STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225429	A. BUILDING _____ B. WING _____	09/24/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
STONEHEDGE HEALTH CARE CENTER	5 REDLANDS ROAD W ROXBURY, MA 02132

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, staff interviews, and medical record review the facility staff failed to monitor and document signs and symptoms of Covid 19 in four of seven new admissions, facility staff failed to wear full personal protective equipment (PPE) while providing care to negative COVID-19 resident and facility housekeeping staff failed to wear full PPE when entering and cleaning the room of a resident who was on 14 days transmission based precautions to prevent the spread of COVID-19 in the facility. Findings include: A review of the facility policy personal protective Equipment Plan dated 7/6/2020 indicated the following: -This Personal Protective Equipment Plan (PPE) is necessary to provide a safe and healthful workplace for our employees, and to comply with the latest guidance set forth by the Center of Disease Control (CDC) and Massachusetts Department of Public Health (DPH). Covid Negative (those who never tested positive for COVID-19) -Staff should wear full PPE to include mask, faceshield/goggles, gown and gloves for high contact activities: a. Dressing b. Transferring c.Changing linens Quarantined or Patients under Investigation (PUI) -Staff should be in full PPE gloves, gowns, N95, face shield or goggles for all resident care and room entry. 1. The surveyor observed Certified Nursing Assistant (CNA) #1 in room [ROOM NUMBER] wearing eye protection, a mask, and gloves while providing care for a resident who was COVID-19 negative and assisting the resident in a transfer from the bed to a wheelchair. The posted signage at the entrance of the room indicated the resident required full PPE including a gown to be worn for high contact care. High contact care includes transferring a resident. On September 25, 2020 at 9:20 A.M., the surveyor observed CNA #1 putting shoes on the resident and then providing physical assist when assisting the resident in transferring from the bed to the wheelchair. On September 25, 2020 at 9:35 A.M., CNA #1 was interviewed and said she does not have to wear a gown when working with the residents in room [ROOM NUMBER], they are not on precautions. CNA #1 said all residents have the same signs on the doorway pointing to rooms #204, 205 and 207 but they are not on precautions they are negative for COVID-19. On September 25, 2020 at 9:42 A.M., the Assistant Director of Nurses (ADON) was interviewed and said room [ROOM NUMBER] was a new admission on 14 day quarantine droplet precautions, all the other residents on this unit are are COVID negative including room [ROOM NUMBER]. The ADON said they have droplet signs posted on their doorway because they are negative Covid residents and require full PPE including eye protection, mask, gloves and gowns for high contact activities. The ADON said CNA #1 should have been wearing full PPE when providing care and assisting the resident from the bed to the wheelchair. 2. The surveyor observed Housekeeping Staff #1 failed to wear the required full PPE when entering room [ROOM NUMBER], which had a posted droplet precautions signage for a new admission on 14 day quarantine. Housekeeping Staff #1 was observed wiping down the bed in room [ROOM NUMBER] and transporting used linen against her body in the room. Housekeeper #1 was observed in room [ROOM NUMBER] wearing eye protection, face covering and gloves while handling dirty linen and wiping down a mattress. On September 25, 2020 at 10:15 A.M., the surveyor observed Resident #2 walking in and out of room [ROOM NUMBER], requesting the facility staff clean the bed in the room before he uses the bed. room [ROOM NUMBER] had a posted sign indicating transmission based precautions, including droplet precautions. On September 25, 2020 at 10:25 A.M., the surveyor observed Housekeeper #1 enter room [ROOM NUMBER] wearing eye protection, facemask and gloves with the resident standing in the room not wearing a face covering. Housekeeper #1 was observed to spray down the mattress and wipe it clean. Housekeeper #1 then went over to the second bed in room and picked up a ball of linen and and held it against her body before placing it on the first bed she had just cleaned. On September 25, 2020 at 10:35 A.M., Housekeeper #1 was interviewed and said both beds were cleaned before the resident was admitted last night. Housekeeper #1 said she picked the ball of linen because the resident insisted she make the bed with the linen he/she used the night before because it was still clean. Housekeeper #1 said she was not aware she had to wear a gown when entering room [ROOM NUMBER]. On September 25, 2020 at 10:40 A.M., the Housekeeping Supervisor was interviewed and said newly admitted residents were on a 14 day quarantine and housekeeping staff should be wearing full PPE including a gown when entering and cleaning the rooms. 