STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075280	A. BUILDING _____ B. WING _____	05/19/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WESTPORT REHABILITATION COMPLEX	1 BURR ROAD WESTPORT, CT 06880

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.** Based on observation, review of facility documentation, facility policy, and interviews the facility failed to develop and implement current policies for the appropriate use of personal protective equipment (PPE) per standard of care for residents with known or suspected Covid 19, failed to ensure PPE was readily available to health care personnel (HCP) in a facility with residents known or suspected of Covid 19, failed to ensure signage on the use of specific PPE was posted outside of a resident room for staff caring for residents with known or suspected Covid 19, and failed to ensure fit testing was conducted for staff wearing specialized N95 masks according to standards of care. The findings include: A) An observation on 5/19/20 at 9:30AM with the DNS identified Housekeeper #1 on a unit with residents suspected of Covid 19 without eye protection. A subsequent observation at 9:45AM identified NA #1exiting a unit with residents known to have Covid19, with PPE that included a Tyvek suit. NA #1 was observed entering a unit unoccupied by residents. Housekeeper #1 was also observed at that time exiting the same unit wearing PPE that included a Tyvek suit. An interview on 5/19/20 at 10:30AM and 12:38PM with Housekeeper #1 identified while s/he was aware of the requirement to wear eye protection on a unit with residents known or suspected Covid 19, s/he did not like to do so as it got too hot. Housekeeper #1 also indicated that while s/he did exit through a unit known to have residents with Covid 19 wearing PPE that included a Tyvek suit, s/he was not working on the unit. Instead, entered the unit through the back stairs and walked through the unit in search of an electric chair device then exited the unit while stilled donned in PPE. An interview on 5/19/20 at 11:04AM with the DNS identified the Infection Preventionist provided staff with a packet of PPE daily that included one isolation gown, gloves, mask, eye protection and hair covering. Staff were required to wear eye protection on units with known or suspected Covid 19 and should have had them on at the time of the observation. The DNS also indicated staff were expected to doff meaning remove PPE prior to exiting a unit with known cases of Covid 19 according to policies. An interview on 5/19/20 at 11:40AM with RN #1 identified s/he provided staff with a packet of PPE daily that included one isolation gown, gloves, one mask, eye protection, and hair protection. PPE was replaced when visibly soiled. Otherwise used for all residents including those working on a unit with suspected Covid 19 where staff were wearing one gown between all residents. Additional gowns would be provided if visible soiled as requested. RN #1 indicated as the Infection Preventionist, s/he did not feel this was safe but can only go by the Administrator and DNS's report of shortages. An interview with NA #1 on 5/19/20 at 11:57AM identified while s/he was aware PPE needed to be removed before leaving a unit known to have residents with Covid 19, s/he had to use the ladies room so instead removed the yellow gown worn over a Tyvek suit which remained on, removed gloves and performed hand hygiene before exiting the unit. NA #1 indicated s/he placed the Tyvek suit in a plastic bag for future use as only one Tyvek suit was provided to staff and instructed to use over. NA #1 ensured the Tyvek suit was brought home and laundered between uses. An interview on 5/22/20 at 12:15PM with NA #2 identified when assigned to a unit known to have residents with Covid 19 s/he was provided a Tyvek suit as part of PPE to wear when assigned to work on the unit. NA #2 indicted s/he had never been provided a new Tyvek suit was instructed not to throw it away, so instead, disinfected the suit with alcohol and stored in a paper bag in his/her care between uses. An interview on 5/19/20 at 12:24PM with NA #3 identified s/he was provided a packet of PPE daily that included one isolation gown, gloves, mask, eye protection and hair covering. NA #3 indicated s/he wore the same gown while caring for residents with suspected Covid 19. An inventory of the facility PPE identified there were 1278 isolation gowns in storage. Review of the facility policy dated 2001 for Transmission Based Precautions directed masks, gown, gloves and goggles be worn if there was a risk of spraying respiratory secretions for a person suspected of infected microorganisms transmitted by droplets. The facility policy dated 4/3/20 for use of PPE directed doffing to take place prior to exiting a patient room. The policy did not include education or strategies on the extended use of eye protection use or care of a Tyvek suit as PPE and its extended use strategies on a unit with residents with known Covid 19. CDC guidance for the extended use of eye protection recommends the practice of wearing the same eye protection for repeated close contact encounters with several different patients, without removing eye protection between patient encounters. Extended use of eye protection can be applied to disposable and reusable devices. CDC guidance for Extended Use Strategies with isolation gowns recommends consideration can be made to extend the use of isolation gowns (disposable or cloth) such that the same gown is worn by the same HCP when interacting with more than one patient known to be infected with the same infectious disease when these patients housed in the same location. Doffing must occur before leaving a resident room or process to be adjusted when utilizing extended use of isolation gowns. The facility failed to develop and implement current policies for the appropriate use of personal protective equipment (PPE) per standard of care with residents suspected or known Covid 19. B) An observation on tour dated 5/19/20 at 9:30AM identified (4) isolation bins on a unit with residents suspected Covid 19 and (8) bins on a unit with known Covid 19, that lacked a stock of readily available PPE. An interview on 5/19/20 with the DNS identified staff had access to PPE. S/he identified the Infection Preventionist stocks the bins daily and provides the staff with a packet of PPE daily that includes one isolation gown, gloves, mask, eye protection and hair covering. The DNS did not know why theses bins were not stocked at the time of observation. An interview on 5/22/20 at 11:40AM with RN #1 identified s/he was responsible for providing staff a packet of PPE daily that included one isolation gown, gloves, mask, eye protection and hair covering. RN #1 indicated s/he was also responsible for stocking the bins on the units. RN#1 reported only one packet of PPE was provided daily and isolation bins on the unit were not stocked as a result of a PPE shortage at the facility. As a result, there was limited supply of PPE provided to staff including those working on a unit with suspected Covid 19 who were wearing one gown between residents. Additional gowns would be provided if visible soiled if requested. RN #1 indicated as the Infection Preventionist, s/he did not feel this was a safe practice but could only go by the Administrator and DNS's report of shortages. An interview with NA #1 on 5/19/20 at 11:57AM identified only one Tyvek suit was provided to staff working on a unit with residents with known Covid 19 and instructed to reuse. NA #1 indicated s/he placed the Tyvek suit in a plastic bag for future use and ensured the Tyvek suit was brought home and laundered between uses. NA#1 indicated there was no other PPE on the unit as the facility did not have any. An interview on 5/22/20 at 12:15PM with NA #2 identified when assigned to a unit known to have residents with Covid 19 s/he was provided a Tyvek suit as part of PPE to wear when assigned to work on the unit. NA #2 indicted s/he had never been provided a new Tyvek suit was instructed not to throw it away, so instead, disinfected the suit with alcohol and stored in a paper bag in his/her care between uses. NA #2 indicated if additional PPE was requested it would be provided reluctantly. An interview on 5/19/20 at 12:24PM with NA #3 identified s/he was provided a packet of PPE daily that included one isolation gown, gloves, mask, eye protection and hair covering. NA #3 indicated s/he wore the same gown while caring for residents with suspected Covid 19 as there were not enough gowns for use between residents. An interview on 5/19/20 at 12:46PM with the Administrator identified PPE is provided based on consumption and the facility was normally provided more as needed. A main warehouse was located offsite, and PPE stored for facility use as needed. The facility was also provided PPE from alternate vendors. The Administrator identified each facility was generally stocked with a five-day supply which had been working well with no shortages. PPE was also provided

