STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225557	A. BUILDING _____ B. WING _____	07/30/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
EASTPOINTE REHAB CENTER	**255 CENTRAL AVENUE CHELSEA, MA 02150**

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.** Based on observation, interview and policy review the facility failed to ensure staff 1.) donned adequate Personal Protective Equipment (PPE) when caring for COVID-19 negative residents and 2.) wore masks properly throughout the building to prevent the spread of Covid-19 infection. Findings include: Review of the facility policy entitled, COVID-19 PPE Use Clarification, dated 7/24/20, included the following: * Covid-19 negative residents- face mask and faceshield/goggles at all times, direct care requires a gown to be worn. * Masks cannot be pulled down or removed for any reason while in the building. On 7/30/20 at 9:10 A.M., observation on the 4th floor unit revealed Social Worker #1 enter into the room of a Covid-19 negative resident and lean close to his/her face to speak to him/her. Social Worker #1 was not wearing an eyeshield/goggles per facility policy, increasing the risk of spread of infection. During an interview on 7/30/20 at 9:15 A.M., Social Worker #1 said she should have had her eye protection on. On 7/30/20 at 9:35 A.M., observation on the 4th floor unit revealed Case Manager #1 as she came out of a resident's room and headed towards the kitchenette to discard the resident's breakfast tray. Case Manager #1 was not wearing eye protection, increasing the risk of spread of infection. During an interview on 7/30/20 at 9:37 A.M., Case Manager #1 said she had just finished conducting a teleconference with the resident and the resident's family and maybe she left it in the resident's room. As the surveyor and Case Manager #1 checked the room, there was no eye protection. Case Manager #1 said she should wear eye protection because the resident's status is Covid-19 negative. On 7/30/20 at 8:10 A.M., observation on the 2nd floor lobby revealed a staff member walking down the hallway towards an office with another staff member. This staff member's mask was positioned down below her chin, increasing the risk of spread of infection. On 7/30/20 at 9:40 A.M., observation on the 4th floor unit revealed the elevator as it stopped at the 4th floor. The door opened and a staff member leaned her head into the unit, looked around and then proceeded to take the elevator to another floor. The staff member's mask was positioned down below her chin, increasing the risk of spread of infection.
F 0885 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify resident's representatives and families of new COVID-19 positive staff members by 5:00 P.M. the next calendar day. Findings include: Review of the facility's COVID surveillance log indicated that 2 staff members were diagnosed with [REDACTED]. Review of a copy of an electronic notification indicated that resident representatives and families were notified of the two staff members that were COVID-19 positive, but it was not dated. During interview on 7/30/20 at 12:15 P.M., the Administrator said that the notification to resident families did not go out until today, July 30, 2020.

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.