STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225404	A. BUILDING _____ B. WING _____	08/10/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WINGATE AT HAVERHILL	190 NORTH AVENUE HAVERHILL, MA 01830

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 0600 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that one Resident (#1) out of 68, was free from a abuse by the use of physical restraints, by placing his/her bed against the wall to contain the resident. Findings include: On 8/10/20 at 12:00 P.M. the Surveyor reviewed the facility policy titled Resident Abuse, with a revised date of 12/2019, which indicated: * The resident has the right to be free from abuse, neglect, mistreatment of [REDACTED]. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, and any physical or chemical restraint not required in treating the resident's symptoms. * Instances of abuse of all residents, irrespective of any physical or mental condition, cause physical harm, pain or mental anguish. Willful as used in the definition of abuse means the individual must have acted deliberately, not the individual must have intended to inflict injury or harm. * When abuse, mistreatment, neglect involuntary seclusion is observed, reported to or suspected by any employee of the facility, staff immediately notifies the DON who assumes responsibility for the investigation. The first steps include: -Remove the accused from all resident contact, interview the employee, obtain their written statement concerning the allegation and suspend the employee pending investigation. -Immediate notification to the Department of Public Health, Health Care Facility Reporting System (HCFRS). This initial report is required to be submitted within 2 hours, regardless of whether or not any injury has been identified. Resident (#1) was admitted to the facility in October 2019, and had [DIAGNOSES REDACTED]. Review of Resident #1's most recent Minimum Data Set (MDS) assessment dated [DATE], indicated that Resident #1 was assessed by staff to have had severely impaired cognition. Further, the MDS indicated Resident #1 had no behaviors, required extensive assist from staff for transfers and bed mobility, and did not require restraints. It also indicated Resident #1 had experienced 2 fall in the past quarter, one with injury. On 8/10/20 at 10:45 A.M., the surveyor made the following observations: * Upon hearing moaning and cries coming from Resident #1's room that could be heard from the hallway, the surveyor entered the room and observed Resident #1 lying in bed, facing the wall, pulling on the right side rail attempting to pull him/herself up. There were no other residents in the room. * The right side of Resident #1's bed was against the wall and at Resident #1's backside a large body pillow the length of his/her body was in place. The positioning kept him/her secured between the pillow and the wall, restricting the resident's movement and he/she was unable to move from the bed. On 8/10/20 at 10:50 A.M., the surveyor and Nurse #1 observed Resident #1 together. Resident #1 was still moaning and pulling at the side rail on his/her right side that was against the wall. Nurse #1 said I personally don't know what to do with Resident #1, whenever I work I put his/her bed like that because I need a way to contain him/her. Further, she explained I need to be able to do my job and not worry that Resident #1 will get out of bed or fall. On 8/10/20 at 10:58 A.M., the surveyor and Certified Nursing Assistant (CNA #1) observed Resident #1 together as he/she pulled at the side rail. CNA #1 said Resident #1's always on the move, wiggly, that's why we put the pillows to stop him/her and when he/she's really agitated we put his/her bed against the wall so he/she can't get out. CNA #1 agreed she could not be certain that this didn't agitate Resident #1 more. During a follow-up interview with the Staff Educator and DON on 8/10/20 at 11:40 A.M., the Staff Educator said that when interviewed, Nurse #1 said that she had put the bed against the wall and the body pillow behind the resident to prevent the resident from getting out of bed. The Staff Educator also said she reviewed Resident #1's medical record and said it failed to indicate a physician's orders [REDACTED]. On 8/10/20 at 11:45 A.M., the Surveyor reviewed Resident #1's medical record which indicated the following: * Resident #1 had a Health Care Proxy in place that was activated by the Physician on 10/23/19 due to incapacity for decision making. * Resident #1 was most recently seen by the Physician's Assistant on 7/29/20. The documentation from that visit indicated that Resident #1 had a history of [REDACTED]. * Resident #1's medical record contained the form titled Informed Consent For The Use of Restraints, which had the resident's name, physician and room number completed, but was otherwise blank. * Review of Resident #1 care plans failed to indicate the need for a restraint. * Review of clinical progress notes indicated a nurse's note dated 7/14/20, which failed to indicate the use of a restraint. On 8/10/20 at 11:19 A.M., the Surveyor met with the Director of Nursing (DON) and Staff Educator and shared the observations and information received from the staff. The DON said That is a restraint. Further, she said the use of a restraint without an assessment, doctor's order, consent or plan of care, was abuse.
