STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225357	A. BUILDING _____ B. WING _____	07/30/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WINCHESTER NURSING CENTER, INC	**223 SWANTON STREET WINCHESTER, MA 01890**

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, interview and Center for Disease Control (CDC) review, the facility 1) failed to ensure that protective gowns were changed in between caring for Covid 19 negative patients to reduce the risk of asymptomatic spread of [MEDICAL CONDITION] on 3 of 4 nursing units, 2) failed to ensure that protective gowns were worn according to facility transmission based precaution policy on 1 of 4 nursing units and 3) failed to ensure that gowns were donned and doffed (put on and off) in a manner to minimize the risk of infection on 1 of 4 nursing units. Findings include: Review of the Centers for Disease Control website (www.cdc.gov), page titled Strategies for Optimizing the Supply of Isolation Gowns, updated on March 17, 2020, indicated the following: - Consideration can be made to extend the use of isolation gowns (disposable or cloth) such that the same gown is worn by the same HCP when interacting with more than one patient known to be infected with the same infectious disease when these patients housed in the same location (i.e., COVID-19 patients residing in an isolation cohort). 1) The facility failed to ensure that protective gowns were changed in between caring for Covid 19 negative patients to reduce the risk of asymptomatic spread of [MEDICAL CONDITION] on 3 of 4 nursing units. During an interview with the Director of Nursing and the Administrator on 7/30/20 at 9:00 A.M., they said that on unit A the facility was caring for 17 residents that were negative for Covid 19, B units was caring for 30 residents that were negative for Covid 19 and C unit was caring for 34 residents that were negative for Covid 19. The said staff should be wearing full personal protective equipment (PPE), (mask, eye protection, gown and gloves) when caring for a resident that was negative for Covid 19, but did not need to change PPE in between residents. During an interview with Nurse #1 on 7/30/20, at 9:40 A.M., she said that all of the residents on B unit were Covid 19 negative or recovered. She said that staff wear the same gown for the entire shift. On 7/30/20 at 9:45 A.M., the surveyor observed Certified Nursing Assistant (CNA) #1 providing care to a resident in room B10. CNA #1 exited the room without removing her protective gown. During an interview at that time CNA #1 said that the resident in B 10 was negative for Covid 19 and she had provided bathing, dressing, grooming assistance. She said she did not need to change her gown during her shift unless she was leaving the unit for a break. On 7/30/20 at 10:10 A.M., the surveyor observed CNA #2 providing care in room A 9. CNA #2 exited the room without removing her protective gown. During an interview with CNA #2 on 7/30/20 at 10:18 A.M., she said that she provided care to 8 residents wearing the same PPE. She said they were all Covid 19 negative so she only needed to change her gown if she was leaving the unit. During an interview with Nurse # 2 on 7/30/20, at 10:25 A.M., she said that all of the residents were negative on the A unit so gowns were only changed at the start and end of the shift. During an interview with CNA #3 on 7/30/20, at 10:25 A.M., she said that she had cared for 4 residents that were Covid 19 negative on her assignment wearing the same gown. She said that she only needed to change her gown if the resident refused to wear a mask. During an interview with Nurse #3 on 7/30/20, at 10:29 A.M., she said that gowns should be changed between caring for residents that were Covid 19 negative. 2) The facility failed to ensure that protective gowns were worn according to facility transmission based precaution policy on 1 of 4 nursing units. On 7/30/20, at 9:20 A.M., the surveyor observed Nurse #1 in the hallway outside of room B 16 wearing a protective gown. She donned a second protective gown and entered the room to assist with personal care of the resident. During an interview with Nurse #1 on 7/30/20, at 9:40 A.M., she said that all of the residents on the unit were Covid 19 negative so she does not need to change her gown in between patients. She said that the resident in room B 16 also has another infection that requires contact precautions ([MEDICAL CONDITION]-resistant staphylococcus aureus(MRSA)) so staff is to use another gown over the existing gown when caring for that resident. During an interview with Nurse #4 on 7/30/20 at 10:45 A.M., she said that staff should never double gown. During an interview with the Director of Nursing on 7/30/20 at 1:05 P.M., she said that there is no written policy, but staff should never double gown. 3) The facility failed to ensure that gowns were donned and doffed (put on and off) in a manner to minimize the risk of infection on 1 of 4 nursing units. Review of the CDC website, page titled, Using Personal Protective Equipment (PPE), updated July 14, 2020, indicated hands are sanitized before putting on a gown. On 7/30/20, at 10:48 A.M., the surveyor observed CNA #4 outside of room D 4 remove her gown by using bare hands on the outside of the arms to remove the sleeves and then bare hands on the outside of the gown to remove the gown over her head. Contaminating her hands. Without performing hand hygiene CNA #4 put on another gown and entered the room and ambulated the resident to the bathroom. During an interview with CNA #4 on 7/30/20 at 10:49 A.M., she said that she had been trained to not touch the outside of the gown during removal and to sanitize her hands before putting on a new gown, but because the resident was already up and walking to the bathroom she wanted to assist the resident quickly and didn't.

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.