STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075324	A. BUILDING _____ B. WING _____	**04/30/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BAYVIEW HEALTH CARE	**301 ROPE FERRY RD WATERFORD, CT 06385**

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, and interviews the facility failed to ensure infection prevention strategies were consistently implemented. The findings include: 1. During tour of the facility on 4/30/20 at 6:50 AM certified nursing assistant (CNA #1) was observed exiting a resident ' s room that was identified with transmission-based infection control precautions without the benefit of required personal protective equipment (PPE). CNA #1 was identified wearing a black mask made of cloth over her mouth and nose without the benefit of a face shield in her possession. The sign posted next to Resident (R #1's) room identified the PPE required for care included use of an isolation gown, gloves, a mask, and face shield. Interview with CNA #1 on 4/30/20 at 6:52 AM identified that for the past two weeks she had worked on the COVID positive unit when she checked in for her shift on 4/29/20 her duty station was changed. She identified and she worked the third shift into 4/30/20 on the non-COVID unit. She identified R #1 was the only resident on the non-COVID unit that was on precautions, that R #1 had been symptom free, and the fourteen-day observation period for R #1 was soon to expire. She identified her PPE of the N-95 mask and face shield were last used when working on the COVID positive unit. She identified that she could have asked a supervisor for new PPE mask and shield on the start of her shift but didn ' t think about it because she was on a non-COVID unit. 2. Observation of the staff screening intake site on 4/30/20 at 7:00 AM identified the hallway where staff lined up for the check-in was without the benefit of markers to signify 6-foot distancing indicators. Staff were frequently reminded by CNA #2 to keep separated and encouraged staff to abide by social distancing facility policies. Potential cross contamination of the monitoring devices used in the screening process were observed. The temporal scanner thermometer prob and the oxygen saturation scanner were repeatedly set down on a table after use to allow CNA #2 both hands needed to open an alcohol prep for cleaning the devices between uses. The cleaned devises were then set back down on the table without the benefit of a clean surface or barrier. Further observations of staff reporting to duty stations identified lack of social distancing when staff entered the elevators together. Interview with the facility Administrator on 4/30/20 at 8:50 AM identified staff were in-serviced on social distancing and were encouraged to use the elevators two at a time. 3. Observation on 4/30/20 at 7:45 AM identified R #2 resided on a non-COVID unit. Outside R #2's door signs posted identified transmission-based infection control precautions were in place. Inspection of the isolation cart outside R #2's room identified a plastic bag inside the cart that contained a white disposable isolation gown and a face shield. A white isolation gown was also identified stuffed in between the wall and had rail next to the isolation cart. On top of the isolation cart was a canister of disinfectant wipes and a box of disposable gloves. Further inspection of the cart identified it was empty without the benefit of equipment or additional supplies. Interview with CNA #3 on 4/30/20 at 8:02 AM identified she had provided care for R #2 earlier in the shift. After providing care for R #2 she identified the gown and shield were placed into the bag for reuse. CNA #3 identified at the start of her shift she was issued the plastic bag that included the gown, a face shield, and a different mask for her PPE use. She reached into her uniform pocket, removed the new mask from the plastic packaging, and exchanged it with the surgical mask she was wearing before donning the rest of her PPE to enter R #2's room. After delivering R #2's breakfast CNA #3 removed the disposable isolation gown and hung it on the door to R #2's bathroom for reuse. After completing hand hygiene, she started to exit R #2 room. Subsequent to Surveyor inquiry CNA #3 sanitized the face shield before exiting the room. CNA #3 identified the next challenge was where to store the clean face shield because the bag intended for that use had been potentially contaminated when the used gown was placed in the bag earlier in the shift. She further identified awareness of the gown stuffed in the handrail because she saw it there at the start of her shift. Interview with the Administrator on 4/30/20 at 8:55 AM identified the isolation gown in the handrail near R #2's room was identified as removed and the railing was sanitized. The isolation cart outside R #2's room had been replaced with a clean cart that included additional supplies of new disposable isolation gowns and brown paper bags for storage of cleaned face shields intended for reuse. The facility failed to ensure infection prevention strategies were consistently implemented.

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