STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225272	A. BUILDING _____ B. WING _____	08/27/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BEAR HILL HEALTHCARE AND REHABILITATION CENTER	**11 NORTH STREET STONEHAM, MA 02180**

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 observation, interview and policy review, the facility failed to ensure that staff on 2 of 4 units observed 1.) properly disinfected a blood glucose meter after use, 2.) properly handled soiled linens 3.) donned goggles while providing a high contact resident activity and 4.) performed hand hygiene after touching residents and their masks which would aid in preventing the spread of infection during the COVID-19 pandemic. Findings include: 1. The facility failed to ensure that Nurse #1 followed the facility policy while disinfecting a blood glucose meter after a resident use. Review of the facility policy entitled, Equipment Cleaning and Disinfection Policy and Procedure, not dated, included the following: * Equipment shared between residents must be cleaned and disinfected prior to use. * Glucometers are to be cleaned at the beginning of the shift, prior to resident use and after each subsequent resident use. * The 1:10 bleach solution that is used for disinfection should wet the equipment on all surfaces that come in contact with the resident and then be allowed to air dry completely before use. On 8/27/20 at 11:40 A.M., during observation of blood glucose testing with a blood glucose meter, revealed Nurse #1 as she completed the testing process for a resident and returned to the nurses' station. Nurse #1 opened an alcohol wipe pad and disinfected the blood glucose meter and placed the meter back into the storage case. Nurse #1 did not use a 1:10 bleach solution to disinfect the blood glucose meter per the facility policy. On 8/27/20 at 11:45 A.M., during an interview, Nurse #1 said that she thought the policy was to disinfect the meter with alcohol. She said she didn't know she was supposed to use a bleach wipe pad. On 8/27/20 at 11:50 A.M., during an interview, the Infection Preventionist said that the facility policy is to use bleach to disinfect the blood glucose meter, not an alcohol wipe. 2. The facility failed to ensure that Laundry Assistant (L.A.) #1 properly removed soiled linens from the Birchwood Unit. Review of the facility policy, entitled Laundry and Linen, dated 1/2014, included the following: * Consider all soiled linen to be potentially infectious and handle with standard precautions. * Do not sort or pre-rinse soiled linen in resident care areas. * Handle soiled linen as little as possible to prevent agitation. * Employees sorting or washing linen must wear a gown and gloves. Review of inservice training for laundry staff conducted by the Infection Preventionist on 8/5/20, entitled, Proper Pick Up and Disposal of Laundry, included the following: * Gowns are to be worn when picking up and sorting laundry. * Plastic or reusable leak proof bags are to be placed in laundry bins. On 8/27/20 at 10:25 A.M., during observation on the Birchwood unit, the surveyor observed as L.A.#1 pulled soiled linen out of a dirty linen cart with a gloved hand. L.A. #1, who was wearing a knitted sweater (no gown), bent over the linen hamper and reached deeply into the linen hamper, contaminating her sweater and pulled out soiled linen and placed the linen in a gray plastic rolling cart. L.A. #1, removed the glove and discarded the glove into the dirty linen hamper. Without performing hand hygiene, L.A. #1 moved on to a second and third dirty linen hamper and repeated the same process. The Infection Preventionist observed while L.A. #1 pulled soiled linen out of the third dirty linen cart and spoke with L.A.#1. On 8/27/20 at 10:33 A.M., during an interview, the Infection Preventionist said that laundry staff should not be placing their arms in a dirty linen cart. She said laundry staff should pull the plastic bag out of the linen cart, tie it and sort the soiled linen downstairs. She also said that the laundry aide should be wearing a gown to protect her clothing. 3. The facility failed to ensure that staff donned appropriate eye protection while cueing and feeding residents that were Covid-19 negative, per the facility policy. Review of the facility policy, Personal Protective Equipment(PPE) Guidance, not dated, indicated that eye protection should be worn during the care of all patients who are negative (for Covid-19). Examples of such eye protection are goggles or reusable face shields. On 8/27/20 at 9:15 A.M., observation on the Birchhill Unit revealed Certified Nursing Assistant #1 as she was cueing a resident, with a Covid-19 negative status, to eat. CNA#1 was standing approximately 2 feet apart from the resident. CNA #1 was wearing her personal eyeglasses, not facility supplied proper eye protection. CNA #1 completed the cueing task with this resident and then moved on to another resident room, the second resident was also known to be Covid-19 negative. CNA #1, without donning proper eye protection sat directly next to the resident and began feeding the resident. On 8/27/20 at 9:20 A.M., the Unit Manager said that CNA#1 should be wearing goggles when feeding residents. 4. The facility failed to ensure Nurse #2 performed hand hygiene after touching residents' masks. Review of the facility policy, entitled Handwashing/Hand Hygiene, dated 8/2015, included the following: *Use an alcohol-based hand rub containing at least 62% alcohol; or alternatively, soap and water before and after coming in direct contact with residents. On 8/27/20 at 9:15 A.M., observation on the Cherryhill Unit revealed Nurse #2 as she picked up a resident's mask from his/her wheelchair and placed the mask on the resident's face. Without performing hand hygiene, Nurse #2 adjusted a second resident's mask which was hanging below the resident's chin and left the area, again without performing hand hygiene. Nurse #2 went to her medication cart and began handling items on the medication cart, without performing hand hygiene, Nurse #2 walked over to the treatment cart and began opening the drawers and touching the items inside the cart. Failure to perform hand hygiene after resident interactions increases the risk of spread of infection.

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