STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225040	A. BUILDING _____ B. WING _____	07/16/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
JULIAN J LEVITT FAMILY NURSING HOME	770 CONVERSE STREET LONGMEADOW, MA 01106

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 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure a nursing assessment was completed prior to transferring Resident #3 from the floor to the wheel chair status [REDACTED].#3 was admitted to the facility in July of 2020. Review of the facility policy entitled Assessing Falls and Their Causes, undated, indicated the following steps in the procedure after a fall occurs: -if a resident has just fallen, or is found on the floor without a witness to the event, the licensed nurse will record vital signs and evaluate for possible injuries to the head, neck, spine and extremities. -if there is evidence of a significant injury such as a fracture or bleeding, the licensed nurse will provide appropriate first aid. -once the assessment rules out significant injury, the nursing staff will help the resident to a comfortable sitting, lying or standing position, and the document the relevant details . During an observation on 7/16/20 from 12:17 P.M. through 12:25 P.M., on the quarantine section of the A1 unit, Resident #3 was observed on the floor with his/her body between the leg rests of the wheel chair which was positioned in the hallway. There was no staff present in the hallway during the observation and the double doors to enter this hallway were closed. The surveyor alerted nursing staff of the resident on the floor and observed Certified Nurse Aide (CNA) #1 don an isolation gown (she already had a face mask and field shield donned). CNA #1 entered the unit, spoke with Resident #3 and then went to the double doors to ask facility staff for assistance. Speech Therapist #1 entered the unit with face mask and face shield in place, entered Resident #4's room (Resident #4 was seated in the doorway in a geriatric chair, dressed in a hospital gown and did not have a face mask on) to don an isolation gown that was hanging upon the entrance to the room, exit the room and joined CNA #1 who was positioned next to Resident #3 still seated on the floor. The surveyor observed both CNA #1 and Speech Therapist #1 provide hands on assistance to lift Resident #3 off of the floor and back into his/her wheel chair. CNA # 1 did not have gloves donned and Speech Therapist #1 had an isolation gown donned that was designated for another resident (Resident #4). As Resident #3 was being transferred, Unit Manager #1 entered the quarantine section of the unit with Full PPE donned, and followed CNA #1 and Resident #3 into his/her room. Speech Therapist #1 was observed to re-enter Resident #4's room with the same PPE in place (gown, gloves, face mask and face shield), go into his/her bathroom where she washed her hands. During an interview on 7/16/20 at 12:30 P.M., Unit Manager #1 said that Resident #3 should not have been moved by CNA #1 and Speech Therapist #1 prior to a nursing assessment being completed. She further said that the resident should have been hoyered (a machine that assist with transfers) off of the floor by the nursing staff and that Speech Therapist #1 should not have assisted with the resident transfer. During an interview on 7/16/20 at 12:33 P.M., the Director of Nurses (DON) said the nurse should have assessed Resident #3 prior to being moved by facility staff. She further said the Speech Therapist should not have assisted CNA #1 during the transfer. Please refer to F880
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 observations and interviews, the facility failed to adhere to infection control guidelines relative to Transmission-Based Precautions (TBP) for care and services of residents with unknown COVID-19 status on one of five units. The facility also failed to ensure that appropriate Personal Protective Equipment (PPE) was appropriately donned by facility staff when providing care and services for COVID negative residents, and that infection control practices were adhered to on two of five units. Findings include: Review of the facility policy entitled Transmission-Based Infection Control Protocol, revised 5/1/20, indicated the following: -Proper handwashing before and after contact with residents, before and after donning gloves, before and after assisting in meals, when hand is soiled, and others. When in doubt, employee must wash hands. -Proper use of personal protective equipment (PPE) according to level of infection exposure. -Use of PPE appropriately, including gloves and gown. Wear a gown and gloves for all interactions that may involve close contact with the patient or the patient's environment. Donning PPE upon room entry and properly discarding before exiting the patient room is done to contain pathogens. Review of the Centers of Disease Control and Prevention (CDC) guidance entitled Preparing for COVID-19 in Nursing Homes updated 6/25/20, indicated the following for New Admissions and Readmissions whose COVID-19 status is unknown: -Placing the resident in a single-person room or in a separate observation area so the resident can be monitored for evidence of COVID-19 -Health Care Personnel (HCP) should wear an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown when caring for these residents. Review of the CDC guidance entitled Infection Control Guidance, updated 7/15/20, indicated the following: -HCP working in facilities located in areas with moderate to substantial community transmission are more likely to encounter asymptomatic or pre-symptomatic patients with COVID-19 infection. If COVID-19 infection is not suspected in a patient presenting for care (based on symptom and exposure history), HCP should follow Standard Precautions (and Transmission-Based Precautions if required based on the suspected diagnosis). They should also: -Wear eye protection in addition to their facemask to ensure the eyes, nose, and mouth are all protected from exposure to respiratory secretions during patient care encounters. -Wear an N95 or equivalent or higher-level respirator, instead of a facemask, for: Aerosol generating procedures and Surgical procedures that might pose higher risk for transmission if the patient has COVID-19, -For HCP working in areas with minimal to no community transmission, HCP should continue to adhere to Standard and Transmission-Based Precautions, including use of eye protection and/or an N95 or equivalent or higher-level respirator based on anticipated exposures and suspected or confirmed diagnoses. Universal use of a facemask for source control is recommended for HCP. During a tour with the Infection Preventionist on 7/16/20 from 10:00 A.M. through 11:00 A.M., the following was observed: -On Unit A1 at 10:23 A.M., Activity Staff #1 had Full PPE donned (isolation gown, gloves, face mask and eye protection) prior to entering Resident #1's room. Signage on Resident #1's door indicated Full PPE was required. Activity Staff #1 had a surgical mask in her gloved hands and prior to entering the resident's room, dropped the surgical mask on the floor. The surveyor observed Activity Staff #1 pick the surgical mask up off the floor, and when asked what she was going to do with the surgical mask, told the surveyor that she was discarding it in the trash can and she would get another one in the resident's room. The surveyor observed Activity Staff #1 take the soiled surgical mask, walk over to the resident's bathroom, discard the surgical mask into the trash receptacle, take another surgical mask within the residents room and place it on the Resident #1 who was seated at his/her wheel chair positioned near the bed. Activity Staff #1 did not doff her gloves after picking up the soiled surgical mask off the floor, nor did she conduct hand hygiene or don new gloves. Activity Staff #1 proceeded to assist Resident #1 out of his/her room for a scheduled outdoor visit. The surveyor and Infection Preventionist accompanied Resident #1 and Activity Staff #1 off of the A1 unit. Upon exiting the A1 unit, Activity Staff #1 doffed her face shield and isolation gown and was observed to hang it on a wall hook near the entrance to the unit. During this time, the Infection Preventionist indicated that Resident

