STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225598	A. BUILDING _____ B. WING _____	**07/30/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WATERVIEW LODGE LLC, REHABILITATION & HEALTHCARE	**250 WEST UNION STREET ASHLAND, MA 01721**

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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to appropriately use Personal Protective Equipment (PPE) related to COVID-19, on 2 out of 3 units. Findings include: Review of the Centers for Disease Control and Prevention (CDC) website, Interim Infection Prevention and Control Recommendations for Health Care Personnel during the COVID-19 Pandemic, dated July 15, 2020, indicated the following related to glove use: Gloves: Put on clean, non-sterile gloves upon entry into the patient room or care area . Remove and discard gloves before leaving the patient room or care area, and immediately perform hand hygiene. Review of the Department of Public Health Memorandum on Comprehensive Use of PPE, dated July 6, 2020 indicated: If needed, extend the use of isolation gowns (disposable or cloth) to allow the same gown to be worn by the same health care personnel when interacting with more than one patient known to be infected with the same infectious disease when these patients are housed in the same location (i.e., COVID-19 patients residing in an isolation cohort). This can be considered only if there are no additional co-infectious [DIAGNOSES REDACTED]. If the gown becomes visibly soiled, it must be removed and discarded. During an interview on July 30, 2020 at 7:30 A.M., the Nurse Coordinator said the second floor unit had COVID-19 negative residents and also residents on 14 day quarantine due to being new or readmissions to the facility. He also said that the fourth floor unit had both COVID-19 recovered and negative residents. 1. During an observation and interview on July 30, 2020 at 7:55 A.M. on the fourth floor unit, Nurse #1 told the surveyor that the staff wore the same gown all day and only changed it if they needed to leave the unit or take a break. She said they had 2 hallways of COVID-19 negative residents and one hallway of COVID-19 recovered. During an observation and interviews on July 30, 2020 at 8:30 A.M. on the fourth floor unit COVID-19 negative hallways, Certified Nurse Aide (CNA) #1 and CNA #2 each had a mask, eye protection, gown and gloves on. Both CNAs were in the dining room, taking the prepared breakfast trays from the serving station and placing them on carts to be delivered to residents. CNA #1 delivered 6 resident breakfast trays from her cart and CNA #2 delivered 3 resident breakfast trays from her cart. Both CNAs kept the same PPE, including the gloves, when they went in and out of each resident's room. Both CNAs told the surveyor that they put their gowns, masks, and eye protection on at the start of the shift and they only changed their gown if they left the unit. CNA #1 said she would take off her gloves when she was done passing out the breakfast trays. 2. During an observation on July 30, 2020 at 9:10 A.M., CNA #3 was observed in the Dining Room with a gown, mask, eye protection and gloves on as she fed a resident their breakfast. Upon completion, CNA #3 removed her gloves and performed hand hygiene. During an observation on July 30, 2020 at 9:35 A.M., CNA #3 continued to have the same gown on and wheeled a COVID-19 negative resident from the dining room to the resident's room to toilet the resident. At 9:45 A.M., Nurse #2 went into the same resident room to assist CNA #3 with care. During an interview on July 30, 2020 at 9:50 A.M., Nurse #2 came out of the resident room wearing the same gown she had entered with, and told the surveyor she and CNA #3 had just toileted the resident. Nurse #2 said the staff on the floor wore the same gown all day when caring for COVID-19 negative residents and only removed it when they left the unit.
F 0885 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	Based on interview and record review, the facility failed to notify residents, their representatives, and families of those residing in the facility by 5 p.m. the next calendar day following the occurrence of two confirmed infections of COVID-19, as required. Findings include: During an interview on July 30, 2020 at 10:45 A.M., the Infection Control Nurse said there were two residents who tested positive for COVID-19 on the third floor two days prior. Review of a Laboratory Report, dated 7/28/20, indicated Resident #1 had a COVID-19 positive result that was reported on July 28, 2020. Review of a Laboratory Report, dated 7/28/20, indicated Resident #2 had a COVID-19 positive result that was reported on July 28, 2020. During an interview with the Social Worker (SW) and Administrator on July 30, 2020 at 11:00 A.M., the SW said she called the legal representatives for Resident's #1 and #2, but had not yet notified the rest of the facility's residents or their representatives. The Administrator said he had planned to do it in the weekly update he sends out to residents and their representatives.

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