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 _____	**07/14/2020**

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 observations, facility policies and staff interviews for two of three sampled residents (Residents #1 and #2) who resided on a unit designated for residents with possible exposure to COVID-19, the facility failed to ensure that the necessary measures were implemented to prevent the transmission of infection during the removal of soiled linen and during care. The findings include: 1. Observations on 7/14/20 at 11:15 AM identified that after APRN #1 left the room of Resident #1, the APRN removed a soiled isolation gown which she was wearing. APRN #1 subsequently put the gown in a container for soiled linen that was in the hallway and used a hand to push the gown into the container. The soiled isolation gown was doffed and handled while the APRN was not wearing gloves. Further observation identified that the hamper which was used for the soiled laundry was overflowing, and the lid did not close. Interview with APRN #1 following the observation on 7/14/20 at 11:15 AM identified that although the soiled isolation gown should have been removed before leaving the room of Resident #1, a container for the linen was not available in the room. APRN #1 stated that gloves should have been worn while removing the gown and when touching the soiled linens. Interview with the Administrator immediately following the interview with APRN #1 on 7/14/20 indicated that the hampers used for soiled linen have been kept in the hallway since the facility did not have enough containers to keep inside the residents' rooms. Subsequent to surveyor inquiry, the Administrator stated additional hampers for soiled linen would be ordered and placed in the rooms on the unit designated for residents with possible exposure to COVID-19. Interview with the Assistant Director of Nursing (ADON) on 7/14/20 at 11:24 AM indicated that the APRN should have worn gloves while removing the soiled gown and placing it in the soiled linen hamper. The ADON further stated that instead of pushing the linens into the container, the APRN should have notified someone that the hamper was full. 2. Observations on 7/14/20 at 11:25 AM identified Nurse Aide (NA) #1 assisting Resident #1, whose room was on a unit designated for residents with potential exposure to COVID-19, to return to the room in a wheelchair. The resident was observed without the benefit of a face mask, and although the nurse aide wore a face mask, no other personal protective equipment (PPE) was worn. NA #1 was subsequently observed to enter the resident's room, assist the resident in transferring from the wheelchair to a bedside chair, cover the resident with a blanket and straighten the linen on the resident's bed without the benefit of the necessary PPE (i.e. faceshield, isolation gown and gloves). Observation of the signage regarding transmission based precautions that was posted at the resident's doorway identified that proper hand hygiene was required before and after every resident contact. The use of a face mask was required at all times, gloves were to be worn when touching a resident or articles close to the resident, and an isolation gown was to be worn when providing care and removed and discarded before leaving the room. The signage also identified that the resident should wear a face mask while being transported. Interview with NA #1 on 7/14/20 at 11:35 AM indicated that although she was aware of the proper personal protective equipment (PPE) to be worn when entering the room of a resident who required transmission based precautions, she had forgotten to wear the necessary PPE or provide the resident with a face mask. Interview with the Administrator and Assistant Director of Nursing following the observations, and interviews on 7/14/20 identified that the resident was to wear a mask when leaving the room and staff were to wear appropriate PPE. The Administrator stated that re-education regarding donning/doffing of PPE would be provided to all staff.

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