STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225225	A. BUILDING _____ B. WING _____	08/11/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SOUTHEAST HEALTH CARE CENTER	184 LINCOLN STREET NORTH EASTON, MA 02356

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** Based on staff interviews, and review of the facility's social media account (Facebook), the facility failed to ensure that residents' rights to privacy were protected and promoted when the facility published first and last names of 25 out of 128 residents on a software program which was not password protected. The social media account was publicly accessible and not secure. Findings include: During interview with the Activity Director (AD) on 8/11/20 at 9:50 A.M., she said that she coordinates outdoor visits for residents and their family/friends. She said that there are three ways to set up the visits: email, snail mail (regular mail), and the facility's Facebook page which has a link to a calendar. She said the visitor can access the calendar via the facility's Facebook page, and choose a day and time for the visit. The AD said that only residents' first names appear on the calendar. Review of the facility's Facebook page indicated a hyperlink to access the resident visitation sign up calendar. After clicking the hyperlink, the program Sign up Genius opened up. There was no password request, and the outdoor visitation calendar appeared on the screen. The page indicated that outdoor visits with residents could be scheduled independently by selecting an available time slot, and entering the resident's name, and the visitor's name. Review of the page indicated a visitation calendar schedule for 8/10/20, 8/11/20, 8/12/20, 8/14/20, and 8/15/20, with time slots ranging from 10:00 A.M., to 6:00 P.M. All of the time slots were filled, and included the first and last names of 25 different residents throughout the week. During telephone interview with the Administrator on 8/12/20 at 9:40 A.M., he said that he was not aware that residents' first and last names were published on a visitation calendar that was unsecured, not password protected, and publicly accessible to anyone on the facility's Facebook page.
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, review of the facility's infection control policies, and review of the Center for Disease Control (CDC) guidance, the facility failed to implement proper infection control prevention and control practices. The facility failed to: 1. follow their facility policy to screen staff and visitors entering the facility 2. ensure that all staff used Personal Protective Equipment (PPE) appropriately, and 3. failed to ensure a sufficient supply of PPE was available for staff use to prevent the development and further transmission of COVID-19 and other communicable diseases and infections for residents on droplet precautions for 49 residents on 4 of 4 units. Findings include: 1. Review of the facility's policy, Coronavirus Surveillance (last revised 6/9/20), included the following: - Heightened surveillance activities will be implemented to limit the transmission of COVID-19. These include, but are not limited to, screening visitors, staff, and residents. - Screening for visitors and staff: a. Signs or symptoms of a respiratory infection, such as a fever, cough, shortness of breath, or sore throat or other symptoms of Coronavirus (i.e. chills, muscle pain, headache, new loss of taste or smell). b. Had any recent travel On 08/11/20 at 7:00 A.M., the surveyor walked into the front entrance of the building behind two staff members. The two staff members were observed to walk through the lobby area, past the reception desk, down the hallway and enter an elevator without being screened upon entry. There was no staff at the reception desk, or anywhere in the lobby area to screen staff or visitors. A few minutes later, the surveyor was greeted by a maintenance staff in the lobby area, and was led through double doors to the nursing station on the Ames Unit. Nurse #1 said that she was the night nurse, and would call facility leadership to inform them of the survey. Nurse #1 neither asked the surveyor if she had been screened, nor screened the surveyor. The maintenance staff informed Nurse #1 that the surveyor would go to the main dining room (directly across from the main entrance) to wait for facility leadership to arrive. At 7:05 A.M., two staff were observed to enter the building through the front entrance, walk through the lobby area, walk down the hall, and entered the elevator without being screened upon entry. At 7:25 A.M., the surveyor approached and introduced herself to the RCCA (Resident Care Coordinator) at the reception desk who was observed to be taking temperatures of staff entering the building. The staff member neither asked if the surveyor had been screened, nor screened the surveyor. During interview with the Administrator at 8:50 A.M., the surveyor informed him that at 7:00 A.M. and 7:05 A.M., staff were