STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075286	A. BUILDING _____ B. WING _____	04/28/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NEWINGTON RAPID RECOVERY REHAB CENTER	240 CHURCH ST NEWINGTON, CT 06111

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, review of facility policy, and staff interviews, the facility failed to ensure Personal Protective Equipment (PPE) was utilized in accordance with infection control standards, failed to ensure staff completed hand hygiene in accordance with facility policy and failed to consistently identify residents who required isolation. The findings include: 1. Observation on 4/28/20 at 11:25 AM with the Director of Nursing (DNS) on the first-floor unit, identified LPN #1 was wearing a disposable protective gown under a hospital gown, gloves, mask, and a hair net. LPN #1 entered a resident room (the resident had a current [DIAGNOSES REDACTED]. Subsequently, and without the benefit of removing the contaminated PPE or hand hygiene, LPN #1 was observed to walk into a second resident room, (the resident was COVID 19 negative) and began to provide care to the Covid 19 free resident while wearing the contaminated PPE. Interview with the DNS on 4/28/20 at 11:35 AM identified LPN #1 should not exit the room of a Covid 19 positive resident without removing the contaminated PPE, using hand sanitizer on contaminated hands, and donning clean PPE if needed. Interview with LPN #1 identified she was not aware that she had to change the PPE every single time she exited the room of a Covid 19 room positive resident. LPN #1 further identified she was only provided with one disposable isolation gown per shift, and she had to keep the gown on over her scrubs for the whole shift in order to protect her clothes. LPN #1 indicated the hospital gown she wore over the disposable gown was to protect the disposable PPE gown, since she only was provided with one for her shift. LPN #1 identified the PPE carts for the units were not stocked with supplies, and the hand sanitizers were empty so she was unable to sanitize her hands when exiting rooms. 2. Observation on 4/28/20 at 11:39 AM identified NA #1 entered the room of a Covid 19 (positive resident), wearing a yellow gown and a hospital gown, a hair net, N-95 mask, face shield and gloves. NA #1 removed the lunch tray which was on the bedside table, and exited the room, without the benefit of removing the contaminated PPE or sanitizing her hands. NA #1 walked 15 feet down the hallway and placed the lunch tray into the meal truck. NA #1 was observed to walk into another resident room (the resident was COVID 19 negative), removed the lunch tray which was on the bedside table, where the resident was sitting, and returned the lunch tray to the meal truck without the benefit of removing the contaminated PPE or hand hygiene. Interview with NA #1 at that time identified she was to remove the PPE upon exiting the room of a Covid 19 positive resident, however, was only given one yellow PPE gown for the whole shift. 3. Observation on 4/28/20 at 2:25 PM on the second floor unit identified LPN #2 was wearing a mask, face shield, and disposable gown. LPN #2 was observed without gloves while providing care to the resident, (with a current [DIAGNOSES REDACTED]. LPN #2 exited the resident's room, used hand sanitizer, and began to work at her medication cart without the benefit of removing the contaminated PPE. Interview with LPN #2 at that time identified she was not aware she was to change the yellow gown every time she exited the room of a Covid 19 positive resident, and identified she is provided one gown per shift, and she does not feel comfortable just taking it off without receiving a new one. LPN #2 further identified she was told they are to only get one gown, so she does not even attempt to try to get a new one, and she was not sure how many yellow gowns are available in the facility. LPN #2 further identified she had not received education for a long time, over a month, regarding any changes to the Covid 19 policy, so she was unsure of the current Covid 19 policy regarding PPE. Interview with the DNS on 4/28/20 at 11:40 AM identified she was not aware the PPE carts were empty. The DNS indicated it was the responsibility of the supervisor to oversee the carts remained full of supplies which were in a locked area within the facility. The DNS indicated yellow gowns were short on supply and that was why the staff was wearing patient gowns over them, however, the patient gowns and gloves were to be removed upon exiting the room of a Covid 19 positive resident followed by hand washing. Subsequent to surveyor inquiry the facility filled the PPE carts, placed hand sanitizers on each cart and provided education to the staff regarding donning, doffing, and hand washing. Review of facility policy on Isolation Precautions identified that clean gloves should be worn when entering the room, and be removed before leaving the room and before hand hygiene. Disposable gowns should be worn upon entering a precaution room, and PPE would be replaced as needed to maintain effectiveness. Review of the facility policy for Covid -19 Virus identified hand hygiene supplies like alcohol-based hand sanitizer would be made available to staff, promote correct use of PPE, and facemask, eye protection, gowns, and gloves would be made available immediately outside of the resident's room. Review of facility hand washing policy identified hand hygiene products and supplies including alcohol-based hand rub shall be readily accessible and convenient for staff use to encourage compliance with hand hygiene policies. The policy further identified that alcohol-based hand rub should be used before and after direct contact with residents, after removing gloves, and before and after entering isolation precaution settings. 4. Observation on 4/28/20 at 1:45 PM identified although rooms #103, 106, 118, 120, 123, 124, 126, 127, 128, 129, 232, 236, 245 and 257 were rooms with residents on transmission based precautions, the rooms were without the benefit of signage outside the room to identify such. Interview with the DNS on 4/28/20 at 2:45 PM identified she ran out of printed copies of the precaution signs from the CDC and was unaware that some of the rooms did not have proper signage. Subsequent to surveyor inquiry, the DNS made copies of the CDC precaution signs for all rooms on transmission based precautions and posted them on the resident doors. Review of the facility infection control isolation precautions policy directed that the facility would implement a sign system to alert staff and visitors to the type of precaution the resident required per the CDC guideline for isolation precautions.

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.