STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225317	A. BUILDING _____ B. WING _____	**08/19/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FALL RIVER JEWISH HOME, INC	**538 ROBESON STREET FALL RIVER, MA 02720**

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.** Based on observation and staff interview, the facility failed to ensure that infection control measures to prevent the transmission of Covid 19, specifically staffs' use of PPE (personal protective equipment), were implemented in accordance with the facility's Infection Control Policy and procedures. Findings include: A Focused Covid 19 Infection Control survey was conducted on 8/19/20. The facility's infection control policies were reviewed and staff PPE practices were observed throughout the the course of the survey. During interview with the MDS (minimum data set) nurse on 8/19/20 at 8:00 A.M., the surveyor was informed that the Infection Control policy mandated all staff in the facility to wear a face mask and eye protection at all times. She further explained that when providing direct care to residents, the Infection Control policy mandated nursing staff don full PPE (face mask, eye protection, gown and gloves). During interview the DON (Director of Nursing) and IP (Infection Preventionist) said that Unit 3 had seven residents who were on quarantine due to a potential exposure to a Covid 19 positive staff member, confirmed positive for Covid 19 the week of 8/6/20 to 8/13/20. Additionally, three other staff members had tested positive for Covid 19 during facility testing on 7/29/20 and 8/3/20. During interview with the IP on 8/20/20 at 9:42 A.M., the IP said that staff were provided additional education on proper PPE wear following a Covid 19 Focused Infection Control Survey on 8/12/20, when concerns were raised by the State surveyor over improper PPE wear by staff. The surveyor observed the following improper PPE wear by staff during the course of the survey on 8/19/20: 1. On Unit 2, at 11:32 A.M., CNA #1 was observed in the corridor after leaving a resident room. CNA #1 was observed to have a mask on with eye goggles positioned on top of her head that provided no protection to the eyes. The surveyor asked CNA #1 why the goggles were not covering the eyes as required. CNA #1 said to the surveyor that the goggles got caught in her hair. She acknowledged that the goggles were not being worn properly and proceeded to position them over her eyes as required. 2. On 8/19/20 at 12:35 P.M., DA #1 (dietary aide) was observed in the facility's main kitchen preparing to distribute meal trays to the residents in the adjacent dining room. DA #1 was observed to have a mask on, however, her goggles were not covering her eyes as required by facility policy. The goggles were positioned on top of DA #1's head and provided no protection to her eyes. The surveyor informed the FSS (food service supervisor) who was heading out of the kitchen past DA #1. The FSS directed DA #1 to place the goggles in the proper position to protect her eyes. DA #1 complied with the FSS's instructions. During the Exit Interview with the administrator, IP, and DON, on 8/19/20 at 2:20 P.M., the surveyor expressed concern over the risk for infection with Covid 19 due to staffs' improper and inconsistent use of PPE, in accordance with the facility Infection Control Policy. They acknowledged how critical proper PPE use by staff was in order to prevent transmission of the Covid 19 virus between staff and residents.

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.