F 0604 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that one Resident (#1) out of 68, was free from a restraint. Nurse #1 said she restrained Resident #1 in bed because she wanted to contain him/her, despite his moaning, agitation and attempts to get up. There was no restraint assessment, consent, physician's orders [REDACTED]. Findings include: The facility policy titled Physical Restraints Standard, revised February 28, 2017, indicated: * It is the policy of Wingate Health Care that the resident has the right to be free from any physical restraint imposed for the purposes of discipline or convenience. A physical restraint is defined through the State Operations Manual as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body. In order for a device to meet the definition of a restraint, it must prevent the resident from performing some task they previously had the ability to perform. The facility respects the rights and independence of its residents, including freedom of movement and the right to be free from physical restraints. * The decision to apply a restraint requires the collaborative opinion of the resident's physician, the resident/Health Care Agent or responsible person, and appropriate interdisciplinary team members. * Written documentation or informed consent signed by the resident or representative must be obtained for any restraint prior to the initiation of restraints. * All restraints will have a specific physician's orders [REDACTED]. * A restraint assessment is required for all residents prior to initiating any form of restraint. * A resident specific care plan for restraint reduction will be developed by the interdisciplinary team. The facility policy titled Resident Abuse, revised 12/2019, indicated: * The resident has the right to be free from abuse, neglect, mistreatment of [REDACTED]. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, and any physical or chemical restraint not required in treating the resident's symptoms. * Instances of abuse of all residents, irrespective of any physical or mental condition, cause physical harm, pain or mental anguish. Willful as used in the definition of abuse means the individual must have acted deliberately, not the individual must have intended to inflict injury or harm. Resident (#1) was admitted to the facility in October 2019, and had [DIAGNOSES REDACTED]. On the most recent Minimum Data Set (MDS)

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 0604 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) assessment dated [DATE], indicated that Resident #1 was assessed by staff to have had severely impaired cognition. Further, the MDS indicated Resident #1 had no behaviors, required extensive assist from staff for transfers and bed mobility, and did not require restraints. It also indicated Resident #1 had experienced 2 fall in the past quarter, one with injury. On 8/10/20 at 10:45 A.M., the surveyor made the following observations: * Upon hearing moaning and cries coming from Resident #1's room that could be heard from the hallway, the surveyor entered the room and observed Resident #1 lying in bed, facing the wall, pulling on the right side rail attempting to pull him/herself up. There were no other residents in the room. * The right side of Resident #1's bed was against the wall and at Resident #1's backside a large body pillow the length of his/her body was in place. The positioning kept him/her secured between the pillow and the wall, restricting the resident's movement and he/she was unable to move from the bed. On 8/10/20 at 10:50 A.M., the surveyor and Nurse #1 observed Resident #1 together. Resident #1 was still moaning and pulling at the side rail on his/her right side that was against the wall. Nurse #1 said I personally don't know what to do with Resident #1, whenever I work I put his/her bed like that because I need a way to contain him/her. Further, she explained I need to be able to do my job and not worry that Resident #1 will get out of bed or fall. On 8/10/20 at 10:58 A.M., the surveyor and Certified Nursing Assistant (CNA #1) observed Resident #1 together as he/she pulled at the side rail. CNA #1 said Resident #1's always on the move, wiggly, that's why we put the pillows to stop him/her and when he/she's really agitated we put his/her bed against the wall so he/she can't get out. CNA #1 agreed she could not be certain that this didn't agitate Resident #1 more. On 8/10/20 at 11:05 A.M., Nurse #1 approached the surveyor and inquired if I get an order for [REDACTED].M., the surveyor met with the Director of Nursing (DON) and staff educator and shared the observations and information received from the staff. The DON said that is a restraint. During a follow-up interview with the Staff Educator and DON on 8/10/20 at 11:40 A.M., they said: * Nurse #1 said that she had put the bed against the wall and the body pillow behind the resident to prevent the resident from getting out of bed. * There was not an order, an assessment or consent for a restraint/the bed to be against the wall. There was a physician's orders [REDACTED].M., Resident #1's medical record indicated the following: * Resident #1 had a Health Care Proxy in place that was activated by the Physician on 10/23/19 due to incapacity for decision making. * Resident #1 was most recently seen by the Physician's Assistant on 7/29/20. The documentation from that visit indicated that Resident #1 had a history of [REDACTED]. * Resident #1 had not been assessed for the use of a restraint, as confirmed by the staff educator and DON on 8/10/20 at 11:40 A.M. * Resident #1 did not have a consent in place for the use of a restraint, as confirmed by the staff educator and DON on 8/10/20 at 11:40 A.M. * The 8/1/20-8/31/20 physician's orders [REDACTED].