STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075410	A. BUILDING _____ B. WING _____	04/26/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AARON MANOR NURSING & REHABILITATION	3 SOUTH WIG HILL RD CHESTER, CT 06412

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 observations, review of facility documentation, and interviews the facility failed to ensure effective infection prevention and control strategies included environmental cleaning of frequently touched surfaces and/or proper use of Personal Protective Equipment (PPE) was worn appropriately by housekeeping staff to prevent potential cross contamination of facility laundered isolation gowns. The findings include: 1. During tour of the facility on 4/26/20 at 8:50 AM, observation identified certified nursing assistant (CNA #1) assisting with the breakfast food service on one of the COVID-19 units. CNA #1 entered a resident room identified with COVID-19 transmission-based precautions while wearing personal protective equipment (PPE) of isolation gown, plastic shower cap type hair covering over a cloth hair cover and a full-face shield over her mask. The meals were served from an open meal service cart and after exiting the room CNA #1 demonstrated doffing off the reusable gown with hand hygiene before leaving the room. CNA #1 was observed removing the cart from the COVID unit through a hallway of the non-COVID unit to deliver the cart to a location outside the facility' s kitchen. CNA #1 was further observed touching a Kiosk screen located directly across the hall from the facility ' s kitchen entrance without the benefit of hand hygiene after touching the cart. Interview with CNA #1 on 4/26/20 at 8:55 AM identified the Kiosk near the kitchen was preferred to document her completion of resident care because the Kiosk on her unit was a little slower for connecting to the electronic health record. Interview with Housekeeper #1 on 4/26/20 at 9:15 AM identified facility products utilized for environmental cleaning was without the benefit of being used to clean the Kiosks. Housekeeper #1 identified not being unaware of how the Kiosk screens were to be cleaned and identified nursing was responsible for cleaning the touch screens on the Kiosks. Observation of Kiosk use and interview with CNA #2 on 4/26/20 at 9:35 AM identified she was unaware of how the touch screen on the Kiosk was cleaned. The facility failed to ensure frequently touchpoint environmental surfaces were cleaned regularly to ensure transmission-based infection prevention strategies were implemented. 2. Observation on 4/26/20 at 9:30 AM identified Housekeeper #2 collected a small clear plastic bag of gowns from a room located on the ground floor of the facility. This room was identified as part of the rehab department that included a kitchen, with household appliances consisting of a washer and dryer utilized by the housekeeping staff to wash and dry the reusable isolation gowns. Housekeeper #2 carried the bag from the rehab laundry through the facility lobby, up the stairs, and through doors onto a COVID unit. She was observed stocking an isolation cart located on a COVID unit with gowns from the bag. The bag was placed on a chair in the hallway next to an isolation cart. Housekeeper #2 wore the gloves she had on in which she had touched the doorknobs from the rehab laundry room and the drawer handle of the isolation cart. Housekeeper #2 reached into the bag, removed a gown, and while standing in the hallway folded several gowns for storage into the isolation cart from this bag. Without the benefit of glove removal and/or hand hygiene Housekeeper #2 proceeded to leave the COVID unit, opened doors and entered the non-COVID unit, setting the bag of gowns on a chair in the hallway on the non-COVID unit. She then removed the gloves from both hands, and discarded the gloves in the refuse container on her housekeeping cart. The Surveyor attempted an interview with Housekeeper #2 during the observation and a language barrier was identified. Interview with Housekeeper #2 on 4/26/20 at 9:33 AM with the facility Administrator, who attempted to convey to Housekeeper #2 the observations and the concerns of the lack of hand hygiene and the potential cross contamination. Observation of Housekeeper #1 and Housekeeper #3 on 4/26/20 at 10:05 AM identified the reusable isolation gowns were collected from COVID rooms and placed in an open cart along with a bag of disposable paper garbage that was collected from a COVID room. Housekeeper #1 with gloves on both hands selected the bag of garbage from the cart and was pushing on the door to leave the COVID unit. Subsequent to Surveyor inquiry Housekeeper #1 received education from the facility Administrator on hand hygiene and gloving before the bag of garbage was removed from the unit. At 10:15 AM Housekeeper #1 and Housekeeper #3 were observed with the process of taking the soiled isolation gowns down to the rehab laundry for cleaning. Without the benefit of clothing protection, eye protection, and/or specialized N-95 mask (masks worn were surgical) the soiled gowns were shaken out of the plastic bags used for transporting the gowns that tumbled the gowns out of the bags and into the wash machine. One cup of bleach and one cup of laundry soap was added to the load before the washer was turned on. Further inspection of the rehab laundry supplies failed to reflect housekeeping staff were supplied with a designated clean surface for folding or storage of the clean laundry. Interview and review of facility documentation with the facility Administrator, DNS, and Infection Prevention Nurse on 4/26/20 at 11:55 AM identified the facility contracted a laundry service that provided laundering of facility articles off site. The Administrator identified the laundering of the gowns at the facility was completed without the benefit of a policy/procedure. Subsequent to Surveyor inquiry an immediate action plan to correct the deficient practice was developed. Review of facility documentation identified housekeeping staff were in-serviced on lessening the possibility of cross contamination in the laundering of the facility ' s reusable isolation gowns.

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