STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075350	A. BUILDING _____ B. WING _____	**07/15/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SHERIDEN WOODS	**321 STONECREST DRIVE BRISTOL, CT 06010**

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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, review of facility documentation, and interviews for two of five newly admitted residents (Resident #1 and Resident #2), the facility failed to ensure that appropriate infection control practices were implemented to prevent and control the spread of infection. The findings include: a. Resident #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. An admission physician's orders [REDACTED]. Resident #1's Care Card dated 7/5/20 identified Resident #1 was alert, confused, forgetful and combative, required assistance with meals and hoyer or total lift with transfers. The Resident Care Card also directed to maintain contact precautions for 14 days and utilize a mask in the hallway. b. Resident #2 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. An admission physician's orders [REDACTED]. Resident #2's Care Card dated 7/9/20 identified Resident #2 was alert and confused, required cueing with meals and the assistance of two staff members with transfers. The Resident Care Card further identified that the resident was on precautions for 14 days and required mask in hallway. Observations and interview with the DNS on 7/15/20 at 11:55 AM identified during a tour of the unit with residents who were on isolation precautions due to unknown COVID-19 status identified Resident #1 was eating lunch with the assistance of NA #1 and Resident #2 was eating lunch with the assistance of NA #2, both residents were sitting in their wheelchairs in the hallway near the nursing station. NA #1 was observed wearing a KN 95 mask, goggles and gloves without the benefit of a protective gown and NA #2 was observed wearing a surgical mask, goggles and gloves also without the benefit of a protective gown. The DNS identified that both Resident #1 and Resident #2 ate their lunch in the hallway due to the need for staff monitoring and that since both residents were newly admitted , they both were on a 14-day transmission-based precautions. Additionally, the DNS identified that residents and staff present in the hallway were not protected. Subsequently to the observation with the DNS, she instructed NA #1 and NA #2 to wear protective gowns and to transfer both residents inside their rooms to prevent potential COVID-19 exposure to residents, staff members and EMT's that were leaving the unit at that time. Interview at that time with NA #1 identified she/he was aware that Resident #1 was on isolation precautions, but the resident was at risk for falls and was already sitting in the hallway. NA #1 further stated if they did not want me to feed the resident in the hallway, they should never put her/him in the hallway. Interview at that time with NA #2 identified she/he was aware that Resident #2 was on isolation precautions, but the resident was a fall risk and was sitting by the nursing station. Further observation identified that outside of Resident #1 and Resident #2's room were bins containing Personal Protective Equipment (PPE). Additionally, signs were taped to the door frames indicating that both residents were on transmission based precautions and there was potential exposure to microorganisms through droplets, via cough, sneeze, etc. Staff were directed to perform hand hygiene before and after every resident contact, wear a mask at all times and a face shield when providing care, wear a gown when providing resident care and to remove and discard the gown when leaving the room, wear gloves whenever touching the resident's intact skin or surfaces and/or articles close to the resident, e.g. side rails, medical equipment, over bed tables, nightstands, etc. dedicate equipment to that resident, draw privacy curtain and encourage resident to dispose of tissues, etc., in appropriate container in the room. The transmission-based precaution sign further identified that resident should wear a mask during transfers. Subsequent to surveyor inquiry the DNS indicated that the facility follows the professional standards and recommendations set forth by the center of disease control and all facility staff will be reeducated regarding PPE use when caring for residents whose COVID-19 status was unknown, and all residents that required transmission-based precautions will be assisted by facility staff to stay in their rooms.

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