STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225532	A. BUILDING _____ B. WING _____	07/08/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MATTAPAN HEALTH & REHABILITATION CENTER	**405 RIVER STREET MATTAPAN, MA 02126**

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, record review, and interviews the facility failed to ensure that proper infection control practices were followed based on guidance from the Center for Disease Control and Prevention. The facility failed to confirm the status of a resident who tested positive for COVID-19 (Resident #1) and implement appropriate infection control practices for a COVID-19 positive resident. The facility also failed to follow infection control practices as evidenced by wearing PPE masks on chin, carrying PPE (Personal Protective Equipment) gown on arm, and not using EPA approved chemicals to clean eye protection. In addition, the facility failed to include symptoms as part of the infection control surveillance for COVID-19. Findings include: 1. Resident #1 was admitted to the facility in May 2019 with a [DIAGNOSES REDACTED]. A review of the medical record indicated on 6/11/20 Resident #1 experienced a change in mental status and was sent to the hospital. The medical record indicated Resident #1 returned to the facility on [DATE] and was placed on quarantine for 14 days due to being readmitted as per CDC guidance. During an interview on 7/8/20 at 10:20 A.M. the Infection Control Preventionist said when Resident #1 was readmitted from the hospital, the facility staff had thought the hospital made a mistake in noting a positive COVID-19 test result and did not think the resident was positive. The Infection Control Preventionist said the facility received the COVID-19 test results approximately 10 days after re-admission. He said Resident #1 continued to be at the status of COVID-19 positive during this interview. A review of the hospital discharge summary dated 6/16/20 indicated Resident #1 tested positive for COVID-19. A review of the nursing progress notes does not indicate a COVID-19 positive status until 7/2/20 (16 days after re-admission). During an interview on 7/8/20 at 1:45 P.M. the Director of Nurses said the staff thought the hospital had incorrect information regarding the COVID-19 status of Resident #1. She said the facility staff called the hospital on [DATE] (14 days after re-admission) for clarification of COVID-19 status and was informed Resident #1 tested positive for COVID-19 on 6/12/20. She said she was not sure why the facility had not obtained clarification when Resident #1 was readmitted to the facility. The Director of Nurses said Resident #1 was currently at the status of COVID-19 positive and would not be moved to the status of recovered' until the information was reviewed by a physician. On 7/8/20 at 11:05 A.M. Certified Nursing Assistant (CNA) #1 was observed to bring Resident #1 in a geri-chair approximately 20 feet down the hall to the elevator. Resident #1 was not wearing a mask. CNA #1 was observed to be wearing a mask, face shield, and was not wearing a gown. At the elevator, CNA #1 placed a mask on Resident #1. The surveyor inquired to CNA#1 where she was taking Resident #1. CNA #1 said she was bringing Resident #1 downstairs for a family visit. Department of Public Health Memorandums regarding visitation dated 6/1/20 and 7/2/20 indicated: A resident who is suspected or confirmed to be infected with COVID-19 cannot be visited. A review of the medical record for Resident #1 indicated Resident #1 was visited by family on 6/17/20, 6/30/20 and 7/8/20. During an interview on 7/8/20 at 1:45 P.M. the Director of Nurses confirmed that COVID-19 positive residents should not have visitation and she was not sure why Resident #1 had visits. On 7/8/20 at 11:55 A.M. CNA #1 and Nurse #1 were observed to be exiting the room of Resident #1 with a mechanical lift. CNA #1 was observed to doff her gown and gloves and perform hand hygiene. CNA#1 was not observed to remove and clean eye protection. CNA #1 was then observed to bring the mechanical lift in to the hall. An ambulatory resident walked up to the mechanical lift and placed his/her hand on the top bar. CNA #1 encouraged the resident to keep walking, no hand hygiene was offered to this ambulatory resident. CNA #1 then took a paper towel and added hand sanitizer and was observed to wipe down the handle (where staff maneuver the mechanical lift), no other parts of the mechanical lift were sanitized after leaving the room of a COVID-19 positive resident. During an