STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075252	A. BUILDING _____ B. WING _____	**09/27/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WESTSIDE CARE CENTER	**349 BIDWELL STREET MANCHESTER, CT 06040**

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 observations, a review of facilty documentation and staff interviews, and a review of the facility policy for one sampled sampled resident (Resident #1), the facilty failed to ensure the appropriate personal protective equipment (PPE) was worn by staff in a room that required transmission based droplet precautions, and failed to ensure staff were properly screened for signs and symptoms of COVID-19. The findings include: 1. Resident (R) #1 was admitted to the facilty on 9/20/20 with [DIAGNOSES REDACTED]. The care plan dated 9/20/20 identified R#1 was recently admitted to the observation unit with a negative COVID test and interventions included to provide R#1 with the appropriate transmission based precuations which included a face mask, eye protection, gown and gloves for 14 days. Observation on 9/27/20 at 9:20AM identified a droplet precaution sign posted on the door of R #1's room that directed staff to clean hands upon entering and leaving the room, wear a facemask, eye protection, a gown and gloves for high contact resident activities. NA #1 walked out of R #1's room wearing a face mask without a gown or gloves. Interview with NA #1 on 9/27/20 at 9:23 AM identified she provided R#1 with a breakfast tray and indicated she forgot to put on a gown and gloves and indicated she should have put them on prior to entering the room. Interview with the Director of Nursing (DNS) on 9/27/20 at 11:30 AM identified R#1 was on the observation unit quarantined for 14 days because R#1 was a new admission to the facilty. Additionally, the DNS identified staff were required to wear a gown, gloves, face mask and face shield in all observation rooms including when delivering a meal tray. The DNS indicated NA#1 should have worn a gown and gloves in R#1's room. Review of the in-service form dated 9/27/20 signed by NA #1 identified NA#1 received education on donning and doffing personal protective equipment on the observation unit and effective immediately NA#1was expected to wear full PPE which consisted of gown, gloves, mask and a face shield when entering the room of any resident on the observation unit with no exceptions. Review of the facilty policy entitled Isolation Policy and Procedures identified droplet precautions are implemented for a resident with known or suspected to be infected with a microorganism that can be generated by the resident via sneezing coughing and talking. The staff were required to perform hand hygiene, apply a gown, mask, goggles or eye protection, and gloves upon entering the residents room. 2) Observation of the employee screening tool on 9/27/20 at 12:00 PM identified NA #2, LPN #1 and LPN#2 signed the screening log that identified they were absent a fever, did not travel, were without signs and symptoms of COVID-19, had recent COVID-19 testing, did not work in a healthcare center with COVID-19 and, was not in contact with any individuals diagnosed COVID -19. Interview with LPN #2 on 9/27/20 at 12:10 PM identified she arrived to work at 6:50AM and no one was available to screen her in the facilty. LPN #2 took her own temperature and completed the screening log questions. LPN#2 identified the staff screen themselves because there was not a receptionist at the front desk. LPN #2 did not know if the supervisor reviewed the screen log and identified she did not review the screening questions with anyone. Further, LPN #2 identified this practice occurred regularly especially on the weekends. Interview with LPN #1 on 9/27/20 at 12:15 PM identified she screened herself at the start of her shift on 9/26/20 because no one was at the desk. Additionally, LPN#1 identified she took her temperature, answered the questions, documented in the log and proceeded to the unit. Interview with NA #1 on 9/27/20 at 12:17 PM identified she screened herself prior to the start of the shift and a supervisor or receptionist did not review the log with her. Additionally, NA#1 identified she completed the screening process by herself on a regular basis. Interview with the Director of Nursing (DNS) on 9/27/20 at 12:30 PM identified staff should not self-screen prior to the start of each shift. The 11:00 PM to 7:00 AM supervisor was responsible to screen the day shift staff prior to 8:00 AM which included temperature checks, screening questions and documentation in the screening log. Additionally, staff and visitors are screened by a receptionist at all other hours. The DNS indicated the night supervisor was responsible to conduct the screening for the facility during his/her shift and did not. The DNS identified she would provide additional education to ensure the screening process. Review of the inservice sheet dated 9/27/20 entitled 'screening employees identified a registered nurse was required to station his/herself at the receptionist area at the beginning of each shift in order to properly screen each employee prior to the beginning of their shift which included taking the employees temperature and completing the questionnaire. The form further identified at no time should an employee self-screen. Review of the facilty policy entitled COVID -19 protocol in part directed that all staff would be screened prior to the start of the shift using the current Centers for Disease Control (CDC) guidelines and if a staff member screens positive for coronavirus, staff would be required to leave the facilty immediately.

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