STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075338	A. BUILDING _____ B. WING _____	07/07/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GOVERNOR'S HOUSE REHABILITATION & NURSING CENTER	36 FIRETOWN RD SIMSBURY, CT 06070

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** Based on observation, interviews and review of facility documentation, the facility failed to remove Personal Protective Equipment (PPE) prior to donning new PPE, failed to ensure a PPE disposal receptacle was inside a resident room (Resident #1) and failed to appropriately store PPE. The findings include: Resident #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Interview with the Infection Control Nurse (ICN) on 7/5/20 at 10:20 AM identified that Resident #1's COVID-19 status was considered exposed because he/she transferred out of the facility for a procedure, returned to the facility, and required specific contact and droplet precautions. Resident #2 was admitted the facility on 3/27/13 with [DIAGNOSES REDACTED]. Resident #2's COVID-19 test dated 6/24/20 and 7/3/20 were negative. Resident #3 was admitted the facility on 4/16/15 with [DIAGNOSES REDACTED]. Resident #3's COVID-19 test dated 7/1/20 was negative. Resident #4 was admitted the facility on 7/12/17 with [DIAGNOSES REDACTED]. Resident #3's COVID-19 test dated 7/1/20 was negative. a. On 7/5/20 at 10:00 AM an observation with the Infection Control Nurse (ICN) identified on the COVID-19 negative units (16 of 16 rooms on the first floor and 15 of 15 rooms on the second floor) signage was posted on the door of all the resident rooms, the oxygen storage rooms, and the supply rooms that identified extended contact plus droplet precautions were in place. The signage further directed to see the nurse prior to entering the room and to wear a face mask, gown, eye protection, and gloves upon entering, following extended-use guidance. (the facility was requiring full PPE usage on a COVID-19 negative unit). Observation on 7/5/20 at 10:10 AM identified Nurse Aide (NA) #1 exiting a resident's room on the COVID-19 negative unit wearing a surgical mask, face shield and isolation gown, cross the hallway and enter another resident's room who was COVID-19 negative. Interview with NA #1 on 7/5/20 at 10:10 AM identified that she wore the isolation gown on the COVID-19 negative unit for her own protection and wore the same gown throughout the shift as directed by the facility. NA #1 further identified she provided resident care that included high touch activities such as assisting with bathing, changing linens and assisting with feeding residents. Additionally, NA #1 identified a PPE storage bin located outside Resident #1's room (a COVID-19 exposed resident), residing on the COVID-19 negative unit. NA #1 stated that the PPE cart outside the room alerted her of the need to change PPE when entering that room, as Resident #1 had special precautions. NA #1 identified she would wash her hands, don a new isolation gown over her extended use gown, put on new gloves and continue to wear the same face shield stating that she would clean her face shield prior to entering Resident #1's room. Additionally, NA #1 identified that she would remove the isolation gown that was previously donned over the extended use isolation gown, remove her gloves, wash her hands and clean her face shield upon exiting, keeping her extended wear isolation gown on. Observation and interview with LPN #1 on 7/5/20 at 10:30AM at the open door to Resident #1's room identified that there was not a PPE disposal container located in the room. Interview with the ICN on 7/5/20 at 10:30 AM identified that it was Corporate policy to wear extended use gowns and shield on the negative cohort unit with proper cleaning of the face shield in between residents but that due to Resident #1's possible COVID-19 exposure, Resident #1 required specific precautions that included donning a new isolation gown and gloves upon entering the room and then taking off the isolation gown and gloves when exiting, the extended use isolation gown should be taken off prior to putting on the new isolation gown. Additionally, the ICN further identified that a PPE disposal receptacle should have been in the room. The facility PPE policy identified: Use, Reuse and Extended Use PPE directs that for residents with patient-specific contact and airborne precautions, signage on the door should identify the resident as having Patient Specific Contact and Droplet Precautions that would require taking off a used isolation gown and putting on a new isolation gown when entering the resident's room and the taking off of that isolation gown when leaving the resident's room. The observed signage on Resident #1's door identified that Resident #1 was on Extended Contact and Droplet Precautions that required the staff to wear a face mask, gown and gloves following extended use guidance and did not have the sign that appropriately identified Resident #1 as being on Patient Specific Contact and Droplet Precautions. Interview and review of the PPE: Use, Reuse and Extended Use PPE with the ICN on 7/6/20 at 9:30AM identified that the correct signage on Resident #1's door should have been the sign entitled Patient Specific Contact and Droplet Precautions that would have directed the staff to put on a new isolation gown upon entering Resident #1's room. Resident #1 did not have appropriate precaution signage as per facility policy and the facility failed to assure appropriate PPE usage between exposed residents and negative residents. Additionally, the facility failed to provide a PPE disposal receptacle inside Resident #1's room. b. Observation and interview with the ICN on the facility's COVID-19 positive unit on 7/6/20 at 11:00 AM identified that the three rooms located at the end of the unit were identified as COVID-19 negative rooms and were occupied by Residents #2, Resident #3, and Resident #4. Interview with Licensed Practical Nurse #1 on 7/6/20 identified that her assignment included all 12 COVID-19 positive residents and the 3 COVID-19 negative residents (Residents #2, #3, and 4) located on the end of the unit. LPN #1 further stated that when she started her care, she would start with the COVID-19 negative residents (Resident #2, #3, and #4), donning a new isolation gown over her extended use gown, a clean face shield and a new surgical mask to wear over her extended use N95. She would continue to wear the isolation gown over her extended use isolation gown to then provide care to the COVID-19 positive residents, taking off the additional isolation gown when done with her care of the COVID-19 positive residents, and not change/remove the extended use gown. LPN #1 further stated that she wears the extended use protective gown throughout the shift donning an additional isolation gown when she moves from caring for the positive COVID-19 residents to the negative COVID-19 residents (residents #2, #3 and #4). Interview with the ICN on 7/6/2020 at 11:05 AM identified that this was not the policy of the facility and LPN #1 should not be wearing the same isolation gown and then put on an additional isolation gown to provide care when moving from caring for COVID-19 positive residents to COVID-19 negative residents; LPN #1 should be taking off the extended use gown prior to starting her care for the COVID-19 negative residents stating that the facility policy was to wear the extended use PPE as directed by the Extended Contact and Droplet Precautions guidelines between COVID-19 negative residents only. The facility policy entitled PPE: Use, Reuse and Extended Use PPE for all staff directs for gown use to a Like to Like Practice indicating that when caring for a resident with NO infectious process such as residents who have tested negative for COVID-19, the staff member may wear the same gown to go in and out of those resident rooms and into the hallway and to not touch the front or sleeves of the gown. Additionally, when caring for residents with the same infectious disease, that staff member may wear the same gown between residents but the gown must be removed in the room and discarded after leaving the room unless going directly to the room of another patient with the same infection. Residents who the facility identified as COVID-19 negative are not infected and the extended use protective gown should have been removed prior to caring for Residents #2, #3 and #4. The facility failed to use isolation gowns as per facility policy when moving from providing care to the COVID-19 positive resident and the COVID-19 negative residents. c. Observation and interview with the ICN on 7/6/20 at 9:30 AM identified 30 large brown paper bags stored in a conference area labeled with staff names and numbered. The ICN identified upon leaving the facility, staff would properly clean their PPE, place their extended use PPE in the labeled paper bag, and then upon arriving for their shift, would take their bag to utilize the stored PPE, adding that PPE storage for the COVID-19 unit was

