STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225313	A. BUILDING _____ B. WING _____	**10/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GOVERNORS CENTER	**66 BROAD STREET WESTFIELD, MA 01085**

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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to ensure staff implemented surveillance monitoring for signs and symptoms of COVID-19 for one (Resident #3) out of four sampled residents. Findings include: Review of the facility policy entitled Process for Monitoring, undated, indicated monitoring of temperature, oxygen (O2) and notifications of abnormal findings every day shift and evening shift for recovered residents. Review of Resident #3's medical records indicated Resident #3 was tested for COVID-19 on 4/27/2020 and was confirmed positive on 4/29/2020. Review of September 2020 and October 2020 Physician's Orders indicated COVID-19 monitoring of temperature, O2 and abnormal findings every day and evening shift ordered on [DATE]. Review of Resident #3's weights and vital signs indicated no data had been entered for September 2020 and October 2020. Further review of Resident #3's September 2020 and October 2020 Medication Administration Record [REDACTED]. During an interview on 9/5/20 at 12:05 P.M., the Assistant Director of Nursing (ADON) stated the process for monitoring recovered residents is every day shift and evening shift. The ADON said that the temperature and O2 should have been documented in the medical record under weights and vitals and on the MAR.

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.