observed to enter the facility, walk through the lobby area, and go onto the elevator without being screened. He was also informed that the surveyor had not yet been screened, nearly two hours after entering the facility. He said that someone should have been in the lobby to screen all staff and the surveyor. At 8:52 A.M., the RCCA entered the conference room and took the surveyor's temperature, and asked if I had been out of the country in the past 14 days, and I had been to any parties? The RCCA failed to ask screening questions such as if the surveyor had symptoms of COVID-19 or had any exposure to anyone with COVID-19 as required. During interview with the Infection Control Preventionist (ICP) at 8:55 A.M., she said that Human Resource staff usually covers the reception desk for screening staff until 8:00 A.M. when the receptionist comes in. However, the Human Resource staff is on vacation, and due to a miscommunication, they did not assign a replacement staff to perform screening. 2. Review of the CDC's Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic (updated July 15, 2020), included the following: -Implement Universal Source Control Measures -HCP should wear a facemask at all times while they are in the healthcare facility -For HCP, the potential for exposure to [DIAGNOSES REDACTED]-CoV-2 is not limited to direct patient care interactions. Transmission can also occur through unprotected exposures to asymptomatic or pre-symptomatic co-workers in break rooms or co-workers or visitors in other common areas. Review of the CDC's Using Personal Protective Equipment (updated July 14, 2020) included the following: -Put on NIOSH-approved N95 filtering face piece respirator or higher (use a facemask if a respirator is not available). -Facemask: Mask ties should be secured on crown of head (top tie) and base of neck (bottom tie). Review of facility policy, Novel Coronavirus Prevention and Response, last reviewed 6/26/20, included the following: -Interventions to prevent the spread of respiratory germs within the facility: e. All staff to wear mask and eye protection while in the facility as a part of source control i. Promote easy and correct use of PPE by: ii. Make PPE, including facemask, eye protection, gowns, and gloves, available immediately outside of the resident's room or where it is accessible to staff or have donning and doffing stations During kitchen observation at 7:20 A.M., one dietary staff working behind the food line was observed to have his mask pulled down onto his chin exposing his nose and mouth, and was not wearing eye protection. Another dietary staff was observed walking throughout the kitchen, and was observed to have his mask pulled down onto his chin exposing his nose and mouth, and was not wearing eye protection. Another dietary staff person was observed in the kitchen with no mask on, and wearing no eye protection. During interview with the Dietary Director at 7:23 A.M., she said that the kitchen staff should be wearing PPE appropriately, Observations of inappropriate use of PPE and/or lack of availability/accessibility of PPE on nursing units were as follows:(NAME)Square Unit (recovered and negative residents) - During observation at 7:28 A.M., Nurse #2 was observed to be wearing a N95 mask with the top strap secured on crown of her head, and the bottom strap hanging loosely in front of her neck and not tied at the base of

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** - Some	(continued... from page 1) neck, which created a gap between her lower face and the mask. Nurse #2 was wearing eyeglasses, and not approved eye protection as required according to facility policy. - There were 10 resident rooms with signs posted outside the door which indicated that the room had a resident(s) on droplet and contact precautions. There were two precaution carts observed on the unit: #1 across the hall from room [ROOM NUMBER] that contained only one glove in the top drawer, disposable gowns in the middle drawer, and one face shield in the bottom drawer; #2 outside room [ROOM NUMBER] that contained a box of gloves in the top drawer, disposable gowns in the middle drawer, and no face shields/eye protection. Traditions Unit (recovered and negative residents) - At 7:35 A.M., there were 11 resident rooms with signs posted outside the door which indicated that the room had a resident(s) on droplet and contact precautions. There were 4 precaution carts observed on the unit, 4 of which did not contain adequate PPE to care for residents on droplet precautions : 1 cart was placed across from room [ROOM NUMBER] that contained a blood pressure cuff in the top drawer, disposable gowns in the middle drawer, and no gloves or eye protection; 1 cart was placed outside of room [ROOM NUMBER] that had a box of gloves on top of the cart with no other PPE in the drawers; 1 cart was placed outside of room [ROOM NUMBER] with clear plastic trash bags in the top drawer, a blood pressure cuff in the middle drawer, and no other PPE in