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.

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) to staff for comfort and confidence which included surgical gowns and Tyvek suits adding the suits were great but one-time use only. Most Tyvek suits were used housekeeping or Covid negative units. While the Administrator identified they were not limiting PPE to staff, s/he was unable to explain why the isolation bins on the units were not stocked and that staff were reporting there were PPE shortages adding communication with staff could have been better. The facility policy dated 2001 for Transmission Based Precautions directed masks, gown, gloves and goggles be worn if there was a risk of spraying respiratory secretions for a person suspected of infected microorganisms transmitted by droplets. Current standards of care recommend sufficient PPE supplies be available to follow infection prevention and control guidelines. The facility failed to ensure PPE was readily available to the staff in a facility with suspected or known cases of Covid 19. C) An observation on 5/19/20 at 9:30 AM identified signage for droplet inside (4) isolation bins on a unit with residents suspected of Covid19 and (8) isolation bins on a unit with residents with known Covid 19. Signage were posted on the door of each resident room on isolation precautions to stop and see the nurse before entering. An interview on 5/19/20 at 12:46PM with the Administrator identified the facility policy directed required signage for a resident on transmission-based precautions indicating the type of precautions or direction to see the nurse before entering the room.The facility policy for Transmission Based Precautions dated 2001 directed appropriate notification was to be placed on the room entrance door of a resident placed on transmission-based precautions and/or instructions to see a nurse before entering a room. Current standards of care pertaining to residents placed on transmission-based precautions related to Covid 19 recommend signage for the use of specific PPE for staff to posted in appropriate locations outside of a resident room. The facility failed to ensure signage on the use of specific PPE was posted outside of a resident room for staff caring for residents with suspected or known Covid 19. D) On observation on 5/19/20 at 9:30AM identified facility staff wearing PPE that included N95 masks required to protect health care personnel (HCP) from airborne contaminants such as some infectious agents). An interview on 5/19/20 at 12:46PM with the Licensed Nursing Home Administrator from Traditions identified s/he had reached out to DPH Mutual Aid and was provided contact information for the Connecticut Fire Academy for fit testing. However, appointment times were four weeks out. The Licensed Nursing Home Administrator was going to get tested though The Occupational Safety and Health Administration (OSHA) but was informed there are no supplies for testing available for testing. An interview on 5/19/20 at 12:46PM with the facility Administrator indicated s/he had not reached out to other community resources for possible fit testing. A subsequent interview on 5/22/20 at 2:23PM with the Licensed Nursing Home Administratorfrom Traditions identified s/he had also contacted other vendors for possible fit testing but was unsuccessful in doing so. Subsequent to surveyor inquiry, the facility secured an appointment with the Connecticut Fire Academy within the upcoming 4 weeks and was attempting to get an earlier appointment through other local community resources. The current standard of care for a resident with known or suspected Covid 19 recommends PPE to include an N95 respirator fit tested in a manner that meet OHSA's requirement that evaluates the fit of a respirator on an individual. The facility failed to ensure fit testing was conducted for staff wearing N95 masks according to standards of care.