STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225544	A. BUILDING _____ B. WING _____	08/18/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WINGATE AT SILVER LAKE	17 CHIPMAN WAY KINGSTON, MA 02364

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 observation, staff interview, record review, facility policy, Center for Disease Control and Prevention Guidelines (CDC) and Department of Public Health (DPH) Guidelines, the facility failed to ensure that staff utilized personal protective equipment (PPE) according to transmission based precaution protocol as required to prevent possible spread of COVID-19 in the facility on three of four units. Specifically, the facility failed to develop and implement a plan for the care and management of a resident potentially exposed to COVID-19 to prevent possible transmission to other residents, and healthcare personnel (HCP). Findings include: Review of the facility's policy, Update for Caring for Long-Term Care Residents During the COVID-19 Emergency Guidance (Replaces Coronavirus 2019 and Comprehensive PPE Clarification), dated 7/30/20 included the following: Policy: Wingate SNF (skilled nursing facility) in Massachusetts will follow Massachusetts DPH and CDC Guidelines for admitting residents and caring for residents with presumed or confirmed COVID-19 and help to mitigate the spread of COVID-19 in the facility. The CDC guidance titled Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 Pandemic (updated July 15, 2020), and DPH Comprehensive Personal Protective Equipment (PPE) Guidance Memorandum dated July 6, 2020 include the following: -DPH has adopted a universal facemask use policy for all HCP; homemade and cloth facemasks are not considered PPE -Implement aggressive social distancing measures (remaining at least six feet apart from others) in common areas -Residents with known or suspected/awaiting test results for COVID-19 should be cared for using all recommended PPE, which includes use of an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a face shield that covers the front and sides of the face), gloves, and gown -If goggles or reusable face shields are used each facility must ensure appropriate cleaning and disinfection between uses according to manufacturer's instructions. -HCP should perform hand hygiene prior to donning and after doffing gloves. The CDC's guidance Using Personal Protective Equipment (PPE) (Updated July 14, 2020), included the following: How to Put On (Don) PPE Gear -Perform hand hygiene using hand sanitizer. -Put on isolation gown. Tie all of the ties on the gown. -Put on NIOSH-approved N95 filtering facepiece respirator or higher -Put on face shield or goggles -Put on gloves. Gloves should cover the cuff (wrist) of gown. How to Take Off (Doff) PPE Gear -Remove gloves -Remove gown -Perform hand hygiene -Remove face shield or goggles -Perform hand hygiene 1. On 8/18/20 at 7:50 A.M., the surveyor walked into the front entrance of the facility behind 2 staff members. The staff members were observed to walk through the vestibule and into the facility without wearing face masks. After stopping at the reception desk, 1 staff member was observed to don (put on) a surgical mask, and the other staff member did not don a mask. While standing at the reception desk waiting to be screened, the employees were observed to stand within 2 feet of each other, and not a social distance of at least 6 feet as recommended by the CDC. After being screened by the receptionist, both employees (1 still not wearing a mask) was observed to walk through the lobby area and get onto an elevator. During interview with the receptionist, she said that she didn't notice that the 1 of the employees did not have a mask on and called to the staff member's office to alert her to put a mask on. During interview with the Administrator and Director of Nursing (DON) at 8:05 A.M., they said that all staff on the Elmwood, Oakwood, and Maplewood Units (COVID-19 recovered, COVID-19 negative) are to wear masks and goggles/face shields at all times (except behind the nursing station). The DON said that last night, a resident was moved from the Maplewood Unit to the Pinewood Unit (quarantine) because he/she spiked a fever, developed nausea and diarrhea and was considered a person under investigation (PUI) for COVID-19. 2. During interview with Nurse #2 at 8:42 A.M., she explained the following color coding of stickers placed on each resident's nameplate outside their door: Green: Negative (mask and eye protection) Blue: Recovered (mask only) Red: COVID-19 positive (full PPE-gown, gloves, mask, eye protection) Orange: Quarantine (full PPE) Yellow: PUI (full PPE) Observations of inappropriate use of PPE on 3 of 4 nursing units were as follows: a. Oakwood Unit (34 negative residents, 5 COVID-19 recovered residents) -At 8:35 A.M. Nurse #1 was observed walking in the unit hallway wearing a surgical mask and no goggles or face shield. b. Pinewood unit (5 negative, 2 COVID-19 recovered, 4 quarantine, 1 PUI) -At 8:53 A.M., CNA (certified nursing assistant) #1 and #2 were observed standing in the hallway talking. At 8:55 A.M., CNA #1 was observed to enter a resident's room (orange dot on the nameplate=quarantine). The CNA entered the resident's room without performing hand hygiene, took a reusable gown from a hook just inside the door and put it on without securing the back ties, donned a pair of gloves without performing hand hygiene, and did not ensure the gloves covered the wrist cuff of the gown, and therefore exposed her skin. At 9:07 A.M., the surveyor and Unit Manager #3 were standing outside of the room, and were able to see CNA #1 in the room with the resident. The surveyor and Unit Manager #3 observed that the CNA's gown was observed to be tied at the neck, but not at the back which allowed the fabric gown to flow freely and touch multiple surfaces such as the bathroom door, resident's bed, over bed table, the resident's legs, and the privacy curtain therefore