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

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) #1's surgical mask was not on appropriately. The surveyor observed the Infection Preventionist (who had only a face mask donned), approach Resident #1 and reapply his/her surgical mask so that it was covering his/her mouth and nose. The Infection Preventionist did not have Full PPE donned during this interaction (gloves, eye protection and isolation gown). Activity Staff #1 was observed to then assist Resident #1 off the unit for the scheduled visit with a face mask only donned. -On Sosin Unit 2 at 10:35 A.M., Rehabilitation Staff #1 and #2 were ambulating Resident #2 in the hallway. The Infection Preventionist stated to the surveyor that all residents residing on Sosin Unit 2 required Full PPE (isolation gown, gloves, face mask and eye protection). Resident #2 had a face mask in place, while Rehabilitation Staff #1 (who was standing beside Resident #2 and providing standby by assistance with ambulation), donned an isolation gown, face shield and face mask but did not have on gloves. Rehabilitation Staff #1 was observed to touch and adjust her face mask numerous times with her ungloved hands and proceed to provide ambulation assistance to Resident #2. There was no hand hygiene conducted during the multiple instances of Rehabilitation Staff #1 touching her face mask. During an interview on 7/16/20 at 11:16 A.M., the Infection Preventionist said that both Residents #1 and #2 required Full PPE (isolation gown, gloves, face mask and eye protection) with staff interactions. The Infection Preventionist said that Rehabilitation Staff #1 should have had gloves donned, should not have touched her face mask and when she did- should have conducted hand hygiene. The Infection Preventionist further said that she should have donned PPE when assisting Resident #1 with his/her face mask placement. During an interview on 7/16/20 at 11:40 A.M., the Administrator said that facility staff are to don Full PPE with COVID negative residents at all times. He further said this would include when facility staff are assisting residents off the units for outdoor visitation. During an observation on 7/16/20 from 12:17 P.M. through 12:25 P.M., on the quarantine section of the A1 unit, Resident #3 was observed on the floor with his/her body between the leg rests of the wheel chair which was positioned in the hallway. There was no staff present in the hallway during the observation and the double doors to enter this hallway were closed. The surveyor alerted nursing staff of the resident on the floor and observed Certified Nurse Aide (CNA) #1 don an isolation gown (she already had a face mask and field shield donned). CNA #1 entered the unit, spoke with Resident #3 and then went to the double doors to ask facility staff for assistance. Speech Therapist #1 entered the unit with face mask and face shield in place, entered Resident #4's room (Resident #4 was seated in the doorway in a geriatric chair, dressed in a hospital gown and did not have a face mask on) to don an isolation gown that was hanging upon the entrance to the room, exit the room and joined CNA #1 who was positioned next to Resident #3 still seated on the floor. The surveyor observed both CNA #1 and Speech Therapist #1 provide hands on assistance to lift Resident #3 off of the floor and back into his/her wheel chair. CNA # 1 did not have gloves donned and Speech Therapist #1 had an isolation gown donned that was designated for another resident (Resident #4). As Resident #3 was being transferred, Unit Manager #1 entered the quarantine section of the unit with Full PPE donned, and followed CNA #1 and Resident #3 into his/her room. Speech Therapist #1 was observed to re-enter Resident #4's room with the same PPE in place (gown, gloves, face mask and face shield), go into his/her bathroom where she washed her hands. During an interview on 7/16/20 at 12:25 P.M., Speech Therapist #1 said that the isolation gown she donned was supposed to be used for Resident #4, not Resident #3. She said she should have donned a new isolation gown prior to assisting with the transfer for Resident #3. During an interview on 7/16/20 at 12:33 P.M., the Director of Nurses (DON) said Speech Therapist #1 should not have utilized an isolation gown designated for another resident prior to assisting Resident #3.