STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225423	A. BUILDING _____ B. WING _____	09/09/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SAVOY NURSING & REHAB CTR	670 COUNTY STREET NEW BEDFORD, MA 02740

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and medical record review, the facility failed to develop a comprehensive care plan consistent with the Resident's goals for the continued use of an indwelling Foley catheter, for one Resident (Resident #4), from a total sample of 4 residents. Findings include: Resident #4 was admitted to the facility in July, 2020, following a hospitalization for a right ankle fracture, status [REDACTED]. The Resident was admitted for short term rehabilitation to strengthen the previously fractured right ankle. On 9/9/20 at 10:30 A.M., the surveyor interviewed Resident #4 in his/her room. The surveyor observed the Resident in bed with a Foley catheter bag hanging off the side of the bed draining light yellow urine. The surveyor asked the Resident why he/she had a Foley catheter. The Resident said I think it was because I had an infection in the hospital. The Resident said that he/she had finished the antibiotics for a urinary tract infection. The surveyor asked if the doctor or staff had discussed a plan about possibly removing the catheter to see if he/she could urinate independently. The Resident said that he/she had not discussed a plan for a voiding trial or removal of the Foley catheter. The surveyor asked the Resident if he/she could urinate independently before the hospitalization . The Resident said yes. Review of the Minimum Data Set (MDS Section I, -) indicated that the Resident has no medical [DIAGNOSES REDACTED]. The Resident's Brief Interview for Mental Status indicated 11, which indicated moderate cognitive impairment. The MDS did not rate urinary continence prior to admission because the Resident was admitted with a catheter in place. The MDS (H0200) also indicated that there is no urinary toileting program During an interview with the Infection Preventionist (IP) on 9/9/20 at 11:00 A.M., she said that she could not print Resident #4's care plan due to a computer issue. The surveyor observed the care plan in the computer system with the IP. The surveyor observed a care plan for the care of a Foley catheter with a creation date of 9/9/20 or the date of the survey (2 months after admitted).
F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and medical record review, the facility failed to ensure that one Resident (Resident #4), admitted with an indwelling Foley catheter and previously continent for bladder function, was assessed for removal as soon as possible, from a total sample of 4 residents. Resident #4 did not have a documented medical [DIAGNOSES REDACTED]. Findings include: Resident #4 was admitted to the facility in July,2020, following a hospitalization for a right ankle fracture, status [REDACTED]. The Resident was admitted for short term rehabilitation to strengthen the previously fractured right ankle. On 9/9/20 at 10:30 A.M., the surveyor interviewed Resident #4 in his/her room. The surveyor observed the Resident in bed with a Foley catheter bag draining light yellow urine. The surveyor asked the Resident why he/she had a Foley catheter. The Resident said I think it was because I had an infection in the hospital. The Resident said that he/she had finished the antibiotics for a urinary tract infection. The surveyor asked if the doctor or staff had discussed a plan about possibly removing the catheter to see if he/she could urinate independently. The Resident said that he/she had not discussed a plan for a voiding trial or removing the Foley catheter. The surveyor asked the Resident if he/she could urinate independently before the hospitalization . The Resident said yes. Review of the Admission Minimum Data Set (MDS Section I, -) indicates that the Resident has no urinary [DIAGNOSES REDACTED]. The Resident's Brief Interview for Mental Status (BIMS) indicated 11, which indicated moderate cognitive impairment. The MDS did not rate urinary continence prior to admission because the Resident was admitted with a catheter in place. The MDS (H0200) also indicated that there is no urinary toileting program. Review of the physician's orders [REDACTED]. On 7/15/20, an order indicated to record urine output and PO (by mouth) intake. The surveyor requested all of the physician's notes since admission. Review of the only Physician's Note dated 8/27/20 for [MEDICAL CONDITION] (at the request of nursing) indicates the following review of systems under urinary: no nocturia (or urinary frequency at night), no burning on urination and no dribbling (Resident #4 had an indwelling at the time of the exam). The only physician's note since admission does not indicate that the Resident had a Foley catheter or a plan of care to remove the catheter or begin a trial urinary toileting program.
