STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225586	A. BUILDING _____ B. WING _____	**10/21/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WESTFORD HOUSE	**3 PARK DRIVE WESTFORD, MA 01886**

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, policy review and interview the facility failed to prevent the possible transmission of infection (Covid-19) as evidenced by 1. staff was not wearing appropriate eye protection and 2. staff failed to handle contaminated linen safely and 3. failed to store clean linen appropriately, on one of three resident units. Findings include: Upon entering the facility the surveyor observed a posting that all staff are to wear goggles (eye protection) on the units. During an interview with the Infection Preventionist Nurse on 10/21/2020 at 7:30 A.M., she said the Abbot Lane Unit had a recent outbreak of Covid-19 positive residents. The IP nurse said the Poes Corner Unit has had no positive Covid-19 cases since the pandemic began in March 2020. 1. On 10/21/2020 at 11:45 A.M., Housekeeper #1 was observed on the(NAME)Lane Unit to be wearing eye glasses, not goggles or any other form of eye protection as he was handling contaminated Personal Protection Equipment (PPE), (gowns) in the hallway. 2. Review of the facility's policy titled Linen Handling, dated revised on 3/1/2018, indicated under purpose to provide effective containment and reduce potential for cross-contamination from soiled linen. Under process the policy indicated to maintain clean linen in a closed storage area, keep clean linen covered. Further review of the policy process indicated to minimize linen handling. Do not shake linen. Handle soiled linen the same. Handle as little as possible, use minimum agitation. A. On 10/21/2020 on the Abbot Lane Unit, at 11:45 A.M., Housekeeper #1 was observed using a gloved hand to directly remove multiple, reusable, contaminated PPE gowns from a covered laundry bin, lined with a plastic bag and placed the gowns in a plastic bag in his other gloved hand. Housekeeper #1, was observed repeating the direct removal of contaminated PPE from multiple bins lining the hallway on the(NAME)Unit, thus increasing the risk of cross-contamination by continually touching and moving uncontained contaminated PPE. During an interview on 10/21/2020 at 1:17 P.M., the IP nurse said the PPE from the laundry bins could be collected without the continued handling. B. On 10/21/2020 at 10:00 A.M., durng an observation on the Poe Unit, an over the bed tray table was observed in the hallway with a short stack of sheets, and what appeared to be pillow cases, out in the open, available for use and not covered. During an interview with Nurse #1 on 10/21/2020 at 10:13 A.M., she said the linen should not be out and on the tray table.

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