3. The facility staff failed to consistently document temperatures, oxygen saturation levels, and monitor residents for signs and symptoms of COVID-19 for four of the seven residents who were newly admitted and on a 14 day quarantine under surveillance for COVID-19. Center for Disease Control guidance (CDC) for Preparing for COVID-19 in Nursing Homes last updated June 25, 2020 indicated the following: -Actively monitor all residents upon admission and at least daily for fever (T=1) and symptoms consistent with COVID-19. Ideally, include an assessment of oxygen saturation via pulse oximetry. A review of the facility policy Novel Coronavirus Prevention and Response dated 8/25/2020 included the following:: -This facility will respond promptly upon suspicion of illness associated with a novel Coronavirus in efforts to identify, treat, and prevent the spread of [MEDICAL CONDITION]. -6. Interventions to prevent the spread of respiratory germs within the facility -h. Monitor residents for fever or respiratory symptoms A review of the facility policy Coronavirus Surveillance, dated 7/6/2020, included the following: -This policy will implement heightened surveillance activities for Coronavirus illness during periods of transmission in the community and/or during a declared public health emergency for this illness: -8. Residents will be monitored for signs and symptoms of Coronavirus illness at least 2 times a day for: fever, cough, Shortness of breath or difficulty,chills, repeated shaking with chills, muscle pain, headache, sore throat, or new loss of taste or smell. A. Resident #1 was admitted to the facility 9/2020 (within the last 14 days) with a [DIAGNOSES REDACTED]. A review of the physician orders for the month of September 2020 indicated the following: -Covid/droplet/airborne precautions every shift for 14 days -Vital signs daily three times a day, every shift A review of the medication Administration record (MAR) indicated: - vitals signs daily three times a day, every shift. There was no documentation of vital signs since admission. A review of the Treatment administration record indicated the following: - Droplet/airborne precautions every shift for 14 days. There were only 13 initialed shifts out of 22 shifts Resident #1 was in the facility indicating the precautions were maintained. On 9/24/2020 at 5:05 P.M., the surveyor and Nurse #2 reviewed Resident #1 medical record for documented vital signs and nursing notes. There were no entries under vital signs for oxygen saturation, temperature or respiratory monitoring. A review of the nurses notes indicated the following inconsistent documentation of Resident #1's vital signs: 9/19/ at 11:02 P.M.: no vitals recorded 9/20 at 9:26 A.M.: only temperature recorded 9/20 at 22:54 P.M.: only temperature recorded 9/21 at 7:30 A.M.: No vital signs recorded 9/23/ at 8:54 A.M.: only temperature recorded 9/23 at 3:58 P.M.: No vital signs recorded 9/23 at 10:46 P.M.: only temperature recorded 9/24 at 9:56 A.M.: No vital signs recorded. Resident left for an appointment at the spine clinic 9/24 at 14:33 P.M:. No vital signs recorded. Resident returned spine joint appointment. During interview on September 24, 2020 at 5:05 P.M., Nurse #2 said the Resident's temperature and oxygen saturation rate are supposed to be recorded on the computer under vital signs. Nurse # 2 reviewed Resident #1's electronic medical record for temperature and vital signs and found no entries. Nurse #1 said sometimes nurses put the information in the nurses notes and she reviewed Resident #1 nursing progress notes since admission and said there are some entries for vitals and signs and symptoms of Covid but not consistently. During interview on September 24, 2020 at 5:10 P.M. Nurse #3 said the Resident's temperature and oxygen saturation rate is supposed to be recorded in the medication administration record (MAR). Nurse #3 reviewed Resident #1's MAR and TAR and there were no

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** - Some	(continued... from page 1) entries for recording Resident #1's vitals signs. Nurse #3 said, sometimes nurses put the vital sign values in the nurses notes on the computer. B. Resident #2 was admitted to the facility September 2020 (within last 14 days) with a [DIAGNOSES REDACTED]. A review of the physician orders for the month of September 2020 indicated the following: -Resident #2 was placed on a 14 day Quarantine. -There were no orders written to monitor for signs and symptoms for COVID-19 A review of the nursing note dated 9/24/2020 indicated Resident #2 continues on Covid precautions. During interview on September 24, 2020 at 4:00 P.M., the Director of Nursing (DON) said there were no orders to monitor for signs and symptoms of Covid-19, no documentation of temperature, oxygen saturation rate or lung sounds in the computer, MAR, TAR or in the nursing notes he had just checked. C. Resident #3 was admitted to the facility in September 2020 (within the last 14 days) with a [DIAGNOSES REDACTED]. A review of the physician orders for September 2020 indicated the following orders: -COVID-19 precautions every shift for 14 days -Droplet/Airborne precautions every shift for 14 days. -COVID-19 monitoring every shift for 14 days A review of the Treatment record administration (TAR) indicated the following: -Monitor for signs and symptoms of Covid 19 every shift for 14 days. Initialed completed by the nursing staff 13 of the 23 shifts Resident #3 was in the facility. There were no vital sign values recorded on the TAR. The facility did not provide nursing notes for review. D. Resident #4 was readmitted to the facility September 2020 (within the last 14 days) with a [DIAGNOSES REDACTED]. A review of the medication administration record (MAR) indicated the following: -Monitor temperature and oxygen saturation every shift 7-3 and 3-11. There was no signatures or values entered on the MAR since Resident #4 was readmitted . A review of the nursing progress notes indicated the following: 9/21 at 11:36 P.M., a full set of vital signs was recorded (includes temperature, oxygen saturation, respiratory rate, pulse and blood pressure) 9/22 at 7:36 A.M., No vital signs recorded 9/22 at 10:33 P.M., full set of vital signs recorded During interview on September 24 at 4:00 P.M., the Director of Nurses (DON) said new admissions are placed on 14 days quarantine on transmission based precautions including droplet precautions and nursing staff are to monitor for signs and symptoms of COVID-19 including temperature and oxygen saturation rate every shift. The DON said his expectation is that the values of the vital signs are recorded in the medical record not just initials indicating monitoring was completed.