F 0711 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and medical record review, the physician failed to include written orders for the continued use of an indwelling urinary catheter, failed to sign medical orders, and failed to evaluate the medical necessity for the continued use of the catheter for one Resident, #4, from a total sample of 4 residents. Findings include: Resident #4 was observed to have an indwelling Foley catheter (a thin tube inserted into the bladder to drain urine into a drainage bag). The surveyor asked the Resident why he/she had a Foley catheter. The Resident said I think it was because I had an infection in the hospital. The Resident said that he/she had finished the antibiotics for a urinary tract infection. Review of the physician's orders [REDACTED]. On 7/15/20, an order indicated to record urine output and PO (by mouth) intake. The physician's orders [REDACTED]. The surveyor requested all of the physician's notes and orders since admission. Review of the only Physician's Note dated 8/27/20 for [MEDICAL CONDITION] (at the request of nursing) indicates the following review of systems under urinary: no nocturia (or urinary frequency at night), no burning on urination and no dribbling (Resident #4 had an indwelling at the time of the exam). The only physician's note since admission does not indicate that the Resident had a Foley catheter or a plan of care to remove the catheter or begin a trial urinary toileting program.
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 and staff interview, the facility failed during the Covid-19 pandemic, 1. to follow the Centers for Disease and Prevention Center (CDC) guidelines for Healthcare personnel by not assessing personnel for signs and symptoms of Covid-19 when entering the facility, 2. the facility failed to have established protocols and/or policy for the screening process of staff or visitors when entering the facility and, 3. failed to develop and implement a policy for environmental cleaning to prevent transmission of COVID-19 virus. Findings include: 1. A Focused Infection Control survey

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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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) was conducted on 9/9/20, for this 39 bed facility with 15 positive cases of Covid-19 in the facility and another four residents in the hospital with Covid-19. The CDC guidelines for Healthcare Personnel During the Coronavirus Disease 2019 Pandemic Infection Control, updated July 15, 2020, indicates the practice of screening and triage everyone entering a Healthcare facility for signs and symptoms of Covid-19. The CDC indicated to screen everyone (patients, visitors, Healthcare personnel and visitors) entering the facility for symptoms consistent with Covid-19 or exposure to others with [DIAGNOSES REDACTED]-CoV-2 infection and ensure they are [MEDICATION NAME] source control. The CDC summary indicates to actively take the temperature and document absence or presence of symptoms consistent with Covid-19 of all staff and visitors. The survey team entered the facility on 9/9/20 at 6:35 A.M., through the designated side door and walked into a stairwell, with stairs going up and down. The surveyors observed two staff enter and walk to the lower level. The surveyor followed and observed staff using the time clock and obtaining eye protection. No screening had been done when first entering the building or in the lower level. The survey team walked onto the first floor, a resident care area with resident rooms by the door, there was no person to screen the team. After standing there a few minutes, SN #1 came to the enclosed nurse's station and asked for our names and than took our temperatures. The nurse never asked us any questions of having signs and symptoms of illness for Covid-19. SN #4 was observed to enter the first floor at 7:00 A.M., looked at nurse's station, found no nurse and went back outside. The nurse re-entered at 7:04 A.M. and was observed to have his temperature taken by SN #1. During interview was SN #4 said he was screened for signs and symptoms of Covid-19. A review of the facility's Visitors/Staff Assessment for Covid-19 form that was to be used when personnel enter for work and for visitors indicated the designated screener was to ask the following: - The person's name, date and time of entry - take their temperature - Have you had any of the following? 1.) Signs and symptoms of respiratory illness, 2.) In the last 14 days have you had any contact with someone with a confirmed case of Covid-19 or are under investigation for Covid-19? 