STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075318	A. BUILDING _____ B. WING _____	**05/21/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
POMPERAUG WOODS HEALTH CENTER	**80 HERITAGE RD SOUTHBURY, CT 06488**

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 policies, and interviews, the facility failed to ensure appropriate infection control practices regarding personal protective equipment were implemented to prevent and control the transmission of COVID-19. The findings include: 1. Observations on 5/21/20 at 12:30 PM during the tour of the COVID-19 positive and results pending unit identified a COVID-19 positive resident and nine (9) additional residents who's tests results were pending had signage outside of their rooms that did not indicate the specific type of precautions the residents were on. The signage had a diagram of a mask, gloves and gown with the word respiratory written in small print on the back of the sign. Interview with the Infection Prevention Nurse on 5/21/20 at 12:32 PM identified that the diagrams on the signage would alert the staff as to the type of precautions the residents were on. The Center for Disease Control guidelines for transmission-based precautions identified that health care professionals who enter the room of a patient with known or suspected COVID-19 should have the use of a respirator (facemask if a respirator is not available), isolation gown, gloves and a facial shield or goggles. 2. Observations on 5/21/20 at 12:40 PM during the tour of the COVID-19 positive and results pending unit identified staff members were storing their N95 masks in brown paper bags with their names written on the bags. Amongst the brown paper bags were two (2) separate plastic bags that had N95 masks and facial shields stored in them with the staffs' name written on the bags. Interview with the Infection Prevention Nurse at 12:42 PM, identified that staff had been educated on the proper storage of N95 masks and was unable to identify why the N95 masks had been stored in plastic bags along with facial shields. The Infection Prevention Nurse identified that he/she would have expected staff to store their N95 masks in a manner that maintained infection prevention. Subsequent to surveyor inquiry, the N95 masks had been placed in brown paper bags. The Center for Disease Control guidelines for the re-use and storage of N95 masks identified N95 masks should be kept in a clean breathable container such as a paper bag between uses and to minimize the potential for cross contamination. 3. Observations on 5/21/20 at 12:45 PM of the COVID-19 unit, identified the licensed nurses and nurse aides had donned rain ponchos when entering the rooms of residents with pending test results for COVID-19. Interview with a charge nurse, Licensed Practical Nurse (LPN) #1 on 5/21/20 at 12:47 PM, she identified she wore a rain poncho for additional protection throughout the shift while caring for the residents with pending test results then disposing of the rain poncho at the end of the shift. LPN #1 identified that she did have disposable gowns available to wear on top of the rain poncho. Interview with the Infection Prevention Nurse at 12:52 PM identified that the staff were wearing the rain ponchos for additional protection over their scrubs and were to don disposable gowns over the rain ponchos when entering a resident's room. The Infection Prevention Nurse identified that staff should have disposed of the rain poncho after leaving the resident's room and donning a new one. 4. Observations on 5/21/20 at 12:55 PM of the COVID-19 unit identified a private duty caregiver for two (2) residents in the same room, who had pending COVID-19 test results. The private duty caregiver was noted to leave the room, walk down the hall to obtain a vital sign cart and then return to the residents' room with the vital sign cart without the benefit of cleaning the equipment before use. Observations of the private duty caregiver in the resident room identified that he/she did not don gloves or a gown while caring for the residents when an isolation cart with personal protective equipment was present. Interview with the Director of Nursing (DON) on 5/21/20 at 1:22 PM identified that private duty caregivers must implement appropriate infection control practices to prevent the transmission of COVID-19. The DON indicated that the facility does supply private duty caregivers with personal protective equipment. Subsequent to surveyor inquiry, the facility provided the private duty caregiver with infection prevention education. Review of facility policy for infection prevention and control identified staff must implement appropriate transmission-based precautions specific to the resident's infection, follow infection/disease specific guidelines established by the Centers for Disease Control, personal protective equipment (PPE) must be wore in such a way infection is not spread such as donning a disposable gown when entering a room and disposing of the gown when exiting the room, dedicate equipment to cohorted residents and if the equipment must be removed from the room it must be adequately disinfected before used on another resident.

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