STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225376	A. BUILDING _____ B. WING _____	**07/06/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
PENACOOK PLACE, INC	**150 WATER STREET HAVERHILL, MA 01830**

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 and interview, the facility failed to ensure that Certified Nursing Assistants (CNA#1 and CNA#2) followed appropriate infection control practices to avoid the potential spread of COVID-19 after providing resident care. Findings include: The facility policy titled Infection Prevention and Control Policy, Hand Hygiene dated October 2019, indicated that hand hygiene was to be performed: *Before and after glove use *Before and after each resident contact *After touching resident belongings. The facility policy titled Infection Prevention and Control, Standard Precautions dated November 2019, indicated: *Hand hygiene must be done after removing gloves because gloves can have a microtear; there is not a solid barrier, hands are contaminated with removal and hands get moist in them and grow microorganisms. On 7/6/20 at 7:45 A.M., the surveyor entered the 2 South Dementia Unit. The surveyor observed a resident seated in a wheelchair in the hallway, wearing a face mask, outside of room [ROOM NUMBER]. A nurse approached the resident and redirected him/her by pushing the wheelchair back into room [ROOM NUMBER]. The nurse returned to her medication cart and without performing hand hygiene, entered information on the computer and potentially contaminated the keyboard. On 7/6/20 at 7:55 A.M., the surveyor observed CNA#1 exiting room [ROOM NUMBER], wearing a glove on each hand and carrying a bag of dirty linen. CNA#1 crossed the hall and using one of her gloved hands picked up a pen and paper that was on top of the dirty linen cart and potentially contaminated the paper and pen. The Surveyor observed CNA#1 lift the cart's cover and place the dirty linen inside. CNA#1 removed both gloves, then picked up the pen and made a notation on the paper, potentially contaminating her hands, and then placed both the pen and paper back atop the dirty linen cart and reentered room [ROOM NUMBER]. The Surveyor observed that CNA#1 did not perform hand hygiene before re-entering room [ROOM NUMBER] and could be observed by the Surveyor from the doorway that she did not perform hand hygiene upon entering. On 7/6/20 at 7:57 A.M., CNA#1 exited room [ROOM NUMBER] and made another notation on the paper with the pen that was atop the dirty linen cart, potentially contaminating both her hands, CNA#1 then walked down the hallway, without performing hand hygiene, and was observed to stop and adjust a facemask on a resident who was walking down the hallway, potentially contaminating the resident's face and the facemask. The Surveyor observed that CNA#1 did not perform hand hygiene after physically assisting the resident with the face mask. On 7/6/20 at 8:00 A.M., CNA#1 returned to the dirty linen cart, put on two gloves and without performing hand hygiene pushed the cart to the dirty utility closet. At the same time, CNA#2 walked from the far end of the hallway, wearing a glove on each hand and carrying a bag of soiled linen. CNA#2 opened the dirty utility closet with one of the gloved hands and entered, potentially contaminating the door handle. Upon exiting the dirty utility closet the surveyor observed that CNA#2 did not clean the contaminated door handle. On 7/6/20 at 8:10 A.M., during an interview with CNA#1 she said to the surveyor that she was not supposed to wear gloves in the hallway and that she should have immediately washed her hands after handling the dirty linen cart and providing care to a resident. CNA#1 said that her documentation (pen and paper) should not be left on top of the dirty linen cart and that she was not supposed to perform her documentation while it was on top the cart. On 7/6/20 at 9:20 A.M., during an interview with the facility's Infection Control Nurse she said that all of the staff on the 2 South Dementia unit were supposed to be wearing full Personal Protective Equipment (PPE) with close monitoring of all the residents due to the recent [DIAGNOSES REDACTED]. Further, the Infection Control Nurse said: *Gloves should not be worn in the hallways. *Hand hygiene was expected to be performed after all care and after contact with items such as the dirty linen cart. *No paper or pens should be kept atop the dirty linen cart, nor should documentation be conducted upon dirty linen carts as they are contaminated. *No resident's face mask should be adjusted without the staff member first performing hand hygiene. At 7/6/20 at 9:45 A.M., during a follow-up interview with the Infection Control Nurse she said that she had spoken with CNA#2 who said that she had forgotten to bring a dirty linen cart with her to all the residents' rooms that day and that was why she was carrying the dirty linen, with a glove on each hand to the dirty utility room. During an interview with the DON on 7/6/20 at 10:00 A.M., he said that CNA#1 and CNA#2 knew what to do and did not do the right thing. He said that it was never okay to wear gloves in the hallway or to document atop a dirty linen cart. Further, he said that it was his expectation, staff always perform hand hygiene before and after resident care and after handling contaminated items.

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