STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	205133	A. BUILDING _____ B. WING _____	**07/07/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HERITAGE REHAB & LIVING CTR	**457 OLD LEWISTON RD WINTHROP, ME 04364**

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)
E 0024 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Establish policies and procedures for volunteers.** Based on Interview and Record Review the facility failed to develop policies for staffing during an emergency which resulted in the facility not having a medical director or provider available to the facility from June 3 - 10, 2020. This could affect all residents in the facility. Findings Include: Record Review of the Heritage Rehab and Living Center EOP and Plan Manual on 07/07/2020 revealed that the facility does not have a plan for obtaining a back-up medical provider for the facility documented in the facility emergency plan. Record Review of the Heritage Rehab and Living Center document entitled Crisis Staffing on 07/07/2020 does not provide any information in the policy about how the facility would obtain physician services if the medical director and/or other facility physician providers were not available. Record Review of Resident #1's medical record on 07/07/2020 in a nurses note dated 06/09/2020 stated No MD available at this time to communicate to in regards to Resident #1 who had a change in their medical condition and who ultimately was sent to the emergency room with bloody stools and low blood pressure (97/88). Interviews with the DON, Facility Administrator, and RN#1 on 07/07/2020 all confirmed that from June 3-10, 2020 the facility did not have a medical director or provider available to cover the facility and that there was no plan in place to obtain medical provider coverage at that time.
E 0030 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**List the names and contact information of those in the facility.** Based on Record Review and Interview the facility failed to document the name and contact information for the current medical director and medical staff providing services to the facility in the facilities Emergency Plan. Findings Include: Record Review on July 7, 2020 between around 10:30am and 2:00pm of the facilities Emergency Plan book revealed that the facilities previous medical director was listed as the medical director in the emergency plan and that the names and contact information for the current medical director and an APRN providing services to the facility were not listed in the Emergency Plan. Interview with the facility Administrator at the time of Record Review confirmed the above finding. Therefore, the facility is not in compliance with 42 CFR 483.73
E 0032 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide primary/alternate means for communication.** Based on Record Review and Interview the facility failed to document the primary and alternative means for contacting the current medical director and medical staff providing services to the facility in the facilities Emergency Plan. Findings Include: Record Review on July 7, 2020 between around 10:30am and 2:00pm of the facilities Emergency Plan book revealed that the facilities previous medical director was listed as the medical director in the emergency plan and that the names, contact information (including a primary and alernative means for communication) for the current medical director and an APRN providing services to the facility were not listed in the Emergency Plan. Interview with the facility Administrator at the time of Record Review confirmed the above finding. Therefore, the facility is not in compliance with 42 CFR 483.73
F 0726 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.** Based on Interview and Record Review the facility failed to ensure that the facilities designated Infection Preventionist had completed specialized training infection prevention and control training. This has occurred since December 2019, has the potential to affect all skilled nursing residents, and could pose more than minimal harm due to the specialized training needed to develop an Infection Prevention and Control Program to prevent the introduction and spread of COVID-19 into and within the facility. Findings Include: Interview during the infection control survey on 07/07/2020 from around 10:30am thru 2:00pm with the facility Director of Nursing (DON) revealed that the DON is the facility designated Infection Preventionist (IP), and he/she has been in that role since at least December 2019. Records of documentation that the DON had completed specialized training in infection prevention and control were requested at the beginning and towards the end of the survey. These documents were not provided prior to exiting the facility. Interview on 07/07/2020 with the DON confirmed that he/she did not complete specialized training in infection prevention and control required of the facilities designated Infection Preventionist. The DON and Facility Administrator also confirmed that no other staff member in the facility had completed specialized training infection prevention and control training required of the facility designated Infection Preventionist. Record Review on 07/07/2020 of the facility policy entitled Infection Control/Exposure Control Plan Review Policy revised on 09/2018 states Facility IP is qualified to conduct infection prevention and control activities as a result of education, training and experience (i.e., s/he is a registered nurse and has completed a program on Infection Prevention and Control for Long Term Care). Interview with the DON on 07/07/2020 confirmed that the he/she was unaware of the what standardized definitions of infection for surveillance in long-term care facilities were being used in the facility to conduct infection surveillance in the facility, and that surveillance data collection tools were not being used in the facility. Record Review on 07/07/2020 of the facility policy entitled Infection Control/Exposure Control Plan Review Policy revised on 09/2018 states The IP .conducts surveillance for facility associated infections and/or communicable diseases. Therefore, the facility failed to ensure that the facilities designated Infection Preventionist had completed specialized training infection prevention and control training and per the facility policy is not qualified to conduct infection prevention and control activities in the facility.
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 Interview, Observation, and Record Review the facility failed to implement the United States Centers for Disease Control's (CDC) and Centers for Medicare and Medicaid Services' (CMS) COVID-19 Long-Term Care Facility guidelines. This could affect all residents in the facility. Findings Include: Observation on 07/07/2020 while entering the facility revealed that the facility did not screen a visitor to the facility for symptoms consistent with COVID-19, or known exposure to someone with COVID-19 prior to allowing the visitor to enter the facility. The facility has a log where visitor was directed to answer questions about symptoms consistent with COVID-19, however the screener (RN#1) did not review this log prior to allowing the visitor entry to the facility. Interview with RN#1 on 07/07/2020 during the afternoon confirmed that RN#1 did not review the screening log prior to allowing the visitor to enter the facility. When asked why the log was not reviewed, RN#1 stated I'm not sure why, I usually review the answers, it's just been a crazy day. Record Review of the United States Centers for Disease Control and Prevention's Preparing for COVID-19 in Nursing Homes updated June 25, 2020 states Screen visitors for fever (T=100.0F), symptoms consistent with COVID-19, or known exposure to someone with COVID-19. Restrict anyone with fever, symptoms, or known exposure from entering the facility. Record Review of the facility policy entitled Infection Control: Interim Policy for Suspected or Confirmed Coronavirus (COVID-19) revised on 6/23/2020

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.

