STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225295	A. BUILDING _____ B. WING _____	**09/22/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
VERO HEALTH & REHAB OF WILBRAHAM	**9 MAPLE STREET WILBRAHAM, MA 01095**

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 ensure staff implemented proper infection control for hand hygiene during two observations and storage of contaminated linens on one of three units. Findings Include: 1. On 9/22/2020 at 9:10 A.M., the surveyor observed Physical Therapist (PT) #1 exit Resident #1's room after providing therapy to him/her. PT #1 did not perform hand hygiene prior to exiting the room. Upon exiting the room PT #1 proceeded to reach into the clean Personal Protective Equipment (PPE) container outside the resident's room and retrieved clean PPE. Review of the facility's policy Handwashing/Hand Hygiene, revised in 2015, indicated the following: - Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (anti-microbial or non-anti-microbial) and water for the following situations: -Before and after direct contact with residents -After removing gloves: *the use of gloves does not replace hand washing/hand hygiene. During an interview on 9/22/2020 at 9:22 A.M. PT #1 said she should have performed hand hygiene before she left Resident #1's room. On 9/22/2020 at 10:34 A.M., the surveyor observed Certified Nurse's Aide (CNA) #1 assisting Resident #2 to the bathroom in his/her room. When CNA #1 was done assisting Resident #2, she doffed (removed) her gloves at the doorway of the resident's room and placed them in the trash receptacle. CNA #1 did not perform hand hygiene after doffing her gloves or prior to exiting the room. Upon exiting the room, CNA #1 proceeded to reach into the clean PPE container outside the resident's room and retrieved clean PPE. During an interview on 9/22/2020 at 10:35 A.M., CNA #1 said she should have performed hand hygiene before she left Resident #2's room. 2. On 9/22/2020 at 9:38 A.M., the surveyor observed several large plastic bags on the floor of the day room. Bags were labeled Do Not Open Until 9/24/2020 and had linen and personal belongings in them. During an interview on 9/22/2020 at 9:39 A.M., Nurse #1 said the items in the bags were dirty linen and personal items that belonged to Resident #3. Nurse #1 said the items had been bagged due to Resident #3's skin infection. On 9/22/2020 at 10:44 A.M., the surveyor observed six residents and one staff member in the day room with the large plastic bags on the floor of the day room. Review of Resident #3's nursing notes, dated 9/9/2020, indicated patient returned from the dermatologist office with a [DIAGNOSES REDACTED]. Review of the CDC's website page titled Scabies Prevention and Control reviewed: October 31, 2018 indicated: -Scabies is prevented by avoiding direct skin-to-skin contact with an infested person or with items such as clothing or bedding used by an infested person The Center for Disease Control's website titled Scabies Frequently Asked Questions reviewed: September 1, 2020 indicated: -Scabies is contagious and can spread quickly in areas where people are in close physical contact. Review of the facility's policy titled Scabies revised 2012 indicated the following: -Store resident's remaining clothing in a storage area for 14 days During an interview on 9/22/2020 at 12:56 P.M., Unit Supervisor #1 and the Regional Nurse said the bagged linen and personal belongings from Resident #3's room should not be stored in the day room. Both were unsure where the bagged items should be stored. During an interview on 9/22/2020 at 1:32 P.M., the Administrator said the bags of contaminated linen and personal belongings should not have been stored in the day room and should have been stored in the facility's biohazard room.

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.