

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER 225331	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/20/2020
NAME OF PROVIDER OF SUPPLIER EAST LONGMEADOW SKILLED NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP 305 MAPLE STREET EAST LONGMEADOW, MA 01028	
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, policy review and interview, the facility was found to be not in compliance with COVID-19 infection control guidelines relative to performing required hand sanitation, on one of four units observed. Findings include: The facility did not perform hand sanitation upon removal of a face shield. Review of the facility policy, COVID-19 Prevention and Outbreak Management, revised 8/13/20, indicated: -to perform hand hygiene with an alcohol-based hand rub (ABHR) before and after all patient/resident contact, contact with potentially infectious material, and before putting on and upon removal of PPE, including gloves. Use soap and water if hands are visibly soiled. During an observation on 8/20/20 at 9:45 A.M., CNA #3 exited a resident room, removed her face shield, and placed it on a hallway handrail. She did not sanitize her hands. She then obtained new linen, donned the face shield that had been on the handrail and prior to entering a resident's room, sanitized her hands. During an interview on 8/20/20 at 11:30 A.M., the DON said CNA #3 should not have placed her face shield on a handrail. She further said CNA #3 did not sanitize her hands upon removal of her face shield, as required.		

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.