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

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GOVERNOR'S HOUSE REHABILITATION & NURSING CENTER	**36 FIRETOWN RD SIMSBURY, CT 06070**

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) located on that unit and not stored in this location. Observation of 6 of the 30 bags identified that face shields/goggles and N95 masks were stored together in the bags. Interview with the ICN on 7/5/20 at 9:30 AM further identified that the N95, KN95 and face shields/goggles were extended use items and that N95 and KN95s should be stored separately in another paper bag as the outside of the N95 and KN95s masks were considered contaminated. Observation and interview with the ICN on 7/6/20 at 11:30 AM on the COVID-19 positive unit's PPE storage area identified 4 large brown paper bags labeled with staff names. The ICN identified the bags as belonging to the staff who were consistently assigned to the COVID-19 unit. Upon opening the bags, 2 of the 4 bags had N95's stored with face shield, 1 bag was labelled with NA #4's name who per the ICN had just left for the day. Subsequent to the surveyor's observation, each bag was inspected by the ICN, and contaminated PPE was disposed of, new PPE was provided as per facility policy based on the residents' precaution needs and a separate bag was supplied for storage of the N95s. The facility policy entitled PPE: Use, Reuse and Extended Use PPE for all staff directs when not being worn the respirator (KN 95 or N 95) is to be stored in its own individual paper bag/breathable container; face shields should be cleaned and disinfected after removal and placed in its own individual paper bag/breathable container. The facility did not store extended use PPE in accordance with the facility policy that would prevent cross contamination of the stored PPE causing potential exposure to Covid-19.