STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075365	A. BUILDING _____ B. WING _____	**08/09/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CURTIS HOME ST ELIZABETH CENTER	**380 CROWN STREET MERIDEN, CT 06450**

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, review of facility policy, and interviews, the facility failed to appropriately screen approved vendors prior to entry onto the nursing unit, failed to ensure staff were appropriately utilizing facial masks, failed to wash hands after removing a face mask, and failed to ensure the facility was monitoring for the out of state travel during the COVID-19 pandemic. The findings include: Observation on 8/9/20 at 10:00 AM identified that the front entry door was unlocked permitting entry into the lobby of the facility. Upon inquiry with Housekeeper #1 on 8/9/20 at 10:01 AM, the Nurse Consultant identified herself as a nurse consultant with the Department and was directed to take the elevator to the first floor, take a right off the elevator, and proceed to the nursing station. The Surveyor was not screened (temperature taken upon entrance into the building. On arrival, Licensed Practical Nurse (LPN) #1 and LPN #2 were seated behind the nursing station looking at a cell phone. LPN #2 had his/her facial mask below his/her chin and was within 2 feet of LPN #1. A resident was noted nearby in a wheelchair. Registered Nurse (RN) #1 was located behind the two LPN's also at the nursing station. LPN #1 inquired how the Nurse Consultant was able to enter the building. The Nurse Consultant responded that the door was unlocked and that a staff member had directed the Nurse Consultant to the nursing unit. LPN #2 then replaced her face mask to the appropriate position and LPN #1 got up to leave. RN #1 then took the Nurse Consultant's temperature, obtained the sign in screening book and proceeded to the elevator. The Nurse Consultant followed. When the elevator doors opened, Laundry Worker #1 came out of the elevator pulling a laundry cart accompanied by a maintenance worker with a floor buffer. Laundry Worker #1 had her facial mask below her chin and was asked by RN #1 to put her mask back on. After proceeding back to the lower level, the Nurse Consultant completed the screening. The facility screening tool did not have any reference to the out of state travel. RN #1 never inquired as to the Nurse Consultant's travel status. Interview with RN #1 on 8/9/20 at 10:26 AM identified that the facility policy identified all staff should be wearing a mask while in the facility. RN #1 identified that Laundry Worker #1 may have forgotten to put his/her mask back on when he/she came up to the floor. RN #1 identified that staff should not have directed the Nurse Consultant up to the unit, and that no visitors should be allowed onto the nursing unit without appropriate facility screening. RN #1 identified that the door is always locked and was not sure how the door became unlocked. Re-interview with RN #1 on 8/9/20 at 11:30 AM identified that he/she had not known that the facility questionnaire had eliminated the question about out of state travel. During a tour of the unit with the Minimum Data Set (MDS) Coordinator on 8/9/20 at 11:40 AM, Nurse Aide (NA) #1 was noted to have his/her facemask below his/her chin. NA #1 was within approximately three feet of another staff member. NA #1 replaced his/her facemask, but pulled it down below his/her chin each of the three times that he/she spoke with the staff member. NA #1 then walked half way down the B unit hall and was stopped by the surveyor. NA #1 identified that he/she had removed his/her mask so that he/she could talk with the staff. Additionally upon Surveyor inquiry, NA #1 identified that he/she should have washed his/her hands after removing his/her mask. Interview and review of facility policy with the Director of Nurses (DNS) on 8/9/20 at 1:10 PM identified that all staff should be wearing masks while in the facility and wash hands after touching their mask, the front door should have been locked and was recently repaired on Friday, staff should not have directed the Nurse Consultant to the nursing unit, and that the travel screening question had been eliminated from the questionnaire but that all staff had been in-serviced. The DNS identified that the question would need to be added to the facility screening tool for any vendors who visited the facility.

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.