STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225494	A. BUILDING _____ B. WING _____	**10/21/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SUNNY ACRES NURSING HOME	**254 BILLERICA ROAD CHELMSFORD, MA 01824**

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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview and facility policy review, the facility failed to prevent the possible spread of COVID-19 infection on 2 of 2 nursing care units as evidenced by (1) multiple CNA's and Nurses on a COVID-19 positive/negative (mixed) unit said that they provided care to both positive and negative residents during the same shift, (2) a Certified Nursing Assistant (CNA #1), who provided direct care to both COVID-19 positive and negative residents, failed to remove her gown and perform hand hygiene after direct contact with a COVID-19 positive resident and (3) a Nurse (Nurse #3) failed to disinfect a blood pressure cuff after use with a COVID-19 positive resident. Findings include: The facility policy titled COVID-19 Resident Prevention, dated 6/19/20, indicated staff will maintain primary/consistent assignments to minimize the number of staff interacting with each resident. Review of the facility's policies indicated there was no reference to changing personal protective equipment after staff contact with a COVID-positive resident on a unit that housed both COVID-19 positive and negative residents. Guidance titled Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, published by the Centers for Disease Control (CDC), dated 7/15/20, indicated HCP (Health Care Personnel) 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. Guidance titled Strategies for Optimizing the Supply of Isolation Gowns, published by the CDC, dated 10/09/20, indicated isolation gowns can be worn for the same health care personnel when interacting with more than one patient housed in the same location and known to be infected with the same infectious disease (i.e., COVID-19 patients residing in an isolation cohort). Guidance titled The Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic, published by the CDC, dated 7/15/20, indicated dedicated medical equipment should be used when caring for patients with suspected or confirmed [DIAGNOSES REDACTED]-CoV-2 infection. All non-dedicated, non-disposable medical equipment used for patient care should be cleaned and disinfected according to manufacturer's instructions and facility policies. Guidance titled Disinfection and Sterilization in Healthcare Facilities, published by the CDC, dated May 2019, indicated to perform low-level disinfection for noncritical patient-care equipment (e.g., blood pressure cuff) that touch intact skin. The guidance also indicated that if dedicated, disposable devices are not available, to disinfect noncritical patient-care equipment after using it on a patient who is on contact precautions before using this equipment on another patient. (1) On 10/21/20 at 9:22 A.M., the surveyors toured the section of the 2nd floor unit that housed a mix of five COVID-19 positive and four COVID-19 negative residents. Two Certified Nursing Assistants were present (CNA #1 and CNA #2). During an interview, both said that although they have their assignments split so that CNA#1 was primarily responsible to care for the positive residents and CNA#2 was primarily responsible to care for the negative residents, they help each other as needed, and therefore both of them care for the negative and positive residents during the same shift. CNA #1 and CNA #2 said they help each other with transferring and repositioning some of these residents. On 10/21/20 at 9:31 A.M., the surveyors toured the section of the 2nd floor unit that housed only COVID-19 negative residents (five residents). Nurse #1 said she was the dedicated nurse for the COVID-19 negative residents, however, at times she assisted the nurse on the mixed unit with treatments for the COVID-19 positive residents. On 10/21/20 at 9:35 A.M., the surveyors returned to the section of the 2nd floor unit that housed a mix of COVID-19 positive and negative residents. Nurse #2 said she was responsible for administering medication and providing treatments to every resident (both COVID-19 positive and negative) on the unit. (2) On 10/21/20 at 9:36 A.M., during the interview with Nurse #2, a resident was observed to exit room [ROOM NUMBER], a room housing three COVID-19 positive residents, and enter the hallway. CNA#1, who wore an isolation gown, approached the resident and provided physical assist to guide the resident back into his/her room. CNA#1 entered the room with the resident and a few moments later exited. Upon exiting the room CNA#1 did not perform hand hygiene or remove her contaminated gown and continued to perform tasks on the unit, potentially contaminating residents who were COVID-19 negative, and potentially contaminating the environment. CNA #1 told the surveyor that all the residents in room [ROOM NUMBER] were in isolation due to their COVID-19 diagnoses. (3) On 10/21/20 at 10:40 A.M., the surveyors toured the COVID-19 positive unit. A Nurse (Nurse #3), was observed exiting a room occupied by COVID-19 positive residents and carrying a blood pressure cuff. Without disinfecting the blood pressure cuff, Nurse #3 placed the cuff on her medication cart, potentially contaminating the cart. During an interview with Nurse #3 she said I will clean it, I just didn't get to it yet.

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