* The plan of care for Resident #1 did not indicate the need for a restraint. * The most recent clinical progress note was a nurse's note dated 7/14/20 and which failed to indicate the use of a restraint, or any documentation that the staff regularly monitored Resident #1 while he/she was restrained. At 12:20 P.M., the surveyor met with the DON and she said, there was no indication in the medical record, progress notes, physicians orders or progress notes that a restraint was required to treat there resident's symptoms.
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to report to the State Agency an allegation of abuse (deliberate placement of a resident's bed against the wall to contain the resident) for 1 Resident (#1) out of 68 residents. For allegations of abuse, that do not result in serious bodily injury, a facility is required to report to the state agency within a 24 hour time frame. Findings include: The facility policy titled Resident Abuse, revised 12/2019, indicated: * The resident has the right to be free from abuse, neglect, mistreatment of [REDACTED]. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, and any physical or chemical restraint not required in treating the resident's medical symptoms. * Instances of abuse of all residents, irrespective of any physical or mental condition, cause physical harm, pain or mental anguish. Willful as used in the definition of abuse means the individual must have acted deliberately, not the individual must have intended to inflict injury or harm. * When abuse, mistreatment, neglect involuntary seclusion is observed, reported to or suspected by any employee of the facility, staff immediately notifies the DON who assumes responsibility for the investigation. The first steps include: -Remove the accused from all resident contact, interview the employee, obtain their written statement concerning the allegation and suspend the employee pending investigation. -Immediate notification to the Department of Public Health Health Care Facility Reporting System (HCFRS). This initial report is required to be submitted within 2 hours, regardless of whether or not any injury has been identified. On 8/10/20 at 10:45 A.M., the surveyor made the following observations: * Upon hearing moaning and cries coming from Resident #1's room that could be heard from the hallway, the surveyor entered the room and observed Resident #1 lying in bed, facing the wall, pulling on the right side rail attempting to pull him/herself up. There were no other residents in the room. * The right side of Resident #1's bed was against the wall and at Resident #1's backside a large body pillow the length of his/her body was in place. The positioning kept him/her secured between the pillow and the wall, restricting the resident's movement and he/she was unable to move from the bed. On 8/10/20 at 10:50 A.M., the surveyor and Nurse #1 observed Resident #1 together. Resident #1 was still moaning and pulling at the side rail on his/her right side that was against the wall. Nurse #1 said I personally don't know what to do with Resident #1, whenever I work I put his/her bed like that because I need a way to contain him/her. Further, she explained I need to be able to do my job and not worry that Resident #1 will get out of bed or fall. On 8/10/20 at 10:58 A.M., the surveyor and Certified Nursing Assistant (CNA #1) observed Resident #1 together as he/she pulled at the side rail. CNA #1 said Resident #1's always on the move, wiggly, that's why we put the pillows to stop him/her and when he/she's really agitated we put his/her bed against the wall so he/she can't get out. CNA #1 agreed she could not be certain that this didn't agitate Resident #1 more. On 8/10/20 at 11:19 A.M., the surveyor met with the Director of Nursing (DON) and staff educator and shared the observations and information received from the staff. The DON said that is a restraint. Never can a restraint be put in place without an assessment, a doctors order, consent of the responsible party and being care planned for it. Further, she agreed the use of a restraint without these items in place was abuse. During a follow-up interview with the Staff Educator and DON on 8/10/20 at 11:40 A.M., they said: * Nurse #1 said that she had put the bed against the wall and the body pillow behind the resident to prevent the resident from getting out of bed. * There was not an order, an assessment or consent for a restraint (the bed to be against the wall) to treat Resident #1's medical symptoms. As of 8/12/20 at 10:04 A.M., the facility had not yet reported the incident to the Department of Public Health's Health Care Facility Reporting System (HCFRS).
