when caring for residents on EBP and that the isolation stations should be stocked with the appropriate PPE.</p> <p>A quarterly MDS assessment for Resident 5, dated August 9, 2024, revealed that the resident was cognitively impaired, required assistance with care needs, had an indwelling catheter, and a diagnosis that included neurogenic bladder.</p> <p>A physician's order for Resident 5, dated August 2, 2024, included an order for EBP related to his indwelling catheter. A physician's order, dated August 2, 2024, revealed that the resident had an indwelling catheter related to his neuromuscular dysfunction of bladder diagnosis.</p> <p>Observations during the facility tour on September 17, 2024, at 9:56 a.m. revealed that Resident 5 had signage on his door that indicated he was on EBP. There was no isolation station containing PPE on his door or in his room/bathroom.</p> <p>An Annual MDS assessment for Resident 6, dated July 19, 2024, revealed that the resident was cognitively intact, required assistance with care needs, had an indwelling catheter, and a diagnosis that included obstructive uropathy.</p> <p>A physician's order for Resident 6, dated April 5, 2024, revealed that the resident had an indwelling suprapubic catheter (a flexible tube that drains urine from the bladder through the abdomen) related to his diagnosis of neuromuscular dysfunction of bladder. A physician's order, dated May 15, 2024, included an order for EBP related to his indwelling suprapubic catheter.</p> <p>Observations during the facility tour on September 17, 2024, at 10:10 a.m. revealed that Resident 6 had signage on his door that indicated he was on EBP. There was no isolation station containing PPE on his door. There was a bin in his room under his sink, but it was empty.</p> <p>A significant change MDS assessment for Resident 7, dated July 23, 2024, revealed that the resident was cognitively intact, required assistance with care needs, and had a urinary tract infection in the last 30 days.</p> <p>(continued on next page)</p>		

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