STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225511	A. BUILDING _____ B. WING _____	07/09/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WILLOW MANOR	30 PRINCETON BOULEVARD LOWELL, MA 01851

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 0658 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure services provided by the nursing facility meet professional standards of quality.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide services that meet professional standards for 1 resident on a COVID-19 positive unit. Findings include: Review of the facility policy titled Medication: Administration: General, revised 11/1/19, indicated: * A licensed nurse, Med Tech, or medication aide, per state regulations, will administer medication to patients. Accepted standards of practice will be followed. On 7/9/20 at 9:17 A.M., the surveyor observed a Nurse (#2) entered the unit by pushing through the threshold door with both her hands. Nurse #2 approached her medication cart and without performing hand hygiene put on a new pair of gloves, potentially contaminating the gloves. Nurse #2, then opened up her medication cart and removed a box of medication. She carried the box to room [ROOM NUMBER] (a room that had a COVID-19 positive resident residing in it), pushed open the door with the same gloved hands and placed the box of medication on top of a trash can in the room. The surveyor overheard Nurse #2 instruct the two (Certified Nursing Assistants) CNAs that were in the room I put it right there to put on her. Nurse #2 then returned to her medication cart and without removing her gloves or performing hand hygiene, made an entry on her computer's keyboard. During an interview with Nurse # on 7/9/20 at 9:23 A.M., she said to the surveyor: 1.) That the licensed nurse was required to administer all medications and treatments ordered by the physician but I sometimes do it and sometimes I give it to the CNA's to do. She verified that she was responsible to document in the Medication Administration Record [REDACTED]. 3.) She verified that on 7/9/20 when the surveyor saw her, she had left [MEDICATION NAME] Powder (a medication ordered to be applied to the armpits, breast and abdominal folds each shift for rash/moisture) on top of the trash can is resident #116's room, she had instructed the CNA's to apply it to the resident, but that she had documented in the resident's record that she had administered the medicated powder herself. Review of the MAR indicated [REDACTED].M., the licensed nursed had signed off that she had applied the [MEDICATION NAME] Powder. During an interview with the Director of Nursing (DON) on 7/9/20 at 10:27 A.M., she said: that Nurse #2 should never have delegated a CNA to administer any type of medication or treatment that was ordered by the physician, as it was outside the CNA's scope of practice, and that the CNA was not trained to assess the skin prior to application. Further, she verified that the resident in room [ROOM NUMBER] was COVID-19 positive, and that it was not acceptable, under any circumstances, to place medication that was to be administered on top of a trash can.
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 and interview the facility failed to ensure that (1.) appropriate screening was performed and education provided to staff and visitors upon arrival to the facility (2.) Certified Nursing Assistants (CNA#1 and CNA#2) followed appropriate infection control practices to avoid the potential spread of COVID-19 after having had contact with the residents and their environment and (3.) a Nurse (#1 and #2) properly removed gloves and performed hand hygiene after contact with the resident's environment. Findings include: Review of the facility policy titled Screening Form-Tips for Screeners, dated 6/18/20, indicated: * Anyone entering the building must clean their hands using the alcohol-based hand rub provided by the screener. * Anyone entering the Center MUST STOP immediately at the entrance and be screened. * Directly ask each person the screening questions on the form and record their answers. The facility policy titled Standard Precautions, dated 11/15/19, indicated: 1.) Staff are required to change gloves: * Between tasks and procedures on the same individual after contact with material that may contain a high concentration of microorganisms. *After contact with patient and/or surrounding environment. 