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 observations, interviews and facility policy review, the facility failed to prevent the possible spread of COVID-19 on 3 of 3 resident units as evidenced by: (1) Dietary Aide (DA#1), Laundry Aides (LA#1 and #2), and Housekeepers (HK#1, #2, #3 and #4) did not properly remove gloves and perform hand hygiene after contact with the resident's environment to avoid the potential spread of COVID-19. Findings include: The facility policy titled Infection Prevention and Control, updated May 2020, indicated: * It is the policy that this facility's Infection Prevention and Control Program (IPCP), is based upon information from the Facility Assessment and follows national standards and guidelines to prevent, recognize and control the onset and spread of infection whenever possible. * Written standards, policies and procedures for the IPCP include hand hygiene to be followed by staff with direct care, handling resident care equipment and the environment. A. On 8/10/20 at 9:13 A.M., the surveyor entered the B Unit. The B unit housed 11 residents who were negative for COVID-19 and 21 residents who were COVID-19 recovered. The following observations were made: 1.) At 9:13 A.M., DA#1 was observed in the unit dining room with a glove on each hand placing items into the refrigerator. DA#1 walked out in to the corridor without removing the gloves and without performing hand hygiene, and went through a container at the nurses station to find a pen, potentially contaminating the pen and all the other pens in the container. DA#1 then returned to the refrigerator, and without removing the gloves and without performing hand hygiene, used the pen to make some notations on items before placing them in the refrigerator, potentially contaminating the items and all items inside the refrigerator. 2.) At 9:16 A.M., DA#1 still wearing the gloves, picked up some items of trash off of the counter and walked across the room to place the trash in a receptacle. DA#1, then returned back to her cart and without removing the gloves and without performing hand hygiene placed food items that were on the cart in a cabinet, potentially contaminating the handle of the cabinet and all items inside. 3.) At 9:20 A.M., DA#1 removed her gloves and placed them in the trash. Without performing hand hygiene, DA#1

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) moved a loaf of bread on her cart and exited the dining room, potentially contaminating the loaf of bread, the cart and the environment. 4.) At 9:20 A.M., as DA#1 exited the dining room a resident entered and asked DA#1 if she could get a drink. DA#1 instructed the resident that there were items in the refrigerator and left the dining room. The resident went to the refrigerator and without performing hand hygiene opened the refrigerator, potentially contaminating the handle. She removed a bottle of ginger ale, poured it into a cup she had in her walker's basket, allowing the bottle's spout to touch her cup, potentially contaminating the ginger ale and bottle. She then closed the bottle and placed it back into the refrigerator, increasing the risk of contaminating the refrigerator and all items inside. 5.) At 9:21 A.M., the surveyor observed LA#1 pushing a cart down the hallway, wearing an isolation gown and a glove on each hand. Without removing the gloves and without performing hand hygiene, LA#1 stopped at a room labeled soiled utility room and using the gloved hands entered a code in the keypad and opened the door to look inside, potentially contaminating the pad and door. LA#1 then, without removing the gloves and without performing hand hygiene, pressed the button for the elevator and left the unit, potentially contaminating the elevator button. 