3.) Have you or someone you know traveled internationally to a country with sustained community based transmission in the last 14 days? 4.) Do you live in a community which has had an increase in respiratory symptoms or where community based spread of Covid-19 is occurring? and 5.) Have you had a recent loss of smell or taste? - Signature of screener \ - Visitor/staff cleared? With a yes or no answer. A review of screening forms revealed three forms, one with each surveyors name on it, and the form was completed. The survey team was never asked any questions. For question 2 the screener answered yes for each of us which was, in the last 14 days have you had any contact with someone with a confirmed case of Covid-19 or are under investigation for Covid-19? The nurse never questioned the surveyors to assess our medical clearance to enter the facility. A Housekeeper's form had a time of 6:40 A.M. with a temperature written but was not signed by a screener and none of the screening questions had been answered. The survey team had been waiting to be screened at the same time of the Housekeeper form being completed and had not seen the housekeeper screened. The Director of Nurses was asked at 9:20 A.M. for the facility's protocols or policy on the screening of Healthcare workers and/or visitors. The Nurse Manager (the key personnel list identifies her as the scheduler) shares the Infection Preventionist role with the Director of Nurse. During interview at 9:40 A.M., the Nurse Manager said that she could not locate any policy for protocols for the screening process. She said she had done an inservice regarding that process. A review of the education record the Nurse Manager had done on 6/17/20, for screening staff and visitors for taking temperatures and questioning them for signs and symptoms of Covid-19. The education attendees did not include SN #1 as having been at that training. There were no other educational trainings for the screening process to review after 6/17/20. During interview on 9/9/20 at 10:30 A.M., the Nurse Manager said, the nurse did not follow the correct way to screen people coming in. The surveyors reviewed the log book and showed her the completed forms the nurse had done without asking the surveyors any questions. We also reviewed the record for the Housekeeper that was not completed and questions were left blank. 2. Based on observation, interview and documentation review, the facility failed to ensure that a policy and system for environmental cleaning was implemented and monitored to help prevent the potential for further transmission of infection during a COVID-19 (Coronavirus) outbreak. Findings include: (COVID-19 is a highly contagious virus which is spread from person to person through droplets released into the air when an infected person coughs or sneezes. It is also transmitted by touching environmental surfaces.) The Center's for Disease Control (CDC) Best Practice for Environmental Cleaning in Health Care Facilities (April 21, 2020), indicates the following: every facility should develop cleaning schedules, including: identifying the person responsible the frequency the method (product, process) detailed SOPs for environmental cleaning of surfaces and non-critical equipment in every type of patient care area. Checklists and other job aids are also required to ensure that cleaning is thorough and effective. On 9/9/20 at 10:00 A.M., the surveyor observed the housekeeper cleaning a resident room, which had a droplet precaution sign posted on the door. The housekeeper had a bucket and mop and was cleaning the floors. At 10:08 A.M., the surveyor interviewed the housekeeper and asked which products were used to clean rooms during the COVID-19 outbreak. The housekeeper brought the surveyor to the janitor's closet where the surveyor observed a jug of Oasis 100 floor cleaner. The housekeeper said that she cleaned the floors with the product. The housekeeper did not know if the product was effective against COVID-19 and said that she tried to clean every room everyday, but would sometimes get called away to clean up other accidents and did not always get to clean every room (15 resident rooms in total on 2 separate floors). Review of the (CDC) List N: Disinfectants for Use Against [DIAGNOSES REDACTED]-CoV-2 (COVID-19) does not include the Oasis 100 cleaning product currently being used during the COVID-19 outbreak. All products on this list meet EPA's criteria for use against [DIAGNOSES REDACTED]-CoV-2, [MEDICAL CONDITION] that causes COVID-19. The surveyor also observed a spray bottle with a handwritten label which indicated bleach, with no date or time. The housekeeper said that she used this bleach spray to disinfect high touch items, such as bedside tables, bed rails and bathrooms. The housekeeper said that she did not know the exact bleach to water ratio, as per the manufacturer's directions for use and was just guessing at the amount of bleach. She said that she did not know how long the homemade bleach spray was effective, but tried to change it every few days. (According to the manufacturer's directions for the bleach, homemade bleach cleaning solutions should be discarded and remade after 24 hours to be effective. The manufacturer's directions for use also recommends following the CDC's table for proper percentage of sodium Hypochlorite/bleach). The surveyor asked to see the housekeeper's