the cart; 1 cart was placed outside of room [ROOM NUMBER] with a blood pressure cuff in the top drawer, and no other PPE in the cart. Borderland Unit (recovered and negative residents) - At 7:46 A.M., there were 13 resident rooms with signs posted outside the door which indicated that the room had a resident(s) on droplet and contact precautions. There were 3 precaution carts observed on the unit, 2 of which lacked adequate PPE to care for residents on droplet precautions: 1 cart was placed across from room [ROOM NUMBER] that contained a blood pressure cuff in the top drawer, gowns in the middle drawer, and no other; 1 cart was placed outside room [ROOM NUMBER] that contained gowns in the top drawer, gloves in the middle drawer, and no other PPE; blood pressure cuff in the top drawer, disposable gowns in the middle drawer, and no gloves or eye protection. Therapy Gym - At 7:55 A.M., Rehab staff #1 and Rehab staff #2 were observed seated at desks talking to each other. Neither one of the staff were wearing face masks, or eye protection as required. Ames Unit (all residents on 14-day quarantine) -At 7:55 A.M., there were 12 resident rooms with signs posted outside the door which indicated that the room had a resident(s) on droplet and contact precautions. There were 3 precaution carts observed on the unit, 3 of which lacked appropriate PPE to care for residents on precautions: 1 cart was placed in-between rooms #110 and #111, was empty and contained no PPE; 1 cart was placed outside rooms #114 and #115, was empty and contained no PPE; 1 cart was placed outside room [ROOM NUMBER] and contained gloves in the top drawer. There was no other PPE in the precaution cart. - The Ames Unit had a donning/doffing room (unit bathroom), but the room contained no PPE, just a trash bin to dispose of PPE, and cleaning solution for sanitizing eye protection, and soap for handwashing. - At 8:00 A.M., CNA #2 was observed to be wearing a N95 mask with the top strap secured on crown of her head, and the bottom strap hanging loosely in front of her neck and not tied at the base of neck, which created a gap between her lower face and the mask. The CNA donned a gown and gloves, then entered a resident's room. -At 8:02 A.M., Nurse #3 was observed at the medication cart wearing a N95 mask with the top strap secured on crown of her head, and the bottom strap hanging loosely in front of her neck and not tied at the base of neck, which created a gap between her lower face and the mask. 3. Review of the CDC's Testing Guidelines for Nursing Homes (7/21/20) included the following: -A single new case of [DIAGNOSES REDACTED]-CoV-2 infection in any HCP or a nursing home-onset [DIAGNOSES REDACTED]-CoV-2 infection in a resident should be considered an outbreak. When one case is detected in a nursing home, there are often other residents and HCP who are infected with [DIAGNOSES REDACTED]-CoV-2 who can continue to spread the infection, even if they are asymptomatic. -Performing [MEDICAL CONDITION] testing of all residents as soon as there is a new confirmed case in the facility will identify infected residents quickly, in order to assist in their clinical management and allow rapid implementation of IPC (Infection Prevention and Control) interventions (e.g., isolation, cohorting, use of personal protective equipment) to prevent [DIAGNOSES REDACTED]-CoV-2 transmission. Review of the facility's policy, Coronavirus Surveillance (last revised 6/9/20), included the following: - Baseline and Surveillance Testing - If the facility has one or more new positive staff members, the facility is required to one time re-testing of all residents by July 30th, 2020 During interview with the Infection Control Preventionist (ICP) at 8:55 A.M., and subsequent interview at 12:15 P.M., she said that staff are to wear face masks appropriately and eye protection at all times in the building. She said that each of the 3 PPE Coaches (1 for each shift) are responsible for ensuring each precaution cart is stocked with adequate PPE, which is stored in the Administrator's office and locked. It is not accessible until the Administrator is in the building. The IPC said that during baseline staff testing for COVID-19, 2 staff members tested positive for COVID-19. A Certified Nursing Assistant (CNA) was tested on [DATE], and received a positive result on 7/24/20, and a per diem Rehabilitation Therapy staff was tested on [DATE], and received a positive result on 7/28/20. The ICP said that as a result of the positive staff tests, all negative residents in the facility were re-tested for COVID-19, with the exception of residents on the Ames Unit (quarantine unit). She said that because the residents had been tested at the hospital prior to admission, they did not need to be tested again. Review of resident census on the Ames Unit from 7/24/20 to 7/28/20, indicated that 13 residents on the Ames unit should have been re-rested for COVID-19 following positive results of baseline testing for 2 staff as required.