STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225219	A. BUILDING _____ B. WING _____	**08/13/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BEAR MOUNTAIN AT WORCESTER	**59 ACTON STREET WORCESTER, MA 01604**

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 and interview, the facility failed to implement proper infection control practices necessary to prevent the transmission of COVID-19 for 33 residents on the second floor unit, (10 negative, 1 quarantined, and 22 recovered). Findings include: 1. The facility failed to ensure Nurse #1 sanitized medical equipment and performed hand hygiene between residents. On August 13, 2020 at 10:51 A.M., the surveyor observed Nurse #1 enter a room with 2 COVID-19 negative residents (#1 and #2). She used a thermometer and an oximeter (device used on finger to check estimated blood oxygen levels and heart rate) on both residents. She did not sanitize the equipment between residents. She did not sanitize her hands when she changed gloves between residents. Nurse #1 then took the un-sanitized medical equipment and attempted to walk into a quarantined resident's room. The Director of Nurses (DON) stopped Nurse #1 during the observation and directed her back to the medication cart and instructed Nurse #1 to sanitize the medical equipment between residents. During an interview on August 13, 2020 at 11 A.M., Nurse #1 said she used the oximeter and the thermometer with both residents. She said she should have sanitized the medical equipment between residents, but she did not.

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.