STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225475	A. BUILDING _____ B. WING _____	08/03/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MADONNA MANOR NURSING HOME	**85 NORTH WASHINGTON STREET NORTH ATTLEBORO, MA 02760**

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** - Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, review of the facility's infection control policies, review of the Center for Disease Control (CDC) guidelines, the facility failed to implement proper infection control prevention and control practices. 1. The facility failed to ensure that all staff and vendors used Personal Protective Equipment (PPE) appropriately, specifically masks, gowns and hand hygiene, and failed to ensure that isolation gowns were stored properly to ensure they were free from contamination. 2. The facility failed to conduct COVID-19 testing on all negative residents in the facility on 2 occasions when healthcare personnel (HCP) and a resident was newly diagnosed with [REDACTED]. The facility had 1 COVID-19 positive resident, 38 recovered residents, and 43 negative (never tested positive for COVID-19) residents. Findings include: The facility's PPE Competency Validation evaluation for Donning and Doffing PPE (dated 9/2016) based on the facility's Standard and Transmission Based Precautions policy (last revised 5/2020) included the following: -Perform hand hygiene -Don gown: fully covering torso from neck to knees, arms to end of wrists -Tie/fasten in back of neck and waist -Don Mask/respirator: secure the ties/elastic bands at middle of head and neck -Fit snug to face and below chin Review of the CDC's Testing Guidelines for Nursing Homes (7/21/20) included the following: -Perform expanded [MEDICAL CONDITION] testing of all residents in the nursing home if there is an outbreak in the facility (i.e., a new [DIAGNOSES REDACTED]-CoV-2 infection in any HCP or any nursing home-onset [DIAGNOSES REDACTED]-CoV-2 infection in a resident). -A single new case of [DIAGNOSES REDACTED]-CoV-2 infection in any HCP or a nursing home-onset [DIAGNOSES REDACTED]-CoV-2 infection in a resident should be considered an outbreak. When one case is detected in a nursing home, there are often other residents and HCP who are infected with [DIAGNOSES REDACTED]-CoV-2 who can continue to spread the infection, even if they are asymptomatic. -Performing [MEDICAL CONDITION] testing of all residents as soon as there is a new confirmed case in the facility will identify infected residents quickly, in order to assist in their clinical management and allow rapid implementation of IPC (Infection Prevention and Control) interventions (e.g., isolation, cohorting, use of personal protective equipment) to prevent [DIAGNOSES REDACTED]-CoV-2 transmission. During interview with the Administrator, Director of Nursing (DON) and Assistant Director of Nursing (ADON) at 9:15 A.M., they said that all staff wear eye protection and a mask throughout the building. They said that staff are to wear a gown and gloves for resident contact, and remove the gown and gloves before leaving the room. If a resident has a blue dot on the nameplate outside of their room, that means that the resident is negative (never tested positive for COVID-19). The first floor unit was closed, the 2nd and 3rd floor unit included COVID-19 recovered and negative residents, and the 4th floor had 1 COVID-19 positive resident. On 7/28/20, observations of breaches in infection control practices, and inappropriate use of PPE were as follows: Unit 2 - At 10:20 A.M., a staff member was observed standing in front of the elevator untying and removing an isolation gown. The staff member did not remove the gown in the resident's room prior to exiting the room. - At 10:23 A.M., a staff member was observed to remove a clean gown from a precaution cart in the hallway, walk down the hallway and enter a resident's room, and put on an isolation gown backward, and fastened the ties in the front of her body which cinched the gown which exposed her clothing underneath to the potential for contamination. The resident's nameplate outside of the room had a blue dot on it, which indicated the resident was negative (never tested positive for COVID-19). - At 10:30 A.M., a housekeeper was observed walking down the hallway wearing a faceshield and N95 respirator mask. The top strap of the mask was placed on the crown of his head, and the bottom strap was hanging loosely underneath his chin and not placed behind his head to ensure a tight fit. A gap between the lower part of the mask and his chin and cheeks was observed. - At 10:40 A.M. at the end of the Hixon hallway, three isolation gowns were observed rolled up, secured with elastic bands, and placed on handrails along the walls. Four rolled up isolation gowns were observed placed on an over bed table in the hallway. The isolation gowns were not stored properly to ensure they were free from contamination. Unit 3 - At 10:45 A.M., Nurse #1 was observed standing at the medication cart wearing an isolation gown which was untied, and exposed her clothing to potential contamination. - At 10:48 A.M., a laboratory staff was observed walking down the(NAME)hallway, pulling a rolling cart to the end of the Hixon hallway. She was observed to rummage through the cart to obtain supplies. She then put on (don) an isolation gown. The lab staff did not perform hand hygiene before donning the gown. She was then observed to run her fingers through her hair three times, therefore contaminating her hands. The lab staff obtained gloves from her rolling cart and put them on without performing hand hygiene. She was then observed to enter the resident's room (a blue dot was on the nameplate) and prepare a resident for a blood draw. The DON and ADON said that two CNAs (certified nursing assistant) and one housekeeping staff were diagnosed with [REDACTED]. However, they did not expand [MEDICAL CONDITION] testing to all residents as soon as the positive cases were identified as per the CDC guidance. All residents were not tested again for COVID-19 until 7/22/20, 14 days after the first CNA tested positive for COVID-19. Staff surveillance testing was conducted on 7/27/20, and eight positive results (four CNAs, two nurses, one contracted Physical Therapist, and one dietary staff) were received on 7/30/20. However, no testing of residents in close contact of the eight staff members was conducted until 8/3/20, four days after the positive results of staff were obtained from the lab. The DON and ADON said that they were not aware of CDC guidance related to re-testing of residents due to positive results of staff or residents during baseline and surveillance testing.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE