STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225173	A. BUILDING _____ B. WING _____	**06/24/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
JEWISH HEALTHCARE CENTER	**629 SALISBURY STREET WORCESTER, MA 01609**

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.** Based on observation, interview and record review, the facility failed to appropriately screen staff for signs and symptoms of COVID-19, failed to appropriately use Personal Protective Equipment (PPE), and failed to appropriately designate staff to the COVID-19 positive wing. Findings include: 1. Review of the facility's COVID-19 Emergency Preparedness Plan indicated all essential healthcare personnel .will adhere to the screening process at gate of entry to the facility including: a. Temperature check b. Centers for Disease Control and Prevention (CDC) recommended questionnaire c. If any answer to questions asked is yes entry will be prohibited Review of the CDC website indicated the facilities must screen all healthcare personnel at the beginning of their shift for fever and symptoms of COVID-19, actively take the temperature of their employees, and document absence of symptoms consistent with COVID-19. During an observation on June 24, 2020 at 7:55 A.M., staff #1 was seated at the entry to screen staff and visitors. Two staff members entered the facility and staff #1 only took the temperatures of each staff member, did not ask questions about signs and symptoms of COVID-19 and did not record the temperatures. During an interview on June 24, 2020 at 9:30 A.M., staff #1 said she takes the temperature of the employees when they enter the building, and tells them what the reading is. She said she does not ask if they are experiencing signs and symptoms of COVID-19 and does not record the temperatures. 2. During an interview on June 24, 2020 at 8:00 A.M., the Director of Nurses (DON) said that the 4th floor had quarantined (those under a 14 day observation due to new admission or recently readmitted from the hospital) residents, one resident who is COVID-19 negative and three residents who are COVID-19 positive and housed on a separate wing on the 4th floor. Review of the CDC website indicated if extended use of gowns is implemented as part of crisis strategies, the same gown should not be worn when caring for different residents unless it is for the care of residents with confirmed COVID-19 who are cohorted in the same area of the facility and these residents are not known to have any co-infections (e.g., Clostridioides difficile). During an observation on June 24, 2020 at 8:25 A.M., of the 4th floor quarantined area, the following was observed: a. Certified Nurse Aide (CNA) #1 had full PPE on (gown, mask, goggles), went into a resident's room who was under quarantine to deliver breakfast tray, set the tray up, adjusted the resident's bed, touched the privacy curtain, exited the room and used hand gel to clean her hands. CNA #1 then went back to the meal truck to take out another breakfast tray, brought it into the resident's room who was COVID-19 negative with the same PPE on, set up the breakfast tray, adjusted the bed, came out of the room without cleaning hands, proceeded to the kitchenette to get sugar packets and then went back to the COVID-19 negative resident with the same PPE on. CNA #1 exited the resident's room, used hand gel and then walked the length of the hall with her facemask under her chin. During an interview on June 24, 2020 at 8:45 A.M., CNA #1 said she didn't change PPE between residents and should have and she should have her mask on at all times. b. During an interview on June 24, 2020 at 8:50 A.M., Unit Manager (UM) #1 said the staff that has to go into the COVID-19 positive wing puts PPE over their base PPE and then removes the outer layer of PPE to come back to the quarantined area. During an interview on June 24, 2020 at 8:55 A.M., CNA # 2 was on the COVID-19 positive wing with full PPE on. She said when she leaves the COVID-19 positive wing she wipes down the gown with a disinfectant wipe and puts on a gown over the gown she wiped down to go to the quarantined area. 3. Review of the facility's COVID-19 Emergency Preparedness Plan indicated Covid designated unit will be behind closed doors with designated staff assigned, remove PPE before exiting the Covid designated unit, there will be no rotation of staff between floors or wings during the period they are working each day. a. During an interview on June 24, 2020 at 8:15 A.M., UM #1 said one nurse and one CNA take care of both quarantined residents and COVID-19 positive residents during the same shift. During an interview on June 24, 2020 at 8:25 A.M., Nurse #1 said she does vital signs and blood sugar checks on the quarantined residents first, then goes to the COVID-19 positive wing to do the same thing there, then goes back to the quarantined area to pass medications to the quarantined residents, followed by returning to the COVID-19 positive wing to pass medications there. She said she then returns to the quarantined area and only goes back to the COVID-19 positive wing if one of those residents needs something. During an interview on June 24, 2020 at 8:55 A.M., CNA #2 said she takes care of the residents on the quarantined area first then takes care of the residents on the COVID-19 positive wing. She said sometimes residents on the quarantined area need her and she will leave the COVID-19 positive area to provide assistance on the quarantined area if needed. b. During an observation on June 24, 2020 at 9:05 A.M., Nurse #1 came through the COVID-19 positive unit with the PPE on from the quarantined area, went to the kitchenette to get creamers then walked through the hall of the COVID-19 positive wing and exited onto the quarantined area without cleansing hands or changing PPE. During an interview on June 24, 2020 at 10:45 A.M., the DON said that ideally the staff wouldn't go from the COVID-19 positive unit back to the quarantined area in the same shift. She said she was unaware that they were not supposed to double gown. She said the nurse should not have walked through the COVID-19 positive wing in the way she did.

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