STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225695	A. BUILDING _____ B. WING _____	08/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WINGATE AT NEEDHAM	589 HIGHLAND AVENUE NEEDHAM, MA 02194

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, record review and interview the facility failed to ensure the prevention of the spread of COVID -19 infection by, 1. failing to disinfect the multi-use oral thermometer between use by staff, 2. failing to keep clean linen free from contamination, 3. failing to perform hand hygiene when indicated, 4. failing to properly use, don (put on) and doff (take off) personal protection equipment PPE) when leaving the screening area and on 2 of 3 units and 5. failing to properly dispose of contaminated PPE on 2 of 3 resident care units. Findings include: Review of the Centers for Disease Control Guidance, updated June 25, 2020, indicated the following: Screen all HCP at the beginning of their shift for fever and symptoms of COVID-19. Actively take their temperature* and document absence of symptoms consistent with COVID-19. If they are ill, have them keep their cloth face covering or facemask on and leave the workplace. *Fever is either measured temperature >100.0oF or subjective fever. Note that fever may be intermittent or may not be present in some individuals, such as those who are elderly, immunosuppressed, or taking certain medications (e.g., NSAIDs). Clinical judgement should be used to guide testing of individuals in such situations. 1. Review of the facility's policy dated effected 7/30/2020 indicated under the heading Screening *All individuals entering the facility will be screened, including health care personal, for symptoms on a daily basis. *All individuals entering the facility will have their temperatures checked and will be asked about COVID-19 symptoms and recent travel. During an observation of the screening process, the following observations were made: * Eight facility health care personnel used the multi-use vital sign tower to take their oral temperature (individual thermometer covers in use). At no time did staff disinfect the machine between use. The nurse present, disinfected the machine after 8 health care personnel used the machine, therefore increasing the risk of exposure to infection. * One health care personnel, after removing their mask to take their oral temperature failed to put the mask back on and proceeded to fill out the screening form and walk away from the screening area before putting the mask back on. 2. On 8/12/2020 at 8:50 A.M., A resident came out of his/her room on the Copley Unit, asking for a new gown (johnny), holding a rolled up johnny. He/she went to a covered linen cart in the hall and lifted the cover and touched the linen looking for what he/she wanted. The resident proceeded to another covered linen cart and lifted the cover and came in contact with the contents of the cart, therefore, contaminating both linen carts. Review of the census provided by the facility indicated that both residents in that resident's room were negative for COVID-19 and during an interview on 8/12/2020 at 2:19 P.M., the infection control preventionist nurse (ICP) said that one of the residents in that room was on contact precautions for clostridioides difficile (an infectious bacteria also called [MEDICAL CONDITION].) 3. On 8/12/2020 at 9:52 A.M., a Certified Nursing Assistant (CNA #1) came out of room [ROOM NUMBER] (identified by the census document that both residents occupying the room as COVID-19 recovered) wearing gloves on both hands and placed a plastic bag in a side by side cart (2 bins one for trash the other for dirty linen). Without performing hand hygiene and wearing the same gloves, the CNA proceeded to move the cart to room [ROOM NUMBER] (identified by the facility's census document that the resident occupying the room was recovered COVID-19). The CNA removed plastic bags from the bathroom in room [ROOM NUMBER] and placed them in the side by side cart and without performing hand hygiene and wearing the same gloves continued to move the cart to the laundry chute room. The CNA exited the laundry chute room with the same gloved hands and without performing hand hygiene moved the side by side cart to the biohazard room. The CNA disposed of the plastic bags and removed the gloves and without performing hand hygiene moved the now empty cart to the bathing room. The use of contaminated gloves and absence of hand hygiene increases the risk of the spread of infections in the resident's environment. On 8/12/20 at 10:05 A.M., Nurse #2 said staff should not wear gloves in the hall. On 8/12/2020 at 2:19 P.M. the Director of Nursing said the CNA should have performed hand hygiene. 4. Review of the facility's instructions for the sequence for donning (putting on) PPE, issued by the Centers of Disease Control (CDC) indicated the following for gowns: *fully cover torso from the neck to knees, arms to the end of wrists and wrap around the back, fasten in the back of neck and waist. On 8/12/2020 at approximately 10:30 A.M., the dietician and a Medical provider (wound doctor) donned gowns outside of room [ROOM NUMBER]. Both tied the gowns at the neck and failed to tie the gowns at the waist, preventing the gown to be secure around the waist for prevention of contamination and spread of infection. They entered the room. The resident in room [ROOM NUMBER] was identified by the facility census to be negative for COVID-19 and during an interview on 8/12/2020 at 2:19 P.M., the ICP nurse said that the resident in room [ROOM NUMBER] was on contact precautions for clostridioides difficile (an infectious bacteria also called [MEDICAL CONDITION].) Review of the facility's doffing PPE (removing), indicated the following: Gown: gown front and sleeves are contaminated, untie ties, pull away from neck and shoulders, touching the inside of the gown only, turn gown inside out, fold or roll into a bundle and discard. On 8/12/2020 at 1:15 P.M., CNA #3 came out of room [ROOM NUMBER] on the(NAME)Unit. (which was identified by the facility census as occupied by 1 resident who was negative for COVID-19 and the other as recovered), and failed to untie the gown and removed the gown by pulling it up over his head increasing the risk of contaminating the wearer or the surrounding environment. CNA #3 then proceeded to dispose of the gown by carrying it through the hall and into a bin 2 doors down the hall. During an interview with CNA#3, he said he had education on doffing PPE and that he mistakenly did not follow the education. CNA #3 said the bins for used gowns used to be in the room but are now located in the hallways. Review of the facility's policy titled Update for care for Long term care resident during Covid-19 emergency July 30 guidance with an effective date of 7/30/2020 indicated under the heading of PPE: *The facility will ensure all staff is using appropriate PPE when interacting with staff in alignment with Department of Public Health and CDC guidance on conservation of PPE. *When there are residents or staff that have tested positive (for COVID-19) in the last 14 days, staff will wear full PPE for high contact activities. Definitions: Full PPE: face mask, face shield /goggle, gown and gloves. On 8/12/2020 at 10:30 A.M., Nurse #3 entered room [ROOM NUMBER] B with the medical provider and dietician. Nurse #2 failed to have on eye protection. On 8/12/2020 at 10:47 A.M., Nurse #3 said she was providing wound care to the resident after the resident was seen by the wound doctor. Nurse #3 said she was told last week that eye protection was no longer needed. 5. On 8/12/2020 at 10:40 A.M., Nurse #3 came out of room [ROOM NUMBER] wearing a PPE gown, she removed the gown down the hall and placed it in a covered bin labeled soiled reusable gowns. During an observation on the(NAME)Unit the following was observed: On 8/12/2020 at approximately 1:05 P.M., Rehab staff came out of room [ROOM NUMBER] B (identified by the facility census as being a resident who is negative for COVID-19), holding PPE, a gown. He placed the gown in the bin for soiled reusable gowns down the hall and without performing hand hygiene went to the nursing desk, wrote something down and then proceeded to leave the unit by entering the Sargent Unit. On 8/12/2020 at 1:15 P.M., CNA #2 came out of room [ROOM NUMBER], (which was identified by the facility census as occupied by 1 resident who was negative for COVID-19 and the other as recovered), holding a reusable PPE gown outside of the room and placing it in bin at least 2 doors down the hall. On 8/12/2020 the ICP Nurse said the process staff should be using for the reusable gowns is to bag them before leaving the room and then place in the soiled reusable bin and staff should not be wearing or bringing contaminated gowns into the hallway.

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.