6.) At 9:38 A.M., the surveyor observed HK#1 walking down the hallway wearing a glove on each hand. At 9:47 A.M., HK#1 was again observed, this time carrying a bag of trash with a glove on each hand. HK#1 placed the bag of trash in the receptacle on her cart, then without removing the gloves and without performing hand hygiene HK#1 entered room #B 103, potentially contaminating the room and the COVID-19 negative resident in the room. 7.) At 9:49 A.M., the surveyor observed HK#2 walking in the hallway wearing a glove on each hand. Without removing the gloves and without performing hand hygiene, he entered a code on a keypad and entered the soiled utility room, potentially contaminating the keypad and door handle. HK#2 removed a wheelchair and a walker and then, without removing the gloves and without performing hand hygiene, HK#2 pressed the button for the elevator, potentially contaminating the elevator button, the wheelchair and walker, and the environment. B. On 8/10/20 at 10:00 A.M., the surveyor entered the A Unit. The A unit housed 4 residents who were on a 14 day quarantine for potential COVID-19 and 4 residents who were negative for COVID-19. The following observations were made: 1.) At 10:00 A.M., HK#2 was observed in the corridor, wearing a glove on each hand and still holding the wheelchair and walker. He placed the items at the end of the hall and exited the unit wearing a glove on each hand and without performing hand hygiene, increasing the risk of contaminating the environment. 2.) At 10:10 A.M., HK#3 exited room #A18 with a glove on each hand and removed the mop head off the mop that she had used to clean the room with. HK#3 then removed the gloves, placed them in the trash receptacle and without performing hand hygiene began pushing her cart down the hall, potentially contaminating the cart and environment. 3.) At 10:18 A.M., LA#2 walked the entire length of the A unit hallway with a glove on each hand. Without removing the gloves and without performing hand hygiene he retrieved the cart of clean linen and pushed it down the hallway to the laundry room, potentially contaminating the linens and cart. 4.) At 10:20 A.M., LA#2 exited the laundry room still wearing a glove on each hand and pushed the clean linen cart back to the end of the corridor. He then returned to the laundry room with a glove on each hand and without performing hand hygiene. C. On 8/10/20 at 10:25 A.M., the surveyor entered the C Unit, the facility's Dementia Unit. The C unit housed 1 residents who was on a 14 day quarantine for potential COVID-19, 8 residents who were negative for COVID-19 and 21 COVID-19 residents who were recovered from COVID-19. The following observations were made: 1.) At 10:27 A.M., HK#4 was observed pushing a cart down the corridor, with a glove on each hand. She stopped outside a bathroom in the hall, and without removing the gloves and without performing hand hygiene, opened the bathroom door, potentially contaminating the door handle. She then closed the door and proceeded down the hall, and entered room #C6, without removing the gloves and without performing hand hygiene, potentially contaminating the resident and room. From the hallway the surveyor observed HK#4 empty the trash, add new toilet paper and mop the floor, all the while wearing the gloves on each hand and not performing hand hygiene. 2.) At 10:36 A.M., HK#4 exited room #C6, still wearing a glove on each hand, and pushed her cart to room #C8. Without removing the gloves and without performing hand hygiene HK#4 entered room #C8, potentially contaminating the room and the COVID-19 negative resident inside. From the hallway the surveyor observed HK#4 empty the trash, add new toilet paper and mop the floor, all the while wearing the gloves on each hand and not performing hand hygiene. 3.) At 10:45 A.M., HK#4 exited room #C8, still wearing a glove on each hand, and pushed her cart to room #C10. Without removing the gloves and without performing hand hygiene HK#4 entered room #C10, potentially contaminating the room and residents inside. During an interview with the Director of Nursing (DON) and the facility's Staff Educator, the DON said that it was never okay to wear gloves in the hallway or to not perform hand hygiene before entering and exiting rooms, due to the risk of contamination and spread of pathogens.