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 1) states the facility will monitor visitors entering the facility for signs and symptoms and will encourage them to follow respiratory hygiene and cough etiquette precautions. Observation on 07/07/2020 during the facility tour revealed that an employee CNA#1 did not wash his/her hands prior to donning gloves. CNA#1 also entered the room of Resident #1 which was on Droplet precautions, placed a lunch tray on the resident's table and helped position the resident from a laying position to a sitting upright position (touching the resident). Upon exiting the room CNA#1 doffed his/her eye protection, sprayed a disinfectant on the eye protection and then immediately wiped the eye protection off without allowed the disinfectant to remain on the eye protection before wiping it down and placing it inside a tub within an isolation cart. Interview with CNA#1 on 07/07/2020 revealed that CNA#1 was unaware that eye protection must be sprayed on and allowed to dwell on the surface of the eye protection for a certain amount of time. When asked how long the disinfectant was supposed to remain on the eye protection before drying it, CNA#1 responded I'm not sure. Interview with Housekeeping Staff #1 on 07/07/2020 revealed that that dwell time (the amount of time the manufacturer requires a disinfectant to remain on the surface of an item to ensure it is properly working) is 3 minutes. Record Review of the product information for the Clorox Germicidal Bleach the facility uses to disinfect eye protection states that the dwell time for the product is 3 minutes. Record Review facility policy entitled Infection Control: Interim Policy for Suspected or Confirmed Coronavirus (COVID-19) revised on 6/23/2020 states 5. Limit only essential personnel to enter the room with appropriate PPE and respiratory protection, PPE include: Eye Protection covering the front of the face .Reusable eye protection will be cleaned and disinfected according to the manufacturer's recommendation. The policy also states Hand Hygiene using Alcohol Based Hand Sanitizer before and after all patient contact. Observation on 07/07/2020 during the facility tour revealed that the room that Resident #1 resided in was on Droplet precautions. The door to the resident's room was open to the hallway and gowns that were used and not disinfected between uses were hanging on the outside of the door which was exposed to the hallway. Interview with the DON during the facility tour confirmed the Observation described above. Record Review of the United States Centers for Disease Control and Prevention's Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic updated July 09, 2020 states Any reusable PPE must be properly cleaned, decontaminated, and maintained after and between uses. Facilities should have policies and procedures describing a recommended sequence for safely donning and doffing PPE. It additionally states Put on a clean isolation gown upon entry into the patient room or area. Change the gown if it becomes soiled. Remove and discard the gown in a dedicated container for waste or linen before leaving the patient room or care area. Disposable gowns should be discarded after use. Cloth gowns should be laundered after each use. Interview with the DON and Facility Administrator on 07/07/2020 from around 10:30am to noon revealed that the DON was not aware of the evidenced-based surveillance criteria used for the facility infectious disease surveillance plan to define infections and could not state what data collection tool was used for surveillance for infectious diseases in the facility. When asked if any residents exhibited signs or symptoms of COVID-19 both the DON and Facility Administrator stated no. When asked if any staff exhibited signs or symptoms of COVID-19 both the DON and Facility Administrator stated that there were staff that were sent for COVID-19 testing, however this was not tracked by the DON or the Administrator and that it was tracked by human resources. Additional Interview with the DON on 07/07/2020 confirmed that the DON reports information about infections in the facility to the QAPI committee, however he/she does not log information about infections such as infectious agent, infection site, tests ordered, medications used, and final outcome of the resident's illness. Record Review on 07/07/2020 from around 10:30am to noon of the facilities infection control binder revealed that the facility had a document entitled Facility Infection Control Risk Assessment, which was blank. The binder also had a Respiratory Illness Tracking Sheet which was blank. The binder did not have any other infection tracking sheets within. Record Review on 07/07/2020 of the FDB Medications Report revealed that Resident #2 was [MEDICATION NAME] two times for six days with a [DIAGNOSES REDACTED]. This resident was not documented on the Respiratory Illness Tracking Sheet in the facility infection control binder. Record Review on 07/07/2020 of the facility policy entitled Infection Control/Exposure Control Plan Review Policy revised on 09/2018 states Standardized definitions of infection for surveillance in long-term care facilities will be utilized. Additionally, surveillance priorities include Respiratory tract infections including: Pneumonia. The facility did not provide the surveyor with a document that described what standardized definitions were used for infection surveillance in the facility, and the DON (who is also the Infection Preventionist) confirmed that he/she was unaware of what definitions were to be used when tracking infections in the facility.