STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225499	A. BUILDING _____ B. WING _____	**07/29/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WEST ROXBURY HEALTH & REHABILITATION CENTER	**5060 WASHINGTON STREET WEST ROXBURY, MA 02132**

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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record review the facility failed to ensure that infection control practices were followed for a newly admitted resident (#1) on droplet precautions. In addition staff were observed to not wear masks while in residential areas. There were nineteen Residents in the facility who had never tested positive for COVID-19 and therefore susceptible to infection. Findings include: 1. A review of the Center for Disease Control and Prevention (CDC) guidance dated 4/30/20 indicated Newly admitted or readmitted residents should still be monitored for evidence of COVID-19 for 14 days after admission and cared for using all recommended COVID-19 PPE (personal protective equipment). A review of the facility policy on isolation/precautions after admission or readmitted d 4/5/20 (revised 5/19/20) indicated all new or readmitted residents would be placed on droplet precautions for the first 14 days. Resident #1 was admitted to the facility on [DATE] from the hospital. During an interview on 7/29/20 at 10:10 A.M. the Infection Preventionist said Resident #1 was the only resident currently on droplet precautions having been admitted to the facility within the previous 14 days. On 7/29/20 at 10:50 A.M. the surveyor observed a precaution cart outside of the door of Resident #1 and lime green signs on the wall indicating droplet precautions. On 7/29/20 at 11:05 A.M. rehabilitation staff #1 was observed to bring Resident #1 to his/her room in a wheelchair. Rehabilitation staff #1 assisted Resident #1 from the wheelchair to bed and then proceeded to leave the room. Rehabilitation staff #1 was wearing a lab coat, which was open in the front, a face shield and a mask. The staff member did not doff her PPE when she exited the Resident's room. On 7/29/20 at 11:15 A.M. the physician of Resident #1 was observed to enter the Resident's room. The physician was wearing an open lab coat, personal eye glasses and a face mask. The physician was not observed to put a disposable gown on, gloves on, or eye protection prior to entering the Resident's room. The physician was observed to sit on the empty bed in the Resident's room and use the over the bed table to lean on while talking to the Resident. The physician left the Resident's room and was not observed to change out of his lab coat and did not perform hand hygiene and walked to the nurses station on the unit. During an interview on 7/29/20 at 11:18 A.M. the physician of Resident #1 said he did not know Resident #1 was on droplet precautions due to being recently admitted to the facility. On 7/29/20 at 11:35 A.M. the Director of Social Services was observed to enter the room of Resident #1 wearing a lab coat, a face mask and personal eye glasses. The Director of Social Services was not observed to donn a disposable gown, eye protection, or gloves. The Director of Social Services was observed to be utilizing the over the bed table in the room of Resident #1 to fill out paperwork. She was observed to leave the room of Resident #1, did not perform hand hygiene and did not remove her lab coat. On 7/29/20 at 2:25 P.M. Certified Nursing Assistant (CNA) #1 was observed to entering the room of Resident #1. CNA #1 was wearing a face mask, a lab coat, and a face shield. CNA #1 was observed to put on gloves prior to entering the room of Resident #1. CNA #1 was observed to then leave the room of Resident #1, did not doff her lab coat, and did not remove her gloves. With the same gloves on, she was observed to walk down the hall, to the kitchenette, leave the kitchenette, grab a trash bag from a roll placed inside a hand rail and then return to the room of Resident #1. At no point during this did CNA #1 remove her gloves and perform hand hygiene. 2. A review of the Center for Disease Control guidance for nursing homes dated 6/25/20 indicated HCP (Healthcare Personnel) should wear a facemask at all times while they are in the facility. The following observations were made throughout the day, on 7/29/20, of staff not wearing a facemask to cover their mouth and nose. - At 11:00 A.M. Certified Nursing Assistant (CNA) #2 was observed to come out of room [ROOM NUMBER] with her mask on her chin, not covering her mouth or nose - At 11:05 A.M. the housekeeper was observed in the hall on the Ripley unit with her mask covering her mouth and not her nose. The housekeeper walked by Nurse #1 who did not offer correction of mask placement. -At 12:35 P.M. CNAs #1, #2, and #3 were observed to be in the hallway on the Ripley unit. They were in a residential hall between rooms #304 and 305. All 3 CNAs were observed to have their masks pulled down on their chins, not covering their mouth or nose. CNA #2 was observed to be drinking from a styrofoam cup. CNA #1 was observed to open a mini can of soda and start drinking from it. During interview, the CNAs said there was a break room down stairs and that they usually took lunch around 1:00 P.M. or 1:30 P.M. The CNAs said they were taking a drink and removing their masks because they were hot. -At 12:45 P.M. CNA #1 was observed to enter room [ROOM NUMBER] (with 4 residents who never tested positive for COVID-19) with her mask on her chin. - At 1:05 P.M. CNA #4 was observed in the hall on the Hawthorne Unit with her mask under her nose. She walked by the Director of Nurses who did not intervene to correct the mask placement.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE