STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075322	A. BUILDING _____ B. WING _____	**05/17/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ESSEX MEADOWS HEALTH CENTER	**30 BOKUM RD ESSEX, CT 06426**

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 observations, review of facility policy, and interviews, during the initial tour of the facility for one resident (Resident #1) and for two of six sampled residents (Resident #2 and #3) reviewed for infection prevention measures, the failed to ensure the use of a facial mask in the facility and failed to ensure social distancing of six feet to prevent the transmission of COVID-19. The findings include: a. Resident #1 was admitted to the facility on [DATE] with a [DIAGNOSES REDACTED]. Observation on 5/17/2020 at 8:21 AM identified Nurse Aide (NA) #1 leave Resident #1's room without the benefit of a facial mask. NA #1 crossed the hall and entered the clean utility room. Interview with Registered Nurse (RN) #1 on 5/17/2020 at 8:22 AM identified that the facility policy directed the use of facial masks by all staff while in the facility. Interview with NA #1 on 5/17/2020 at 8:24 AM identified that although he/she new the facility policy always directed the use of facial masks, he/she had forgotten to wear one. a. 1. Resident #2 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. 2. Resident #3 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Observation and interview with RN #1 on 5/17/2020 at 8:25 AM identified Resident #2 and Resident #3 outside of their doorway, eating breakfast in the hallway. Neither resident was wearing a mask or face shield and the residents were between 4.5 and 5 feet apart. RN #1 identified that both Resident #1 and Resident #2 always ate their breakfast outside of their doors due to the need for staff monitoring. RN #1 identified that the residents were not appropriately social distanced (six feet), and subsequently requested of stafff that the residents be separated to six feet apart.

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.