STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	225515	A. Building B. Wing	02/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
D'Youville Senior Care	981 Varnum Avenue Lowell, MA 01854

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 - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41105 Based on observation and interview the facility failed to ensure 1.) staff performed hand hygiene when indicated and 2.) wore proper Personal Protective Equipment (PPE) when treating a COVID-19 positive resident, during a COVID-19 outbreak at the facility. Findings include: Review of the facility's policy titled, Handwashing/ Hand Hygiene, dated 9/2021, indicated Hand Hygiene must be performed minimally under the following conditions: K. After removing gloves; N. Upon completion of duty. Review of the facility's policy titled, Personal Protective Equipment (PPE), reviewed 1/2022, indicated B. Gowns, in addition to wearing a gown as outlined in Standard Precautions, wear a clean gown when entering the room if you anticipate that your clothing will have substantial contact with the resident, environmental surfaces or items in the resident's room or if the resident is incontinent, has diarrhea etc. C. PPE, Appropriate PPE is to be used during the following high-contact resident care activities: A. Dressing B. Bathing/Showering C. Transferring D. Providing Hygiene E. Changing Linens F. Changing briefs or assisting with toileting (continued on next page)

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.

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Gloves and gown are donned prior to the high-contact care activity. Change PPE before caring for another resident. During an initial interview on 2/7/23 at 8:45 A.M., the Nursing Home Administrator, Infection Preventionist Nurse and Director of Nursing (DON) indicated that the facility had been in a COVID-19 outbreak since 12/31/22. The Infection Preventionist Nurse said that the most recent COVID-19 positive case for residents was on 2/3/22 and that there remained 7 residents in the facility that were presently COVID-19 positive. 1.) During an observation on 2/7/23 at 9:45 A.M., the surveyor observed Housekeeper #1 cleaning the [NAME] Unit main dining room, wearing a glove on each hand. Housekeeper #1 finished cleaning, removed the gloves, then without performing hand hygiene pushed his cart to the exit door, pushed open the door with his hand, contaminating the door's surface and exited the dining room. During an observation on 2/7/23 at 9:50 A.M., on the [NAME] Unit (6 residents on the unit are presently COVID-19 positive) the surveyor observed Housekeeper #2 exit a resident room, remove his gloves and place the gloves in the trash. Then, without performing hand hygiene, Housekeeper #2 pushed open an exit door, contaminating its surface and exited the unit. The surveyor continued to make the following observation on the unit: * At 9:57 A.M., Housekeeper #3 exited the soiled utility room with a glove on each hand. Housekeeper #3 removed his gloves in the hallway and placed them in the trash. Then, without performing hand hygiene, was observed to push his trash cart to the unit exit, push open the exit door with his hand, contaminating the door's surface and exit the unit. During an observation on the [NAME] Unit on 2/7/23 at 10:20 A.M., the surveyor observed a Certified Nursing Assistant (CNA) exit a resident room, wearing a glove on each hand and carrying a bag of soiled linen in each hand. The CNA walked to the soiled utility closet, and with a gloved hand entered a code in the keypad and pushed open the door, contaminating the surfaces of both the keypad and door. During an interview on 2/7/23 at 12:01 P.M., the Administrator, Infection Preventionist Nurse and DON said it was the expectation that staff perform hand hygiene before and after they DON and DOFF gloves. Further, they said it was their expectation the staff not wear gloves in the hallway or touch surfaces, such as the keypad to the soiled utility room and it's door, while wearing gloves. 2.) During an observation on 2/7/23 at 11:10 A.M., on the [NAME] Unit (6 residents on the unit are presently COVID-19 positive) the surveyor observed an Occupational Therapist (OT) #1 in a COVID 19+ resident room treating the resident. OT #1 was not wearing a protective gown. A sign hanging on the door at the entryway to the room indicated the staff were to follow ISOLATION droplet/contact precautions and were required to wear a gown when in the room. The surveyor continued to make the following observations: * At 11:10 A.M., OT #1 had her right arm around the resident's waist and her left hand on the resident's walker as she walked the resident to the bathroom. OT #1 entered the bathroom with the resident and could be overheard guiding the resident through the removal of his/her pants. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	* At 11:14 A.M., a Certified Nursing Assistant (CNA) knocked on the door and asked OT #1 to step out and assist her. The two walked down the corridor and entered another resident room. The CNA was overheard instructing OT #1 to wear a protective gown while working with the resident in the COVID-19 positive room. * At 11:15 A.M., OT #1 walked back up the corridor and said to the surveyor I should be wearing a gown when providing personal care, as she placed on a gown on and re-entered the room. During an observation and interview with OT #1 on 2/7/23 at 11:34 A.M., the surveyor observed OT #1 exiting the COVID-19 positive resident room. As OT #1 exited the room, she grabbed her satchel bag that she had hung in the resident's room and placed it around her neck. OT #1 said that she should have been wearing a protective gown when providing care to a resident on COVID-19 precautions. OT #1 then exited the unit and went to the facility's dementia unit to provide further therapy. During an observation in the Dementia unit's shared dining room on 2/7/23 from 11:42 A.M., to 11:48 A.M., the surveyor observed OT #1 adjusting a resident seated at a table of 3 residents. The surveyor observed OT #1 less than 6 feet apart from the residents, talking closely to them and still wearing the contaminated satchel bag around her neck. During an interview on 2/7/23 at 12:01 P.M., the Administrator, Infection Preventionist Nurse and DON said it was the expectation that staff wear full PPE, including a gown during therapy and high contact care such as toileting, to a COVID-19 positive resident. Further they said staff should not take personal items into a COVID-19 positive room and then wear the item to other units in the facility. 43846