STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225295	A. BUILDING _____ B. WING _____	07/16/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
VERO HEALTH & REHAB OF WILBRAHAM	9 MAPLE STREET WILBRAHAM, MA 01095

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** - Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility was found to be not in compliance with COVID-19 infection control guidelines relative to 1). Failure to screen staff and visitors upon entry into the facility; 2) Failure to don required Personal Protective Equipment (PPE); 3.) Failure to perform hand hygiene when indicated. The facility total census of 91 included 8 residents under quarantine, 22 residents that had tested negative for COVID-19 and 61 residents that had recovered from COVID-19. Findings include: 1. The facility failed to ensure staff and visitors were screened for COVID-19 symptoms upon entering the facility. Review of the Centers for Disease Control (CDC) Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, updated 7/15/20, indicated to: -Limit and monitor points of entry to the facility -Consider establishing screening stations outside the facility to screen individuals before they enter -Screen everyone (patients, Health Care Personnel (HCP) and visitors) entering the healthcare facility for symptoms consistent with COVID-19 or exposure to others with severe acute respiratory syndrome coronavirus 2 ([DIAGNOSES REDACTED]-CoV-2) infection and ensure they are [MEDICATION NAME] source control. -Actively take their temperature and document absence of symptoms consistent with COVID-19. Fever is either measured temperature =100.0Fahrenheit (F) or subjective fever. -Ask them if they have been advised to self-quarantine because of exposure to someone with [DIAGNOSES REDACTED]-CoV-2 infection. During an observation on 7/16/20 at 7:00 A.M., the surveyor entered the facility and three oncoming staff members were seen checking their own temperatures and completing the screening log that was located at the receptionist desk. There was no screener present at the entrance of the facility. One licensed staff member entered the facility, attempted to take her own temperature, failed to get a reading and said, This is useless and walked away from the receptionist desk. A phlebotomist was observed taking her own temperature, completing the screening log and said It was self-serve here. She then proceeded to don PPE and enter a nursing unit. A Housekeeping/Laundry Supervisor approached the reception desk and took a temperature reading of a staff member. She said the temperature was 96.3 F. The staff member then commented saying That is low. I'm putting down 97.3 on the paper. She then wrote on the log sheet and walked away. The Housekeeping/Laundry Supervisor then greeted the surveyor and escorted the surveyor to the conference room. The surveyor was not screened upon entry to the facility. The surveyor returned to the receptionist desk and informed the Activity Director that was sitting at the desk that she was never screened and she screened the surveyor. During an interview on 7/16/20 at 7:20 A.M., the Food Service Director (FSD) said dietary staff come in early in the morning and take their own temperature readings as there is no screener available and staff completes the log form prior to going to the kitchen. During an interview on 7/16/20 at 7:30 A.M., the Rehab Director said she took her own temperature reading and completed the log form as there was no screener at the reception desk. During an interview on 7/16/20 at 11:10 A.M., the Infection Preventionist (IP) said the receptionist/screener shift begins at 8:00 A.M The IP said a licensed staff member working on Unit B1, the unit is adjacent to the lobby, is responsible to screen staff and visitors entering the facility prior to the arrival of the receptionist/screener. She further said the licensed staff member could have been performing nursing duties and was unable to leave the unit to screen staff and visitors entering the facility, as required. 2. The facility failed to don facemask's upon: A.) Entry into the facility; B.) Entry onto a unit that housed recovered and quarantined residents. Review of the Centers for Disease Control (CDC) Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, updated 7/15/20, indicated: -Healthcare Personnel (HCP) should wear a facemask at all times while they are in the healthcare facility, including in breakrooms or other spaces where they might encounter co-workers. A.) During an observation on 7/16/20 at 7:00 A.M., three staff members entered the facility and were not wearing facemask's. One staff member was observed going up the stairwell. One staff member was observed entering the elevator and one staff member exited the lobby and went down a hallway. No one applied a facemask prior to exiting the lobby. During an observation on 7/16/20 at 9:30 A.M., one staff member entered the facility and was not wearing a facemask. The employee was screened at the reception desk and proceeded to walk down the hallway. The employee did not apply a facemask. During an interview on 7/16/20 at 11:10 A.M., the Infection Preventionist (IP) said the staff entering the facility that did not wear facemask's did not follow the CDC guidelines that masks must be worn when entering the facility. B.) During an observation on 7/16/20 at 10:35 A.M. with the Director of Nurses (DON) present, one staff member entered Unit B1. This unit housed 8 residents under quarantine, 13 residents that had tested negative for COVID-19 and 6 residents recovered from COVID-19. The staff member was wearing a facemask and did not don PPE. The PPE supply was labeled and located outside the unit doors. The staff member carried supplies to the unit. The staff member then exited the unit. During an interview on 7/16/20 at 10:40 A.M. with the DON present, the staff member said she was a Hospitality Aide and entered the unit, walked down the hall to the nursing station and handed supplies to the nurse. The Hospitality Aide did not don PPE, as required. During an interview on 7/16/20 at 11;10 A.M., the IP said the Hospitality Aide did not follow the procedure in the facility as all staff were to wear full PPE (included gown, face shield, gloves and facemask) when entering any nursing unit. 3. The facility failed to sanitize hands prior to donning gloves. Review of the Centers for Disease Control (CDC) Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, updated 7/15/20, indicated: -Healthcare Personnel (HCP) should perform hand hygiene before and after all patient contact, contact with potentially infectious material, and before putting on and after removing PPE, including gloves. Hand hygiene after removing PPE is particularly important to remove any pathogens that might have been transferred to bare hands during the removal process. During an observation on 7/16/20 at 9:20 A.M., Nurse #1 was preparing medications at the medication cart. She picked up a white item off the floor and discarded it in the trash receptacle on the side of the cart. She continued to prepare medications and then donned gloves to open a medication capsule. The surveyor stopped the nurse and interviewed her. When the surveyor asked the nurse if she had sanitized her hands after picking up the item off the floor and before donning gloves, she said, Oh, okay. During an observation on 7/16/20 at 9:30 A.M. of Unit B1, Nurse #2 exited a resident's room carrying a plastic bag with soiled linen and a rolled up disposable gown. She discarded the items in the receptacle that was outside the room and proceeded to put on a new disposable gown and gloves. She was observed to not sanitize her hands after leaving the resident's room or prior to donning PPE to enter room [ROOM NUMBER]. The sign outside the room indicated the residents in the room were under quarantine. During an interview on 7/16/20 at 9:33 A.M., Nurse #2 said she did not sanitize her hands after doffing and before donning PPE, as required

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.