STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225199	A. BUILDING _____ B. WING _____	07/09/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WORCESTER REHABILITATION & HEALTH CARE CENTER	**119 PROVIDENCE STREET WORCESTER, MA 01604**

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 policy review, the facility failed to ensure 1.) staff donned and doffed appropriate Personal Protective Equipment (PPE) when caring for residents that are newly admitted from the hospital setting and on contact/droplet precautions, 2.) staff wore N95 masks while caring for COVID-19 positive residents and 3.) that social distancing was maintained. Findings include: Review of the facility policy, Novel Coronavirus Prevention and Response, dated 6/26/20, included the following: * All new admissions and readmissions should be placed on isolation for 14 days after admission and placed on Contact/Droplet Precautions (wearing gown, masks, eye goggles and gloves). * Restrict residents to their rooms (to extent possible) except for medically necessary purposes and perform social distancing (efforts are made to keep them at least 6 feet away from each other). Review of the facility policy, Personal Protective Equipment Plan, dated 7/6/20, indicated that full PPE including a N95 should be worn when caring for a COVID-19 positive resident. Review of the CDC guidance: Considerations for new admissions or readmissions to the facility, last updated 4/30//20, indicated that a single negative test upon admission does not mean that a resident was not exposed or will not become infected in the future. Newly admitted residents or readmitted residents should still be monitored for evidence of COVID-19 for 14 days after admission and cared for using all recommended COVID-19 PPE. Review of the Centers for Disease Control (CDC) Guidance: How to Safely Remove PPE, indicated that staff must remove all PPE before exiting the patient room except a respirator, if worn. On 7/9/20 at 9:30 A.M., observation on the 2nd floor unit (residents that are negative, recovered and suspected (new admissions) for COVID-19 reside on this unit) revealed Recreation Assistant (RA) #1 as she was in the process of delivering newsletters and coffee to each resident room. RA #1 was observed wearing a blue isolation gown, face mask and eye goggles. RA #1 entered a room that was identified as a quarantine space with both residents on droplet precautions, without donning gloves, with coffee and a newsletter for one resident. She left the room and prepared another cup of coffee and newsletter for the second resident in the same room. She reentered the room a second time to give another resident his/her coffee and newsletter. Without removing her now contaminated isolation gown, she moved over to the next resident room (a room that was not a quarantine space) and delivered coffee and newsletters to the residents in that room. On 7/9/20 at 9:35 A.M., during an interview, RA #1 said that she didn't know the first room she went into was a precaution (quarantine) room. She said it is confusing in regard to what to wear or not wear. She said she didn't know she should have donned gloves before entering the precaution room or that she should have discarded her isolation gown before she exited the precaution room. On 7/9/20 at 9:40 A.M., observation on the 2nd floor unit revealed Social Worker (SW) #1 coming out of a resident room that was labeled as a quarantined space requiring droplet precautions, with an isolation gown on. SW #1 then walked down the corridor and began to enter her office with the same isolation gown on. On 7/9/20 at 9:41 A.M., during an interview, SW #1 said she thought it would be ok to take her isolation gown off and store it in her office. She then said, it does make sense that she should have taken the isolation gown off while she was still inside the quarantine room. On 7/9/20 at 10:00 A.M., observation on the 2nd floor unit revealed Licensed Nurse #1 enter a room with two residents, that was designated a quarantined space, requiring droplet precautions. Licensed Nurse #1 flushed the intravenous line of one of the residents. He then removed his gloves and performed hand hygiene. He did not remove his contaminated isolation gown and proceeded back to his medication cart. On 7/9/20 at 10:05 A.M., during an interview, Licensed Nurse #1 said he wasn't sure he had to remove his gown, but then said he should have. Licensed Nurse #1 continued to say that he needed to refer to his Unit Manager for guidance. On 7/9/20 at 10:25 A.M., observation on the 2nd floor unit revealed 6 people get on to the elevator. 4 residents, 1 staff member and 1 consultant. They were not observing social distancing of 6 feet apart. On 7/9/20 at 10:45 A.M., observation on the 3rd floor unit (residents that are COVID-19 negative and recovered reside on this unit) revealed 4 residents that were congregated in the hallway, not observing social distancing of six feet apart. One out of the 4 residents was wearing his/her mask below his/her chin. Staff did not intervene to separate them to ensure social distancing was maintained. On 7/9/20 at 10:40 A.M., observation on the 4th floor(this unit housed negative, recovered and suspected (new admissions) residents) revealed 3 residents sitting across from the nurses station. All 3 residents were wearing masks below their chin, leaving the mouth and nose exposed. The 3 residents were sitting directly next to each other, not observing social distancing of 6 feet apart. Staff did not intervene to separate them to ensure social distancing was maintained. On 7/9/20 at 10:50 A.M., observation on the 4th floor revealed 5 people getting on to an elevator. 4 residents and 1 staff member. They were not observing social distancing of six feet apart. On 7/9/20 at 11:00 A.M., observation on the 5th floor unit (the designated COVID-19 Unit with a census of 5 Positive COVID-19 residents and 9 COVID-19 recovered residents)) revealed 2 CNAs, 1 licensed nurse and 1 housekeeper. All four staff members were not wearing N95 masks, rather they were wearing surgical masks. On 7/9/20 at 11:05 A.M., CNA #1 said that she can't wear the N95 mask. She said it makes her feel like she can't breathe. She said she has not reported this to anyone in management. On 7/9/20 at 11:10 A.M., Housekeeper #1 said he thinks he has an N95 mask, but prefers the surgical mask. On 7/9/20 at 8:45 A.M., during an interview, the Infection Preventionist said that all staff on the COVID-19 unit wear an N95 mask as part of their PPE. On 7/9/20 at 11:30 A.M., observation of the 5th floor COVID-19 designated unit, revealed the Assistant Maintenance man, wearing an isolation gown, and the Director of Maintenance, leave the unit using the designated cleanstairwell, not the designated dirty stairwell that all staff must utilize when exiting the COVID-19 designated unit. On 7/9/20 at 11:35 A.M., during an interview, the Director of Maintenance said that both he and his assistant should have used the designated dirty stairwell to leave the unit. He also said that his assistant should have discarded his isolation gown before leaving the unit.

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