STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225196	A. BUILDING _____ B. WING _____	09/24/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GARDNER REHABILITATION AND NURSING CENTER	59 EASTWOOD CIRCLE GARDNER, MA 01440

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** - Few	**Provide and implement an infection prevention and control program.** Based on policy review, observation, interview, and record review, the facility failed to ensure that staff adhered to Standard Precautions for one resident (#1) and Transmission-Based Precautions for three residents (#1, #2, and #3) and on the East One Unit to prevent the spread of COVID-19 related to hand hygiene, linen management, and proper use of personal protective equipment (PPE). Findings include: 1) The facility failed to ensure that staff adhered to Standard Precautions related to hand hygiene and linen management for one resident (#1) on the East One Unit. Review of the facility's Infection Control Policy for Standard Precautions undated, on 9/24/20 indicated the following: -Wash hands after touching blood, body fluids, secretions, excretions and contaminated items, whether or not gloves are worn. -Remove gloves promptly after use, before touching non-contaminated items and environmental surfaces. -Handle, transport and process soiled linens in a manner that prevents transfer of microorganisms to other environments. During an observation on 9/24/20 at 10:19 A.M., Certified Nursing Assistant (CNA) #1 exited Resident #1's room. She wore gloves on both hands, carried an uncontained towel as she walked through the hallway, opened the utility room door, and discarded the towel. During an interview on 9/24/20 at 10:30 A.M., CNA #1 said that she did not perform hand hygiene or remove her gloves after providing care to Resident #1, or before she entered the hallway. She said that she kept her gloves on while she transported the linen from Resident #1's room through the hallway to the utility room because it was contaminated from resident care. She said that she did not remove her gloves or perform hand hygiene until after she discarded the contaminated linen. During an interview on 9/24/20 at 12:04 P.M., the Director of Nursing (DON) said that CNA #1 should have removed her gloves and performed hand hygiene after she provided care in Resident #1's room and that she should not have transported uncontained contaminated linen through the hallway. She also said that CAN #1 should not have touched the outside door handle of the dirty utility room with contaminated gloves. 2) The facility failed to ensure that staff adhered to Transmission-Based Precautions related to the proper use of PPE for three residents (#1, #2, and #3) on the East One Unit. Review of the Centers for Disease Control and Prevention (CDC) guidelines for Healthcare Workers titled Preparing for COVID-19 in Nursing Homes, updated 6/25/20, indicated placing new admissions in an area designated for observation of evidence of COVID-19 for 14 days. Review of the facility's Infection Control Policy for Contact and Droplet Precautions undated, on 9/24/20 indicated that staff were required to dispose of PPE by the door, before leaving the resident room. Review of the facility's policy titled COVID Unit Instructions, undated, on 9/24/20 indicated that that staff were required to clean their eye protection with bleach wipes or warm soap and water in between each room on the East One Unit. It also indicated that staff were required to wash their hands and don (put on) new PPE, including a new gown, when entering a resident's room. a) During an observation on 9/24/20 at 10:07 A.M., CNA #1 exited Resident #1's room and entered the hallway. She did not remove or dispose of her gown before leaving the resident's room, and she did not clean her eye protection when she left the room. She walked to the dirty utility room, disposed of linen, then entered Resident #2's room wearing the same gown she wore in Resident #1's room. The surveyor observed signage on Resident #1 and Resident #2's room doors that indicated Contact and Droplet Precautions were required. During an interview on 9/24/20 at 10:19 A.M., CNA #1 said that she did not change her gown after she provided care to Resident #1 or before she entered Resident #2's room. She said that she did not know how frequently she was required to change her gown or clean her eye protection, and that she only changed these items once a day, at the end of her shift. During an interview on 9/24/20 at 12:04 P.M., the DON said that CNA #1 should have donned (put on) a new gown before she entered Resident #2's room and that she should have cleaned her eye protection after she provided care in Resident #1's room, as required by the facility's policy. b) During an observation on 9/24/20 at 10:30 A.M., Nurse #1 wore a gown, mask, and eye protection when she exited Resident #1's room. She did not remove or discard her gown or clean her eye protection when she