

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER 225781	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/01/2020
NAME OF PROVIDER OF SUPPLIER SEVEN HILLS PEDIATRIC CENTER		STREET ADDRESS, CITY, STATE, ZIP 22 HILLSIDE AVENUE GROTON, MA 01450	
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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to maintain infection control standards to prevent the further spread of COVID-19 in the facility. Findings include: During inspection of the facility on 7/1/20, at 9:36 A.M., the surveyor observed Certified Nurse's Aide (CNA) #1 in a resident's room and pull down her mask off of her nose and mouth, contaminating her hands, and then lean down to speak to a resident. The surveyor also observed CNA #1 then touch items in the resident's room without performing hand hygiene (HH), contaminating the items in the resident's environment. At 9:39 A.M., the surveyor observed CNA #1 exit room [ROOM NUMBER] wearing contaminated gloves and not performing HH before walking down the hallway and enter room [ROOM NUMBER]. CNA #1 then obtained a scale from room [ROOM NUMBER], exited the room without changing her gloves or performing HH and enter room [ROOM NUMBER] wearing her contaminated gloves. CNA #1 then provided direct care to the resident in room [ROOM NUMBER]. During an interview on 7/1/20, at 10:35 A.M., the Director of Nursing said that HH is to be performed each time you leave a room. Review of the facility policy titled Infection Control Hand Hygiene and dated revised 2/2015, indicated that hand hygiene is to be performed after touching a resident, touching a resident's surroundings and before donning and after removing gloves.		

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.