F 0886 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, review of the facility's staff testing logs and the facility's testing policy, the facility staff failed to follow their policy and complete 100% testing of the facility staff within 3-7 days of an active outbreak in the facility and failed to ensure the staff test results were returned within 48 hours. Once the facility staff identified the test results were not being returned within 48 hours, the facility staff failed to notify the local board of Health or the Massachusetts Department of Public Health (DPH) as directed by their facility policy and the Centers for Medicare & Medicaid Services (CMS) memo. Findings include: A review of the facility's policy COVID-19 Pandemic Resident and Staff Testing dated 9/11/2020 indicated the following; -Per latest Center for Medicare (CMS) guidance, Athena facilities will continue to test resident and and facility staff based on parameters and frequency as set forth by the Health and Human Services (HHS) Secretary. *For outbreak testing, all staff and residents should be tested , and all staff and residents that test negative should be tested every 3 to 7 days until testing identifies no new cases for a period of 14 days. Testing of staff and Residents in Response to an Outbreak -An outbreak is defined as a new COVID-19 infection in any healthcare personnel (HCP) or any nursing home-onset COVID-19 infection in a resident. -Upon identification of a single new case of COVID-19 infection in any staff or residents, all staff and residents should be tested . All staff and residents that tested negative should be retested every 3 days to 7 days until testing identifies no new cases of COVID-19 infection among staff or residents for a period of 14 days since the most recent positive result. - If the 48-hour turn around time cannot be met due to community testing supply shortages, limited access or inability of laboratories to process tests, the facility should have documentation of its efforts to obtain quick turn around test results with the identified laboratory or laboratories and be in contact with the local and state health departments. A review of the current staff testing log provided by the Assistant Director of Nursing (ADON) indicated a continued delay of greater than 48 hours for the four testing dates listed below, exceeding the 48 hour turn around time as of September 24, 2020. 9/17/2020- A total of 8 tests were performed with 5 test results still pending. 9/18/2020- A total of 6 tests performed with 4 test results still pending. 9/20/2020- A total of 6 tests performed with 2 test results still pending. 9/21/2020- A total of 34 tests performed with 32 test results still pending. A review with ADON (Assistant Director of Nursing) of the facility's previous weeks staff testing results indicated that staff tests performed on 9/14, 9/15, and 9/16 had results reported as late as 9/21/2020, exceeding the 48 hour turn around time. On September 24, 2020 at 1:15 P.M., the surveyor and the ADON reviewed the facility's contracted laboratory results for Staff Member #1. The COVID-19 test was performed on September 4 and the results were reported to the facility on [DATE]. The ADON said Staff Member #1 was scheduled and did work within the time frame of 9/4 thru 9/15/2020 as normally scheduled. The ADON said the facility was aware the test results were not being returned within the 48 hours as required by CMS. The ADON said she had emailed the laboratory and had phone conversations with laboratory, but the facility staff did not contact the local Board of Health or the Massachusetts DPH of the late test results. The ADON said the staff testing positive on 9/15/2020 changed the status of the building to be considered having an out break requiring 100% of COVID negative staff and residents be tested within 3-7 days. The ADON said she just completed 100% resident and staff testing on September 23rd. A review of the testing log showed 70 tests results still pending as of September 24, 2020, of which 43 of them are over the 48 hour turn around time. On September 24, 2020 at 4:30 P.M., Nurse #2 said she was tested for COVID-19 on September 17, 2020 at the facility. Nurse #2 said she checked for her results on 9/22 and was told they were not back yet and she has not had a chance to see if the results are back today.