STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225537	A. BUILDING _____ B. WING _____	**06/29/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
TOWN AND COUNTRY HEALTH CARE CENTER	**259 BALDWIN STREET 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 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 south unit on 6/29/20, at 10:15 A.M., Therapist #1 exited room [ROOM NUMBER] S (a room whose resident is under quarantine) without removing her clothing protector and walked down the hallway to the nurse's station. Therapist #1 then returned to room [ROOM NUMBER] S. During an interview on 6/29/20, at 10:16 A.M., Nurse #1 said that staff should remove clothing protectors before exiting a quarantine room. During inspection of the south unit on 6/29/20, at 10:24 A.M., the surveyor observed Housekeeper #1 enter room [ROOM NUMBER] S and exited without removing his clothing protector or performing hand hygiene (HH). At 10:34 A.M., the surveyor also observed Therapist #1 exit room [ROOM NUMBER] S carrying a water container to fill for the resident without removing her clothing protector. During an interview on 6/29/20, at 10:37 A.M., Therapist #1 said that she wasn't aware that the resident in room [ROOM NUMBER] S was under quarantine. She also said that she didn't notice the sign that was posted on the door of room [ROOM NUMBER] S that indicated that a resident was under quarantine. Review of the facility policy titled Person Under Investigation for COVID-19 and not dated indicated that prior to exiting the resident room you will remove gloves and precaution gown, place in trash and perform HH.

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.