STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075201	A. BUILDING _____ B. WING _____	**05/18/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
REGALCARE AT WEST HAVEN	**310 TERRACE AVE WEST HAVEN, CT 06516**

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, review of facility policy, and interviews, the facility failed to properly utilize Personal Protective Equipment (PPE) during the COVID-19 pandemic. The findings include: a. During a tour, observation. and interview with the Director of Nurses (DNS) on 5/18/2020 at 11:38 AM on the facility COVID-19 negative unit, it was identified, in the resident lounge, clothesline type storage of blue gowns, Tyvek suits from multiple manufacturers, yellow gowns, face shields and paper bags containing face masks. The DNS identified a Santec product was being used to clean the various types of gowning PPE when staff had removed the item to go on a break or to leave the facility at the end of the shift. The DNS identified that when the staff returned after break or to the facility the next day, the PPE that had been sprayed with Santec was then re-utilized. The DNS identified that the PPE kept in the lounge was from all units including the negative, suspected, and positive areas. Interview and review of facility policy with Licensed Practical Nurse (LPN) #1 on 5/18/2020 at 11:58 AM identified that he/she was wearing a blue gown and that the facility policy was for him/her to spray the gown with the Santec chemical located in the lounge, hang the item up on a hanger, place it on the clothesline, and then re-don the item after the break or the next day. Additionally, the facility policy was to spray the face mask with a hydrogen peroxide solution and place in a paper bag to be re-used after break or the next day. Interview with the Maintenance Director on 5/18/2020 at 12:10 PM identified that the chemical being used was a Santec product known as sienna and provided the label that the chemical was effective against the [DIAGNOSES REDACTED] associated coronavirus and was Virucidal after five minutes. b. During a tour of the COVID-19 positive unit and interview with the DNS on 5/18/2020 at 12:15 PM it was identified that LPN #2 was wearing a blue PPE gown on backwards (opening in the front). LPN #2 had approximately four inches of open gown and her uniform was visible. Interview with LPN #2 identified that he/she was wearing the gown backward because the outer straps came off. LPN #2 identified that he/she had not requested another gown from the DNS. Interview with the DNS identified that if he/she had been asked for a new gown by LPN #2, one could have been provided as the facility did have a supply of gowns. Additionally, the DNS identified that he/she felt LPN #2 was adequately covered. Still wearing the open gown, LPN #2 was then observed to enter and immediately exit a COVID negative room, on the COVID positive unit carrying an injection device and wearing one glove, holding the other glove with the injection device. LPN #2 went next door to another COVID-19 negative room, opened the door handle, stopped, then closed the door, turned around, walked to the medication cart, placed the glove and injection on top of the medication cart and removed his/her glove and threw it away. LPN #2 then began removing the gown holding onto the outside of the material to doff the gown, got the gown stuck on a lanyard with a key that was around /hisher wrist, removed the lanyard and placed it on top of the medication cart and continued to remove the gown by pulling on the outer and inner sides of the gown. LPN #1 then washed his/her hands, donned a new gown with the assistance of the DNS, picked up the glove, injection device, and lanyard from the top of the med cart and continued back into the COVID-19 negative room, without the benefit of sanitizing his/her hands. c. Resident #1's [DIAGNOSES REDACTED]. The Resident care plan dated 3/4/2020 identified an ESBL infection and a risk of developing an active infection of multidrug resistant organism. Interventions directed staff to wear proper PPE when dealing with bodily fluids. PPE cart with information on type of infection in the cart, kept outside of the resident's room. Observation on the COVID-19 positive unit with the DNS on 5/18/2020 at 12:38 PM identified that NA #1 exited an enhanced precaution room (COVID-19 negative) with his/her mask loops over her ears, the facemask down pulled down under his/her chin, exposing the nose and mouth, and his/her arms at his/her sides. Additionally, NA #1 had on a disposable yellow gown. NA #1 identified that he/she had pulled the mask down due to coughing and choking. NA #1 identified that he/she should have removed the gown prior to exiting the room. The DNS identified that gowns should be removed inside of the resident's room requiring the PPE. Interview with the DNS and ADNS/Infection preventionist on 5/18/2020 at 1:00 PM identified that it was not appropriate for the staff to wear a gown with the opening in the front and that staff are educated to keep the opening in the back. Additionally, when removing a gown, the only side of the gown that should be touched is the inner clean side as the outer side is considered contaminated, and that the gown should be rolled downward keeping the clean inner surface facing outward. Interview and review of facility in-servicing with the DNS identified that both LPN #2 and NA #1 had appropriate PPE education.

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.