STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225133	A. BUILDING _____ B. WING _____	07/06/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BLUEBERRY HILL REHABILITATION AND HEALTHCARE CTR	**75 BRIMBAL AVENUE BEVERLY, MA 01915**

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 record review the facility failed to maintain infection control standards to prevent the further spread of COVID -19 in the facility. Findings include: Review of the facility policy titled Personal Protective Equipment-Using Gowns and dated March 2016, indicated that when removing a gown touch the inside of the gown only to prevent self contamination. Review of the facility policy titled Handwashing/Hand Hygiene dated revised October 2016, indicated that hand hygiene is to be performed before donning and after removing gloves. During inspection of the(NAME)unit (residents that have never had COVID-19) on 7/6/20, at 9:33 A.M., the surveyor observed Certified nurse's aide (CNA) doff her gown without gloves on, touching the outside of the sleeves to pull them off of her arms and remove the gown. CNA then exited the unit without performing hand hygiene (HH). During an interview on 7/6/20, at 9:36 A.M., CNA #1 said that she should not have touched the outside of her contaminated gown and she forgot to perform HH before exiting the unit. During inspection of the Cabot unit (residents with active COVID-19) on 7/6/20, at 10:41 A.M., the surveyor observed a female housekeeper exit room [ROOM NUMBER] doff her gloves and don new gloves without performing HH and therefor contaminating them. She then re-entered room [ROOM NUMBER] and touched items in the resident's environment with her contaminated gloves. During inspection of the Cabot unit on 7/6/20, at 10:53 A.M., the surveyor observed a male housekeeper enter room [ROOM NUMBER] (a room with a COVID-19 positive resident) without Personal Protective Equipment (PPE) on. He then entered the resident's bathroom, removed a garbage bag and exited the unit through the plastic barrier without donning PPE or performing HH. During inspection of the Cabot unit on 7/6/20, at 10:54 A.M., the surveyor observed Therapist #1 removed a clean gown from a basket dropping another clean gown on the floor, contaminating it. Therapist #1 then picked up the contaminated gown and placed it on top of the basket containing the remainder of the clean gowns. During an interview on 7/6/20, at 10:54 A.M., Therapist #1 said that it was an honest mistake and he did not realize he had contaminated all the remaining gowns by placing the contaminated gown on top of the clean ones. The surveyor then observed Therapist #1 walk down the hallway without removing the contaminated gowns from the clean supply of PPE. The surveyor then observed 2 nurses enter the PPE donning area and reach for the contaminated gowns before the surveyor informed them that the gowns had been contaminated. During inspection of the Cabot on 7/6/20, at 11:54 A.M., the surveyor observed a housekeeper exit room [ROOM NUMBER], remove her gloves and attempt to use sanitizer from a wall dispenser but found that it was empty. She then walked all the way down the hall to the housekeeping closet, passing 3 full wall sanitizer dispensers and 3 bottles of hand sanitizer on top of carts. The housekeeper, without performing hand hygiene, obtained a set of keys from her pants pocket, opened the housekeeping closet, contaminating the door handle and walked back down the hall to place the sanitizer refill in the dispenser, contaminating it. During inspection of the Balch unit (residents with active COVID-19) on 7/6/20, at 1:42 P.M., the surveyor observed a staff member in room [ROOM NUMBER] assisting a resident in bed without gloves on. The surveyor then observed a male housekeeper exit the unit through closed double doors, pulling a trash cart while wearing gloves. The male housekeeper then entered the(NAME)unit without changing gloves or performing hand hygiene.

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