STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225110	A. BUILDING _____ B. WING _____	**06/17/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SOLDIERS HOME IN MASSACHUSETTS	**91 CREST AVENUE CHELSEA, MA 02150**

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 observations and interviews, the facility staff failed to appropriately don facemasks while in resident care areas and while providing care. Findings include: Review of The Centers for Disease Control (CDC) guidance, updated 5/18/20, indicated that all health care providers should wear a facemask at all times while they are in the healthcare facility. Review of the facility's Personal Protective Equipment (PPE) Policy, dated 4/21/20, indicated that all health care personnel should don facemasks prior to entering the facility and must be worn at all times while inside the facility. On 6/17/20 at 10:00 A.M., the surveyor and Nurse Supervisor #1 entered the 3 Central ward and observed a CNA seated in the corner of the resident care area with her facemask resting below her chin exposing her nose and mouth. The CNA told Nurse Supervisor #1 that the facemask was bothering her allergies [REDACTED]. Upon seeing the surveyor, the CNA fixed his facemask to cover his nose and mouth and continued to give care to the resident. During an interview with Nurse Supervisor #1 on 6/17/20 at 10:10 A.M., she said that staff should not remove their masks at any time while in a resident care area to prevent possible transmission of Covid-19.

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