2.) Staff are required to remove gloves after contact with a patient and/or surrounding environment. 3.) Before exiting a room, remove and bag PPE and perform hand hygiene; remove bagged PPE from the room and discard. The facility policy titled Infection Control Policies and Procedures, COVID-19, revised 7/2/20, indicated: * For those permitted entry (into the building), the visitor must pass all screening criteria as outlined in Screening of Visitors and must be instructed to frequently perform hand hygiene. * Patients who must leave the Center regularly for medically necessary purposes (e.g., patients receiving [MEDICAL TREATMENT]) must be cohorted. The facility policy titled Supplemental Guidance for the Placement of Admissions and Readmissions, revised 6/16/20, indicated: * Create an Admission Quarantine Unit (AQU) that will be utilized for the placement of new admissions and readmissions in order to segregate patients during a 14 day observation period. * Those (residents) requiring routine outpatient services (such as [MEDICAL TREATMENT], [MEDICAL CONDITION], etc) should be placed on the AQU. * Due to the increased risk of exposure, patients with unknown COVID-19 status who attend routine outpatient services should be tested periodically. * All patients on the AQU are to be placed under both Airborne and Contact Precautions. * [MEDICAL TREATMENT] patients should be placed on patient specific Airborne and Contact precautions, meaning that gowns should be changed after caring for each [MEDICAL TREATMENT] patient, and not worn to other patients. The facility policy titled Hand Hygiene, reviewed 11/15/19, indicated staff were required to perform hand hygiene: * After patient care. * After contact with the patient's environment. On 7/9/20 at 6:45 A.M., the surveyor arrived at the facility behind a staff member and observed the screening process: * The facility Screener (designated staff member who was screening all staff and visitors prior to entering the facility for potential COVID-19 symptoms) checked the staff member's temperature. * The Screener asked the staff member any signs or symptoms, contrary to the facility's policy which indicated the that the staff should be directly asked the COVID-19 screening questions on the form and have their answers recorded. * The Screener then said you are all set and the staff member entered the building, at no point performing or being advised to perform hand hygiene, contrary to the facility's policy indicating anyone entering the building must clean their hands using the alcohol-based hand rub provided by the screener, On 7/9/20 at 6:47 A.M., the surveyor was greeted by the facility Screener. The Screener took the surveyor's temperature and stated let me take you to a conference room. She did not ask the surveyor any questions related to potential COVID-19 exposure or symptoms and did not instruct the surveyor to perform hand hygiene, contrary to the facility's screening policy. The surveyor continued to observe the screening process as staff arrived at the facility. At least 4 to 5 staff had their temperature taken and were asked any signs and symptoms by the Screener, without being asked the detailed questions as required by the COVID-19 screening policy. One of the staff asked for clarification as to what signs and symptoms meant. Additionally, none of the staff were observed to perform hand hygiene or advised to perform hand hygiene. On 7/9/20 at 7:27 A.M., the surveyor was on the AQU. The surveyor observed a Nurse (#1) enter room [ROOM NUMBER], where a [MEDICAL TREATMENT] resident resided. Nurse #1 entered the room wearing a gown, mask and face shield. Moments later the nurse opened the door, exited the room and shut the door behind her. She was still wearing a gown, mask and shield and carried a piece of paper that was her report sheet. Without removing the gown, mask or shield, and without performing hand hygiene, the nurse exited through the threshold doors, potentially contaminating the environment, the threshold doors when she opened them with her hand, as well as all of the residents on the COVID-19 negative unit that she entered on to. On 7/9/20 at 7:46 A.M., the surveyor observed a housekeeper in the hallway on the COVID-19 negative unit wearing a glove on each hand. The housekeeper, without removing the gloves or performing hand hygiene, walked into the unit day room and using the same gloved hands

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.

