STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075437	A. BUILDING _____ B. WING _____	**05/24/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AVALON HEALTH CARE CENTER AT STONERIDGE	**186 JERRY BROWNE ROAD MYSTIC, CT 06355**

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 observation, clinical record review, facility documentation and staff interviews for three of three residents who required transmission-based infection control precautions (Residents #1, #2 and #3), the facility failed to ensure that clean linen was properly stored and further failed to ensure that isolation gowns were discarded or laundered following each use. The findings include: 1. During a tour of the facility on 5/24/20 at 8:37 AM observation identified a clean linen cart stored in the hallway without the benefit of a cover. Interview with Nurse Aide (NA) #1 on 5/24/20 at 8:40 AM indicated the cover that was attached to the top of the linen cart should have been closed in order to keep the linens clean during storage. Interview with the Director of Nursing Services (DNS) on 5/24/20 at 9:40 AM identified the facility would immediately ensure that linens were covered during storage, 2. Review of the facility's Long Term Care Respiratory Surveillance Line List on 5/24/20 identified twenty-two of the facility's twenty-five current residents had been tested for coronavirus disease 2019 (COVID-19) through a Point Prevalence Survey (PPS) on 5/19/20. The PPS screening results dated 5/21/20 and 5/22/20 identified that the twenty-two residents had tested negative for COVID-19. Further review of the line list indicated that three residents (Residents #1, #2 and #3) had not been included in the testing. Interview and clinical record review with the Director of Nursing Services (DNS) on 5/24/20 at 9:10 AM identified that although the three residents had tested negative for COVID-19 prior to admission to the facility, all newly admitted residents were placed on droplet transmission-based isolation precautions for a fourteen-day observation period on a separate nursing unit and were isolated from the other facility residents. Resident #1 had been admitted to the facility on [DATE], Resident #2 was admitted on [DATE] and Resident #3 was admitted on [DATE]. Observations during a tour of the nursing unit designated for residents who had been placed on transmission-based isolation precautions and interview with Licensed Practical Nurse (LPN) #1 on 5/24/20 at 9:43 AM identified three storage units that were stocked with personal protective equipment (PPE) that included yellow disposable isolation gowns as well as cloth gowns. Further observations and interview with LPN #1 identified that hooks were attached to the inside of the door of each resident's room. The hooks, which were labeled C for the CNA and N for the licensed nurse, were used to hang the isolation gowns after each use. LPN #1 stated that the gowns were reused throughout a shift by the assigned nurse aide and nurse. Subsequent interview with the Director of Nursing Services on 5/24/20 at 9:50 AM and review of current guidance issued by the Centers for Disease Control and Prevention and the State of Connecticut identified that the practice of reusing isolation gowns placed the healthcare professional at increased risk of self-contamination with each reuse. The guidance recommended that the gown be removed and discarded after each use if designed as a disposable gown or laundered after each use if the gown was washable.
F 0921 **Level of harm -** Potential for minimal harm **Residents Affected -** Many	**Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of facility Mechanical Check logs and staff interviews, the facility failed to ensure that hot water was maintained in a safe range. The findings include: During a tour of the facility on 5/24/20 at 8:30 AM observation identified the temperature of hot water in room [ROOM NUMBER] was 127.7 degrees Fahrenheit. room [ROOM NUMBER] was subsequently identified with a hot water temperature of 122.4 degrees Fahrenheit at 8:33 AM on 5/24/20. Following the observations, Medical Records Assistant #1 was immediately notified of the temperatures that exceeded a safe range. Interview with Physical Plant Staff Person #1 on 5/24/20 at 8:43 AM indicated that he had adjusted the hot water mixing valve to ensure hot water temperatures were within a range of 110 degrees to 120 degrees Fahrenheit. . Following the facilty's adjustment of the mixing valve, the surveyor identified the temperature of the hot water in room [ROOM NUMBER] to be 116.4 degrees Fahrenheit. Review of Mechanical Check Logs identified water temperatures were monitored daily on each shift, and temperatures on the wing where room [ROOM NUMBER] was located had been documented at 119.6 degrees Fahrenheit on 5/24/20 at 7:26 AM.

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