assignment and cleaning schedule. The housekeeper did not have a schedule or job aide with instructions on which rooms to clean first (based on transmission based precautions), which cleaning products were appropriate for COVID-19 or how frequently to change the mop bucket cleaning solution. The housekeeper said that she cleaned the COVID-19 positive rooms first, followed by the COVID-19 negative resident rooms (or incorrectly from a highly contaminated room to a less contaminated room and with susceptible residents. The CDC Best Practice for Environmental Cleaning in Health Care Facilities, April 21, 2020, bullet 4.1 indicates Proceed from cleaner to dirtier areas to avoid spreading dirt and microorganisms. The housekeeper said that she cleaned the COVID positive rooms first because she said, they were most important. (Negative residents are residents who have never tested positive for COVID-19 and are therefore, susceptible to [MEDICAL CONDITION]). The housekeeper also said that she changes the mop bucket cleaning solution every few rooms, but could not explain the process because there was no documented in-servicing or cleaning program. The surveyor asked the housekeeper who she reported to for her daily assignment, responsibilities and training. She said that she reported to the person that hired her who was an administrative assistant with no infection control background. On 9/9/20 at 12:00 P.M., the surveyor interviewed the Infection Preventionist (IP). The IP said that she did not know which products were on the CDC's List N for being effective against COVID-19 and was not aware that there was a list. The IP said that although she normally attends the Quality Assurance Performance Improvement (QAPI) meetings to discuss infection control, the last meeting was held in May and the scheduled August meeting was postponed by the Medical Director. The facility failed to develop a policy or process, according to the current CDC guidelines for training staff the appropriate environmental cleaning techniques and cleaning products during a COVID-19 outbreak. On 9/10/20 at 11:00 A.M., the surveyor interviewed the Director of Nursing by telephone. The Director confirmed that the person in charge of housekeeping and laundry was an administrative assistant with no background in infection control. She said that she had an informal talk with the housekeeper yesterday to start cleaning the negative rooms first and move to the COVID-19 positive rooms (as per to CDC guidelines).
F 0886 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	Based on observations and staff interviews, the facility failed during the Covid-19 pandemic, to follow the Centers for Medicaid & Medicare Services (CMS) requirement for Long-Term Care Facility Testing Requirements for Staff and Residents by not having established a policy and procedure for Residents and Staff who refuse Covid-19 testing. Additionally, the facility failed to correctly document the testing requirements for 15 residents who tested positive for Covid-19.

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F 0886 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) Findings include: During the entrance conference on 9/9/20 at 7:30 A.M., the Director of Nurses informed the survey team that the facility had 15 residents who had tested positive for Covid-19 and another four residents in the hospital with Covid-19. The Director of Nurses was asked for her documentation or surveillance log for the completed residents tested . The Centers for Medicaid & Medicare Services (CMS) requirement, dated 8/26/20, for Long-Term Care Facility Testing Requirements for Staff and Residents includes having an established procedure for Residents and Staff who refuse Covid-19 testing. The testing requirement indicates for symptomatic residents and staff, to document the date(s) and time(s) of the identification of signs and symptoms, when testing was conducted, when results were obtained, and the actions the facility took base on the results. The requirement indicated to have a procedure in place for addressing residents or staff who refuse testing or are unable to to be tested , document the refusal and how the facility will address those cases. The Director of Nurses provided a piece of paper with the residents' name and date the residents were tested . The testing was from 8/27/20 - 9/8/20. There was no other information on the list. The Director of Nurses said she was not aware of having to have the other information documented such as the signs and symptoms, results of the test, when those results were obtained and actions the facility put into place when results were received During interview with the Nurse Manager at 10:15 A.M. she said she looked for a policy for residents and staff who refuse Covid-19 testing and said there is not one. She explained that the facility's Owner/Administrator sent in a rough draft of a policy at 7:58 A.M. this morning, but it has not been reviewed and formatted to the facility's policies.