exited the room. She performed hand hygiene and proceeded to the medication cart in the hallway and prepared medications. She performed hand hygiene and entered Resident #3's room at 10:35 A.M., wearing the same gown she wore in Resident #1's room. She checked Resident #3's vital signs, adjusted the resident's position in the bed, and adjusted the bed using the bed control. Nurse #1 then exited the room, performed hand hygiene, and returned to the medication cart in the hallway. She did not remove her gown or clean her eye protection. She performed hand hygiene then re-entered Resident #3's room and provided medication to the resident. While the resident took the medications, he/she was observed to cough without covering his/her mouth. Nurse #1 exited Resident #3's room at 10:45 A.M. She performed hand hygiene but did not remove or discard her gown , or clean her eye protection. The surveyor observed signage on Resident #1 and Resident #3's room doors that indicated Contact and Droplet Precautions were required. During an interview on 9/24/20 at 10:45 A.M., Nurse #1 said that staff were always required to wear a gown on the East One Unit and that they were not required to change their gowns when they entered and exited resident rooms unless they provided resident care. She said that she did not consider providing medications, taking vital signs, adjusting the resident's position and bed, or touching items in the resident's environment resident care. During interviews on 9/24/20 at 12:04 P.M. and 1:10 P.M., the DON said that the facility followed CDC guidelines for placing residents in quarantine for 14 days after admission or re-admission to the facility and that the East One Unit was designated for placement of these residents. She said that Nurse # 1 was originally scheduled to work on the South 2 Unit, but that she was placed on the East One Unit for training. She also said that Resident #1 and Resident #2 were newly admitted , Resident #3 was newly readmitted , and that each of these residents were in quarantine and under observation for COVID-19. The DON said that Nurse #1 should have removed and disposed of her gown and cleaned her eye protection after she provided care to Resident #1 and Resident #3, and that she should have donned a new gown before she entered Resident #3's room, as required by the facility's policy. The DON further said that staff were required to adhere to the facility's Infection Control Policy and COVID Unit Instructions when caring for residents on the East One Unit. 3. The facility failed to ensure that the facility staff adhered to Transmission-Based Precautions related to proper mask use on the East One Unit. Review of the facility's policy titled COVID Unit Instructions, undated, indicated that staff were always required to wear an N-95/kN-95 mask while on the East One Unit. During an observation on 9/24/20 at 10:00 A.M., the surveyor observed a sign posted on the entrance door to the East One Unit that indicated full PPE, including an N-95 mask, was required for unit entry. On 9/24/20 at 10:04 A.M., the surveyor observed Housekeeper #1 don a gown by the housekeeping supply closet on the East One Unit. Housekeeper #1 wore a face shield and a surgical mask. Housekeeper #1 was observed entering multiple resident rooms to empty trash and mop floors. During an interview directly following the observations, Housekeeper #1 said that she was wearing the appropriate PPE required for the unit. During an interview on 9/24/20 at 1:20 P.M., the DON said that Housekeeper #1 should have worn an N-95 or kN-95 mask while she worked on the East One Unit, according to the facility policy.
F 0882 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and website review, the facility failed to ensure that there was a person designated as the Infection

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

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F 0882 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 1) Preventionist that had completed specialized training in infection prevention and control, since November 2019. Findings include: During interviews on 9/24/2020 at 7:30A.M. and at 1:10 P.M., the Director of Nurses (DON) stated that the facility does not have an Infection PreventionistControl Nurse. The DON stated that when she arrived at the facility in November of 2019, there was no one in the role of Staff Development Coordinator (SDC)/Infection Preventionist (IP). An SDC/IP was hired in April of 2020 and was instructed to obtain certification, but she never did. The SDC/IP left the faciity on [DATE]. The DON states she has been the designated IP since that date and has never been certified but is actively looking for someone to fill the role. The DON provided a copy of the posting on Indeed.com, a web- based employment platform, for the position. A review of the printed posting for an SDC/IP on Indeed.com indicated the position was posted 9 days prior to the survey (9/15/2020).