interview on 7/8/20 at 12:00 P.M. CNA #1 said she had assisted Resident #1 in getting out of bed, getting dressed, going to see family, feeding and then putting the Resident back to bed. CNA #1 was asked about cleaning her face shield after placing Resident #1 back in bed. CNA #1 said she had previously been in the room a long time and had cleaned the face shield the prior time she had left the room, but did not clean it after putting the COVID-19 positive resident to bed. 2. CDC guidance indicated Health Care Personnel should wear a facemask at all times while they are in the facility. On 7/8/20 at 9:30 A.M. CNA #2 was observed to be walking down the hallway of the resident unit on the 2nd floor. CNA #2 was observed to not have her face mask covering her mouth, the mask was pulled down to her chin. CNA #3 was observed at 9:31 A.M. to not have her face mask covering her mouth, the mask was pulled down to her chin. CNA #2 and CNA #3 were observed to go in to the kitchenette on the 2nd floor unit, the kitchenette standing room was approximately 3 feet by 4 feet. Both CNAs were observed to come out of the kitchenette with their masks on their chins. The CNAs were observed to walk past two nurses, neither nurse intervened. During an interview on 7/8/20 at 9:33 A.M. CNA #3 was speaking with the surveyor with her mask on her chin and then continued down the resident hall with her mask on her chin. 3. During an interview on 7/8/20 at 8:30 A.M. the Infection Control Preventionist said the facility was operating under full Personal Protective Equipment (PPE) for all resident areas. He said there was a donning area on the stairwell on the 2nd floor for gowns, masks, eye protection. He said there were doffing areas on both units for staff. He said the elevators, the stairwells and the ground floor were considered clean areas and PPE (aside from masks) were not to be worn. On 7/8/20 at 9:35 A.M. CNA #2 was observed to take her gown off in the hallway between the elevator and the nurses station (not near the doffing room), place the gown over her arm, push a food cart into the elevator and leave the unit. At 9:40 A.M. CNA #2 was observed to return on the elevator with an empty food cart and her gown still placed over her arm. CNA #2 was observed to donn the gown in the hallway between the elevator and the nurses station. No hand hygiene was observed during this time. 4. CDC guidance indicated Health Care Personnel should be reprocessed any time it needs to be removed (such as leaving the unit). The CDC guidance indicated the outside of the eye protection (faceshield or goggles) should be carefully wiped down with an EPA-registered hospital disinfectant. The 2nd floor designated doffing room was observed on 7/8/20 at 9:45 A.M. The doffing area contained two bins, one indicated for disposable PPE and the other indicated for PPE that could be laundered. The room did not contain hand sanitizer or any disinfectant. On 7/8/20 at 12:00 P.M. CNA #1 said she cleans her faceshield with hand sanitizer when she removes it. A review of the EPA-registered hospital disinfectant list does not include hand sanitizer for cleaning face shields. On 7/8/20 at 12:50 P.M. CNA #4 said she cleans her goggles with small square alcohol swabs, she said this usually takes about 3 seconds to dry. She then puts her goggles in to a plastic bag and takes them home. A review of the CDC EPA-registered disinfectants indicated that [MEDICATION NAME] alcohol has a recommended contact time of 5 minutes to [MEDICAL CONDITION]. 5. A review of the facility infection surveillance tracking, titled: Infection Control Reporting was conducted. The information provided to the surveyor was for tracking each resident in the facility who had been tested for COVID-19. The Infection Control Reporting form had a column to indicate if the resident had symptoms and another column to indicate what the symptoms were. The form failed to include any documented symptom information for any resident. During an interview on 7/8/20 at 1:25 P.M. the Infection Control Preventionist said he did not know why the form did not have the resident symptoms listed as part of the surveillance. He said the Director of Nurses was responsible for the form. During an interview on 7/8/20 at 1:45 P.M. the Director of Nurses said the facility should have been tracking the symptoms of residents on the Infection Control Reporting form, but the information was not tracked for surveillance.

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.

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