| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **225379** | A. BUILDING _____ B. WING _____ | **07/01/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **LUTHERAN REHABILITATION & SKILLED CARE CENTER** | **26 HARVARD 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<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | **Provide and implement an infection prevention and control program.**<br><br>Based on observation, interview and record review, the facility failed to appropriately use Personal Protective Equipment (PPE) on one of two units. Findings include: 1. Review of the Centers for Disease Control and Prevention (CDC) website indicated newly admitted or readmitted residents should be monitored for evidence of COVID-19 for 14 days after admission and cared for using all recommended COVID-19 PPE which includes use of an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown. Further review indicated that all PPE was to be removed prior to exiting the room . Review of the facility's Bed Board (color coded document that included the COVID-19 status of each resident and which room they were in), indicated Unit 2 had both recovered and negative residents, and had one room with three residents in their 14 day quarantine due to being new admissions to the facility. During an observation on July 1, 2020 at 9:10 A.M., Nurse #1 had gown, mask, and eye goggles on and was at the medication cart. Nurse #1 then entered the room with the quarantined residents, took a gown from behind the door and put it over the gown he had on and then entered the room to help set the breakfast tray up. Nurse #1 removed the gown and hung it on the door, performed hand hygiene, exited the room and went back to the medication cart. He then prepared medications, went back to the room where he again donned a gown over the gown he was wearing, removed the outer gown when he exited the room and then performed hand hygiene. During an interview on July 1, 2020 at 9:15 A.M., Unit Manager (UM) #1 said the staff was supposed to put a gown over the gown they had on prior to entering the quarantined room. She said they were supposed to wear a face shield as well. During an interview on July 1, 2020 at 9:20 A.M., Nurse #1 told the surveyor he had been told to put a gown over a gown before entering the quarantined room. He said he wasn't sure about a face shield but would find out. UM #1 joined the conversation and said Nurse #1 should have put on a face shield to go into the quarantined room and clean it before exiting the resident's room. |

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