

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER <b>225455</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED <b>09/01/2020</b>
NAME OF PROVIDER OF SUPPLIER <b>CRANEVILLE PLACE REHABILITATION &amp; SKILLED CARE CT</b>		STREET ADDRESS, CITY, STATE, ZIP <b>265 MAIN STREET DALTON, MA 01226</b>	
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  <b>Level of harm</b> - Minimal harm or potential for actual harm  <b>Residents Affected</b> - Few	<p><b>Provide and implement an infection prevention and control program.</b></p> <p>Based on observation, interview, and policy review, the facility failed to provide proper Standard Precautions for infection control practices related to hand hygiene on two out of three units. Findings Include: Review of the facility policy titled Handwashing/Hand Hygiene (Revised 8/14/2017) indicated the following: Use of an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap and water for the follow situations: -Before and after direct contact with residents; -After contact with objects (e.g., medical equipment) in the immediate vicinity of the resident. During an observation on 9/1/2020 at 8:10 A.M., on Unit 2, Nurse's Aide (NA) #1 was assisting Resident #1 and Resident #2 in the hallway. NA #1 applied Resident #1's cloth face mask, coming in contact with Resident #1 on the head/face area. NA #1 proceeded to push Resident #1 partially down the hallway in his/her wheelchair. She then returned to Resident #2 and applied Resident #2's cloth face mask touching Resident #2 on the head/face area. During an interview on 9/1/2020 at 8:12 A.M., when asked if NA #1 should have done anything between assisting Resident #1 with his/her mask and assisting Resident #2 with his/her mask, NA #1 said she should have performed hand hygiene. During an observation on 9/1/2020 at 10:04 A.M., on Unit 1 Activities Assistance (AA) #1 was preparing a bin of art materials for resident use. She donned plastic gloves in preparation of pouring paint. Resident #3 was sitting behind AA #1 in the common area and Resident #3's tissue box fell from his/her over bed table to the floor. AA #1 proceeded to pick up the tissue box with her gloved hands and placed it back on Resident #3's over bed table. AA #1 then proceeded to pick up art materials from the bin with her still gloved hands. During an interview on 9/1/2020 at 10:05 A.M., when asked if AA #1 should do anything before touching the activities materials she said she should have performed hand hygiene. At which point she doffed gloves, placed them in the trash, and utilized alcohol-based sanitizing rub (ABSR).</p>		

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.