potentially contaminating the surfaces. Unit Manager #3 told CNA #3 that she had to secure both ties of the gown every time she put it on, and to make sure to perform hand hygiene before putting on PPE. -At 9:10 A.M., Nurse #3 was observed at a medication cart outside of a resident's room identified as a PUI (full PPE). The nurse was wearing a surgical mask, and eye glasses. The nurse was observed to put on a gown that was on a hook just inside the door (extended use and potentially contaminated), secured the ties around her neck only, donned gloves, then put eye protection on and then approached the resident to feed him/her their medication with a spoon. The gloves were observed to not cover the wrist cuffs of the gown exposing her skin. The fabric gown flowed freely and was observed to touch the resident's bed. To maintain effective infection control, the nurse should secured both ties of the gown, and should have donned eye protection before donning gloves. After administering medications, Nurse #3 removed her gloves, eye protection, removed the gown and hung it on the hook just inside the door and performed hand hygiene. At 9:13 A.M., Nurse #3 was observed to don PPE as follows: gloves, eye protection, and gown that was secured only around the neck, and not the back. To maintain effective infection control, the nurse should have first put on the gown, secured both ties of the gown, applied eye protection, then gloves that fit over the wrist cuffs of the gown with no skin exposed. -At 11:26 A.M., the door to the PUI resident's room was wide open. The call light above the door was illuminated. At 11:29 A.M., CNA #2 approached the resident's room, put on a gown that was hanging on a hook just inside the room (extended use and potentially contaminated), donned gloves, pushed the gown out of the way with her gloved hands to access goggles that were in her pocket, and put them on without first decontaminating them. The CNA should have donned a gown, goggles, then gloves to avoid contaminating the PPE. The CNA was observed to close the window shades at the resident's request, then she removed her PPE, cleaned her goggles, then placed them back in her pants pocket. During interview at 11:33 A.M., CNA #2 said that she cleans her goggles with wipes prior to putting them in her pocket, but does not clean them again after she removes them from her pocket and uses them. She said that after thinking about it, she understood the goggles were contaminated from being in her pocket. c. Elmwood Unit-Dementia Special Care Unit (23 COVID-19 negative, 11 COVID-19 recovered, 1 quarantine) -At 9:22 A.M., Housekeeper #1 was observed sweeping the floor and cleaning tables in the dining room wearing a cloth, cheetah print face mask. There were 5 Residents seated in the room the housekeeper was cleaning. 2 of the 5 residents seated in the room were asleep with their mask pulled down to

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 -** Few	(continued... from page 1) their chin exposing their noses and mouths, increasing their susceptibility of exposure [MEDICAL CONDITION] expelled by staff not wearing adequate PPE as required. -At 9:30 A.M., Housekeeper #1 was observed cleaning tables in the unit activity room wearing a cloth, cheetah print face mask. There were 7 residents in the room, 1 of which was not wearing a face mask, therefore increasing his/her susceptibility of exposure [MEDICAL CONDITION] expelled by staff not wearing adequate PPE as required. 2. CDC's guidance Preparing for COVID-19 in Nursing Homes (updated June 25, 2020) included the following: -Have a plan for how roommates, other residents, and HCP who may have been exposed to an individual with COVID-19 will be handled (e.g., monitor closely, avoid placing unexposed residents into a shared space with them). During interview with the DON at 10:15 A.M., she said that last night, a resident on the Maplewood Unit spiked a fever, developed nausea and vomiting, and was moved to the Pinewood Unit and quarantined. She said this resident was previously a negative resident, and was now categorized as PUI for COVID-19. She said the resident had a COVID-19 test swab done, and expects to get the results of the test in 2 or 3 days. Review of the facility floor plan indicated that the PUI resident had a roommate before being transferred to the quarantine unit. On the Maplewood Unit at 1:01 P.M.,the surveyor observed the nameplate outside of the PUI resident's former room had a green dot on it which indicated that the resident's former roommate was always negative for COVID-19. The door to the room was wide open, and no one was observed in the room. During interview with Nurse #4 at 1:05 P.M., she pointed out the resident seated in a wheelchair in front of the nursing station. The resident was wearing a surgical mask, positioned with his/her back to the nursing desk, and was facing the dining room. Both staff and residents were observed to walk back and forth past the resident, and some residents were observed seated in wheelchairs nearby. During subsequent interview with the DON at 1:45 P.M., she said that the former roommate of the PUI resident was on standard precautions like other negative residents, and even though his/her roommate was suspected of having COVID-19, and was transferred to the quarantine unit, and had a COVID-19 test pending, she had no plan to initiate any strategies such as to monitor the resident closely, or avoid placing unexposed residents into a shared space with the resident to prevent transmission of COVID-19 to other residents or HCP due to potential exposure to [MEDICAL CONDITION]. Review of the PUI resident and his/her roommate's medical record indicated that the facility did not develop and implement a plan for the care and management of a resident potentially exposed to COVID-19 for more than 17 hours after the PUI resident spiked a fever of up to 103.2, developed nausea and vomiting, and was transferred to the quarantine unit.