STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225009	A. BUILDING _____ B. WING _____	07/09/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HERMITAGE HEALTHCARE (THE)	**383 MILL STREET WORCESTER, MA 01602**

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 -** Many	**Provide and implement an infection prevention and control program.** Based on observation, interview and record review, the facility failed to have Personal Protective Equipment (PPE) accessible to health care personnel and failed to appropriately use PPE on three out of three units related to COVID-19. Findings include: Review of the Centers for Disease Control and Prevention (CDC) website- Preparing for COVID-19 in Nursing Homes- indicated the following: -If extended use of gowns is implemented as part of crisis strategies, the same gown should not be worn when caring for different residents unless it is for the care of residents with confirmed COVID-19 who are cohorted in the same area of the facility and these residents are not known to have any co-infections (e.g., Clostridioides difficile). Review of the CDC poster titled, How To Safely Remove PPE, indicated: -Remove all PPE before exiting the patient room except a respirator, if worn. -Remove the respirator after leaving the patient room and closing the door. 1. During an observation on July 9, 2020 at 8:05 A.M., on the Sunburst Unit Covid-19 negative wing, Certified Nurse Aide (CNA) #1 was seated on a resident's bed, feeding the resident who was seated in a chair adjacent to the bed. CNA #1 had full (gown, mask, eye protection, gloves) PPE on. CNA #1 exited the resident's room when she was done feeding him/her, removed gloves only and performed hand hygiene. CNA #1 kept the remainder of her PPE on and then went into another resident's room. Further observation indicated no available PPE (except gloves) outside of the resident rooms on the COVID-19 negative wing. During an interview on July 9, 2020 at 8:15 A.M., CNA #1 said that she wore the same PPE all day long and only changed her gloves between residents. She said all of the residents on her assignment had tested negative for COVID-19. 2. During an observation on July 9, 2020 at 8:30 A.M., on the Sunrise Unit Covid-19 negative wing, CNA #2 was observed in a resident room with the privacy curtain pulled closed. CNA # 2 then exited the room with the same PPE on that she had on when providing resident care. Further observation indicated no available PPE (except gloves) outside of the resident rooms on the COVID negative wing. During an interview on July 9, 2020 at 8:40 A.M., CNA #2 said that she wore the same gown/coverall suit, mask and eye protection all day and that she only changed her gloves between residents. She said all of the residents on her assignment had tested negative for COVID-19. 3. During an observation on July 9, 2020 at 9:10 A.M., on the Sunset Unit Covid-19 negative wing, CNA #3 was observed in the hallway with full PPE on. She gathered towels and washcloths, proceeded to a resident's room and pulled the privacy curtain. At 9:20 A.M., she came out of the resident's room with the same PPE on (except she had removed her gloves). Further observation indicated there was no available PPE (except gloves) outside of the resident rooms. During an interview on July 9, 2020 at 9:20 A.M., CNA #3 said that she wore the same PPE all day and only changed her gloves between residents. She said all of the residents on her assignment had tested negative for COVID-19. 4. During an observation on July 9, 2020 at 9:30 A.M., on the Sunrise Unit (quarantine wing-newly admitted residents under observation for signs and symptoms of COVID-19 for 14 days), CNA #4 was in the hallway with a gown, mask and eye protection on. She donned another gown over the one she had on and proceeded into a resident's room with towels and a washcloth. At 9:45 A.M., CNA #4 came out of the resident's room, with the second gown already removed. During an interview on July 9, 2020 at 9:45 A.M., CNA #4 said that the facility policy was to put a second gown on when taking care of residents under quarantine. 5. During an observation on July 9, 2020 at 9:50 A.M., Nurse #1 was observed in the hallway with full PPE on. She then donned another gown over the one she had on and was preparing to enter a resident's room on the quarantine wing. The surveyor asked her why she was putting on another gown and Nurse #1 said it was the process. During an interview on July 9, 2020 at 11:30 A.M., with the Administrator, Director of Nurses, Assistant Director of Nurses, and the Corporate Clinical Nurse; the Corporate Clinical Nurse said they were following corporate policy and didn't know there was anything written about what to wear for residents who tested negative for COVID-19. She said the staff should have known not to double gown.

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.