STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075085	A. BUILDING _____ B. WING _____	**05/15/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ST MARY HOME	**2021 ALBANY AVE WEST HARTFORD, CT 06117**

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, review of facility documentation, interviews, and review of policy, the facility failed to ensure staff working on a designated COVID-19 unit donned the appropriate and recommended personal protective equipment and failed to ensure the Tyvek suits were utilized according to the recommendations of the Center of Disease control(CDC) during a pandemic to ensure staff and residents were protected from a risk of infection. The findings include: During a tour of the COVID-19 designated unit, West 3, with the Director of Nursing (DON) and the Infection Control Nurse, Registered Nurse, RN #1, on 5/15/20 at 9:45 AM two (2) Nurse Aides (NA), NA#1 and NA #2, were observed wearing cloth masks. NA #1 was in a room actively caring for the residents identified as COVID-19 positive and NA #2 was observed in hallway. The West 3 unit has the residents that have been diagnosed with [REDACTED]. A review of the facility's personal protective equipment supplies on 5/15/20 identified the facility with 4,200 N95 masks and 11,500 isolation and washable gowns at hand. In an interview with NA #2 on 5/15/20 at 9:50 AM, NA #2 stated the fabric mask was her choice as it was more comfortable than the N95 provided by the facility. A review of the signage posted on the entrance doors to rooms of residents with COVID-19 infection identified that use of N95 masks was recommended for staff unless a N95 was unavailable. Further tour of the facility with the DON and RN #1 on 5/15/20 at 10:00 AM identified a designated room with approximately fifty (50) Tyvek suits hanging from rods identified as dirty and a second rod identified as clean. RN #1 indicated that after wearing the Tyvek suits for a shift, staff would place the suit on the dirty rack, spray the suit with an Oxivir solution (hydrogen peroxide), then hang the suit on the clean rod and retrieve the Tyvek suit on the next work day. In an interview with the 7-3 charge nurse on West 3 unit, Licensed Practical Nurse (LPN) #1, and LPN #2, the charge nurse on East 3 Unit, on 5/15/20 at 10:15 AM, LPN #1 and LPN #2 indicated that Tyvek suits were worn for a shift, hung up, sprayed, and then reused on their next shift. In an interview with the Administrator on 5/15/20 at 10:45 AM, the administrator stated it was the expectation that staff used the Personal Protective Equipment (PPE) per the facility's practice and indicated that N95 masks were provided to staff. A review of the facility's PPE guidance for staff in communities during COVID-19 state of emergency policy, indicated PPE use for COVID outbreaks or on cohorted units and identified, staff caring for residents will be issued a N95 and surgical masks and all employees will continue to wear a N95 or surgical face mask (based on availability) while in the facility.

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