

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER 075250	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/02/2020
NAME OF PROVIDER OF SUPPLIER PARKVILLE CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP 5 GREENWOOD STREET HARTFORD, CT 06106	
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, review of facility documentation and interviews the facility failed to adhere to infection control practice to ensure that medical approved personal protective equipment (PPE) was worn while in a resident care area. The findings include: During observation on 6/2/20 at 10:05 AM Nursing Assistant (NA) #1 was observed wearing a cloth mask when exiting a resident room. During an interview with NA#1, at that time, she indicated that she did not have a surgical mask and was wearing a cloth mask while caring for residents. Interview with the Director of Nursing (DON) on 6/2/20 at 10:10 AM indicated that nursing staff are required to wear a surgical mask at all time while in the facility and cloth mask can be worn over the surgical mask but not alone. During further interview with the DON on 6/3/20 she indicated that facility does not have a policy regarding the use of cloth masks and the facility followed Center for Disease Control (CDC) guidelines regarding the use of masks. According to CDC guidelines, cloth face coverings are not considered PPE and should not be worn for the care of patients with known or suspected COVID-19, or other situations where a respirator or facemask is warranted.		

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.