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) pushed two tables together, potentially contaminating the tables. The housekeeper then walked to the threshold doors, and while still wearing the same gloves on each hand, pushed open the doors and entered the quarantine unit. Moments later the housekeeper returned, wearing the same gloves, carrying sheets and re-entered the unit day room where she used the sheets to clean up water that was on the floor surrounding the radiator. The housekeeper then placed the sheets in a plastic bag and left them on the floor. She returned to her cart, and without performing hand hygiene, or removing the gloves, opened a package of hand paper towels, therefore contaminating the paper towels. She opened the paper towel dispenser over the sink in the unit day room and placed the paper towels inside, therefore contaminating the paper towel dispenser. On 7/9/20 at 8:42 A.M., the surveyor observed a Certified Nursing Assistant (CNA #1), on the AQU, in quarantined room [ROOM NUMBER] wearing Personal Protective Equipment (PPE), consisting of a gown, mask and face shield, assisting a resident. The surveyor observed CNA #1 exit room [ROOM NUMBER] wearing the same PPE, without removing / bagging the PPE or performing hand hygiene, and entered room [ROOM NUMBER] to assist another resident furthering the potential spread of contamination. On 7/9/20 at 8:44 A.M., the surveyor observed CNA #1 exit room [ROOM NUMBER] wearing the same PPE, carrying a breakfast tray. Without removing the PPE or performing hand hygiene, CNA #1 pushed open the threshold door and entered the COVID-19 negative unit, potentially contaminating the door and the negative unit. On 7/9/20 at 8:46 A.M., the surveyor observed CNA #2 entered quarantined room [ROOM NUMBER], and without performing hand hygiene or changing PPE enter room [ROOM NUMBER]. She exited the room carrying a breakfast tray cover and placed it on a cart in the hallway. During an interview with CNA #2 on 7/9/20 at 9:03 A.M., she said that: 1.) On the AQU the staff were required to remove all PPE, in the doorway of the resident rooms, place the PPE in a bag and place the bag of PPE in the soiled linen bin in the hallway. 2.) The staff were required to perform hand hygiene prior to entering and exiting all rooms on the AQU. 3.) The staff were required to place all food trays on the designated cart in the AQU hallway. She explained that the unit had a designated elevator for the unit. She said that the staff should never take a tray over to the COVID-19 negative unit due to the risk of contamination. On 7/9/20 at 9:10 A.M., the surveyor entered the 1st floor unit, which was comprised of COVID-19 positive and COVID-19 recovered residents and made observations of Nurse #2. The surveyor observed a Nurse (#2) standing in the hallway at a medication cart, wearing a glove on each hand and typing on her computer keyboard. Without performing hand hygiene and without removing the gloves Nurse #2, opened a drawer on the medication cart and moved medication around, potentially contaminating the drawer and the medication containers inside. At 9:15 A.M., the surveyor observed Nurse #2 lock her medication cart and exited the unit without removing her gloves or performing hand hygiene. Wearing the same gloves, Nurse #2 opened the threshold door and entered the other side of the unit, potentially contaminating the door, and contrary to the facility's hand hygiene policy. On 7/9/20 at 9:17 A.M., the surveyor observed Nurse #2 re-enter the unit through the threshold doors, return to her medication cart and without performing hand hygiene place on a new pair of gloves, potentially contaminating the gloves. Nurse #2, without performing hand hygiene or removing the gloves, opened up her medication cart and removed a box of medication. She carried the box to room [ROOM NUMBER] (a room designated to have a COVID-19 positive resident residing in it), pushed open the door with the same gloved hands and placed the box of medication on top of a trash can in the room. Nurse #2 instructed the two CNA's that were in the room I put it right there (motioning to the trash can) to put on her. During an interview with Nurse # on 7/9/20 at 9:23 A.M., she said to the surveyor: 1.) She was never supposed to wear two gloves in the hallway but that it made her feel more secure (from COVID-19) and that she was expected to never enter the COVID-19 negative unit wearing the same gloves and without performing hand hygiene, due to the risk of contamination, but that she had done so without realizing. 2.) She was required to administer all medications and treatments ordered by the physician but I sometimes do it and sometimes I give it to the CNA's to do. She verified that she had to sign off in the Medication Administration Record [REDACTED]. 3.) She verified that on 7/9/20 what the surveyor had observed her she had left [MEDICATION NAME] Powder (a medication ordered to be applied to the armpits, breast and abdominal folds each shift for skin care) on top of the trash can is resident #116's room, she had instructed the CNA's to apply it to the resident, but that she had documented in the resident's record that she had administered the medicated powder herself. During an interview with the Director of Nursing (DON) on 7/9/20 at 10:27 A.M., she said: 1.) The staff are required to change all PPE and leave it in the receptacle in the hallway when they exit any room on the AQU. Further, it was required that staff don new PPE prior to entering any resident room on the AQU. 2.) That CNA #1 should never left a room on the AQU wearing PPE and entered the COVID-19 negative unit carrying a used breakfast tray, as both instances present high risk of contamination of the COVID-19 negative unit. 3.) That Nurse #2 should never have left medication that was to be applied to a resident on a trash can due to the high risk of contamination. Further, she verified that the resident in room [ROOM NUMBER] was COVID-19 positive, and that after a medication cream was applied the container was expected to be returned to the cart, where in this instance it could potentially contaminate the cart and all the items inside.