STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225491	A. BUILDING _____ B. WING _____	**10/07/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SHREWSBURY NURSING & REHABILITATION CENTER	**40 JULIO DRIVE SHREWSBURY, MA 01545**

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 policy review, record review, observation, and interview, the facility failed to ensure that staff adhered to Transmission-Based Precautions for the proper use of personal protective equipment (PPE) related to the use of eye protection in order to prevent the spread of COVID-19, for one resident (#1) on one out of three units. Findings include: Review of the Centers for Disease Control and Prevention (CDC) example signage for Droplet Precautions, last reviewed 1/7/16, indicated that everyone must make sure their eyes, nose, and mouth are fully covered before room entry. Review of the facility's policy titled COVID-19 Negative: Negative Case indicated that residents who tested negative for COVID-19 would be placed on Droplet Precautions, and that staff were required to wear PPE for Droplet Precautions to include the use of eye protection when prolonged exposure occurred in the room. Review of Resident #1's record indicated that he/she tested negative for COVID-19 on 6/25/2020. On 10/7/2020 at 9:57 A.M., the surveyor observed Therapist #1 as he provided treatment to Resident #1 in the resident's room. Signage next to the resident's door indicated that the resident was negative for COVID-19. The therapist wore a facemask that covered his mouth and nose, but he did not wear eye protection. On 10/7/2020 at 10:03 A.M., the surveyor and Nurse #1 observed Therapist #1 as he continued to provide treatment to Resident #1 in the resident's room. Therapist #1 wore a facemask, but he did not wear eye protection. During an interview on 10/7/2020 at 10:05 A.M., Nurse #1 said that the sign next to Resident #1's room door indicated that he/she had tested negative for COVID-19. She said that this sign was in place to alert staff of the resident's status and indicated that a facemask and eye protection was required, according to the facility's policy. During an interview on 10/7/2020 at 12:45 P.M., the administrator said that staff is always required to wear a facemask and eye protection when prolonged exposure occurred in the rooms of residents who tested negative for COVID-19. She further said that prolonged exposure included any resident care provided by staff, and that Therapist #1 should have worn eye protection while he provided treatment to Resident #1. During an interview on 10/7/2020 at 1:00 P.M., Therapist #1 said that staff was always required to wear a facemask and eye protection when they provided care to residents who tested negative for COVID-19. He said that he wore a facemask, but that he did not wear eye protection when he provided treatment to Resident #1 because he forgot to put it on. Therapist #1 said that he provided treatment to Resident #1 for approximately 40 minutes and that he should have worn eye protection throughout the treatment session, as required by the facility's policy. During interviews on 10/7/2020 at 10:40 A.M. and 1:30 P.M., the Infection Preventionist (IP) said that staff were always required to wear a facemask and eye protection when they provided care to residents who tested negative for COVID-19. She further said that Therapist #1 should have worn eye protection when he provided treatment to the resident, as required by the facility's policy.
F 0886 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	Based on policy review and interview, the facility failed to ensure that procedures were in place to address residents and staff that refused testing or were unable to be tested as required, to prevent the spread of COVID-19. Findings include: Review of the facility's Employee COVID Testing Policy, dated 9/23/2020, did not indicate procedures to address staff who refused testing or were unable to be tested . There was no policy available for review that addressed residents who refused testing or were unable to be tested . Review of the facility's employee COVID testing log for the testing period of 8/27/2020-9/10/2020 indicated that Nurse #2 worked at the facility during that period, but did not indicate the test date or test results for Nurse #2. Review of the facility's employee COVID testing log for the testing period of 9/10/2020-9/24/2020 indicated that Nurse #2 worked at the facility during that period and that Nurse #2 refused testing on 9/10/2020. During interviews on 10/7/2020 at 8:40 A.M. and 1:30 P.M., the Infection Preventionist (IP) said that Nurse #2 worked at the facility during the testing periods of 8/27/2020-9/10/2020 and 9/10/2020-9/24/2020 and that Nurse #2 was approached during both periods for COVID-19 testing, but he refused. She also said that Nurse #2's refusal for testing on 9/9/2020 was accidentally recorded on the testing log under Certified Nursing Assistant #1's name and that was why the refusal was not indicated next to Nurse #2's name on the log. The IP further said that the facility did not have procedures in place to address residents or staff that refused testing or were unable to be tested .

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.