STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225767	A. BUILDING _____ B. WING _____	**07/13/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CONTINUING CARE AT BROOKSBY VILLAGE	**400 BROOKSBY VILLAGE DRIVE PEABODY, MA 01960**

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 guidance review, the facility failed to ensure 1.) staff donned and doffed appropriate Personal Protective Equipment (PPE) when caring for residents that are newly admitted from the hospital setting and on contact/droplet precautions, and 2.) staff disinfected non disposable equipment (electronic blood pressure monitoring device) after use with a resident that was on quarantine. Findings include: Review of the Centers for Disease Control (CDC) guidance: Considerations for New Admissions or Readmissions to the Facility, last updated 4/30/20, indicated that a single negative test upon admission does not mean that a resident was not exposed or will not become infected in the future. Newly admitted residents or readmitted residents should still be monitored for evidence of COVID-19 for 14 days after admission and cared for using all recommended COVID-19 PPE. On 7/13/20 at 8:45 A.M., during interview, the Director of Nurses (DON) said that all residents that are new admissions or readmissions are kept in quarantine for 14 days and staff are expected to don full PPE (N95 mask, face shield, gloves and gown) while caring for these residents. She said that the gloves and gown are removed prior to leaving that room and a new gown and gloves would be donned after exiting the room. On 7/13/20 at 11:00 A.M., observations on the second floor unit revealed two staff members (Nurse Practitioner #1 and Licensed Nurse #1) in a room with a resident designated as a quarantine room. After several minutes, both staff members left the resident's room still wearing the same gown they had on as they entered the room. Licensed Nurse #1 walked out of the room and down the hallway with the electronic blood pressure device and plugged it into an electrical socket. Licensed Nurse #1 did not disinfect the device upon leaving the quarantined resident's room. Licensed Nurse #1 walked around the corner and returned back to the area of the same quarantine room at approximately 11:15 A.M. with a drink in hand for the resident. On 7/13/20 at 11:00 A.M., during an interview, Nurse Practitioner #1 said that (despite the precaution signage and precaution cart set-up) the resident in that room had been back from the hospital for well over 14 days and the staff must have forgotten to take down the precaution signage and cart. On 7/13/20 at 11:10 A.M., review of the Admission Report, dated 7/13/20, indicated that the resident in the quarantine room had been admitted on [DATE] (10 days prior, not well over 14 days). On 7/13/20 at 11:15 A.M., during an interview, Licensed Nurse #1 said that he wasn't sure about when the electronic blood pressure device gets disinfected. He said he thought someone else disinfected it every few hours or so. He said that he didn't know he should have disinfected it himself after leaving the quarantined resident's room. On 7/13/20 at 1:00 P.M., during an interview, the Assistant Director of Nursing/Infection Control Nurse said that the electronic blood pressure device should have been disinfected once it was removed from the quarantined resident's room by the nurse who used it. She also said that Nurse Practitioner #1 and Licensed Nurse #1 should have discarded their isolation gowns in the room and donned new gowns once they left the quarantined resident's room.

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