STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225430	A. BUILDING _____ B. WING _____	**07/28/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ST PATRICK'S MANOR	**863 CENTRAL STREET FRAMINGHAM, MA 01701**

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, staff interviews, review of the facility's infection control policies, review of the Center for Disease Control (CDC) and Department of Public Health (DPH) guidelines, the facility failed to implement proper infection control prevention and control practices. The facility failed to ensure that all staff used Personal Protective Equipment (PPE) appropriately and determined that staff were competent on how and when to wear gloves, wash hands, don and doff gowns, discard, extend and/or reuse gowns, appropriate use of face masks and cleaning of face shields. The facility population included five residents with a [DIAGNOSES REDACTED]. Findings include: Review of CDC infection control guidance, titled Using Personal Protective Equipment as it relates to steps in donning an isolation gown, dated July 14, 2020, included the following: - Step 1: Perform hand hygiene using hand sanitizer - Step 2: Put on isolation gown. Tie all of the ties on the gown Review of CDC guidance,titled Strategies for Optimizing the Supply of Eye Protection (reprocessing) dated July 15, 2020, and Strategies of Optimizing the Supply of Isolation Gowns, dated March 17, 2020, included the following: - While wearing gloves, carefully wipe the inside, followed by the outside of the face shield or goggles using a clean cloth saturated with neutral detergent solution or cleaner wipe - Carefully wipe the outside of the face shield or goggles using a wipe or clean cloth saturated with EPA-registered hospital disinfectant solution - Wipe the outside of face shield or goggles with clean water or alcohol to remove residue - Remove gloves and perform hand hygiene - Train healthcare personnel on PPE use and have them demonstrate competency with donning and doffing any PPE ensemble that is used to perform job responsibilities - Contingency capacity: Shift gown use towards cloth isolation gowns temporarily during periods of expected isolation gown shortages. Review of the facility's policy, Coronavirus (COVID 19), last revised 6/11/20, included the following: - Follow the state and federal guidelines if PPE are not available. On 7/28/20, observations of breaches in infection control practices, and inappropriate use of PPE were as follows: -At 11:40 A.M., a Nurse Practitioner (NP) was observed at the nursing station on the Sacred Heart Unit. The NP was wearing a respirator mask with a surgical mask on top of it (double masking). -At 12:04 A.M., a Certified Nursing Assistant #1 (CNA) entered the PPE DON/DOFF room on the(NAME)Unit wearing a mask and holding a brown paper bag in her hands. The CNA said that she was a [MEDICATION NAME] (agency staff), had worked at the facility for 4 days. She said that she was assigned to work on the(NAME)Unit from 7:00 A.M. to 3:00 P.M., and had just returned from a break. She was observed to place the bag down on a chair, reach into the bag and pull out a plastic isolation gown that had been rolled into a ball. The CNA failed to perform hand hygiene prior to touching the gown, and failed to ensure that her hands did not come into contact with the outside of the gown which was contaminated due to having worn it on the unit earlier in the day. She then pulled a face shield from the bag brought the face shield to the sink and washed the inside and outside of the shield with hand soap from the dispenser mounted to the wall, and dried it with a dry paper towel. The CNA did not wipe the outside of the face shield using a wipe or clean cloth saturated with EPA (Environmental Protection Agency) registered hospital disinfectant solution, and did not wipe the outside of the face shield with clean water or alcohol to remove residue. Review of CNA #1's orientation training file (provided by the nursing agency's lead educator), failed to indicate evidence that she demonstrated competency in following infection control practices including hand hygiene while donning PPE. During interview with the Infection Control Preventionist (ICP) at 3:45 P.M., she said that CNA #1's orientation training file was complete, and there was no documentation that the CNA had demonstrated competency in following infection control practices including hand hygiene while donning PPE. -At 12:15 P.M., Nurse #2 was observed on the St.(NAME)Unit, seated alongside a resident in his/her room feeding them lunch. Nurse #2 was observed to be wearing a gown, mask, and eye protection. The nurse was not wearing gloves. Interview with Nurse #3 at 12:24 P.M., identified the resident being fed by Nurse #2 as being negative for COVID-19. Nurse #2 was not wearing gloves for direct care of this resident. -During interview with the Director of the Dementia Special Care Unit in the DON/DOFF area at 12:45 P.M. on the Lourdes Unit, she was observed to touch her face mask with her hands 5 times, therefore contaminating her hands. At 12:50 P.M., she began to exit the area and enter the unit. The Director did not perform hand hygiene before entering the unit. -At 12:58 P.M., Nurse #1 was observed on the St. Joseph's Unit at a medication cart. She was observed to be wearing a mask, eye protection which was pushed on top of her head and resting on her hair and therefore contaminated, a plastic over-the-head isolation gown with apron ties not secured, allowing the gown to flow loosely and not fully protecting her clothing underneath the gown. During interview with Nurse #1 at 1:04 A.M., she was observed to pull down the eye protection in place without sanitizing them. During the interview, Nurse #1 touched her face mask 2 times, and did not perform hand hygiene before resuming her duties. -At 1:05 P.M., the NP was observed on the St. Joseph's unit wearing street clothing, a lab coat over the street clothing, and a plastic over-the-head isolation gown (double gowning). -During interview with Nurse #4 at 1:30 P.M. on the Rosarie Unit, she was observed to be wearing a respirator mask covered by a surgical mask (double masking). - At 1:36 P.M., on the St.(NAME)Center Unit (COVID-19 Unit), Nurse #5 said that there were 5 residents that were COVID-19 positive on the unit. The positive residents were housed in a section of the unit closed off by double fire doors. The surveyor asked Nurse #5 to accompany onto the unit. During preparation for entering the unit, the nurse told the surveyor that a gown could be donned over the gown already on, and remove the outer gown prior to leaving the unit to make it easier (double gowning).

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