STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075111	A. BUILDING _____ B. WING _____	**09/21/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WOLCOTT HALL NURSING CTR	**215 FOREST ST TORRINGTON, CT 06790**

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, facility documentation review, facility policy review, and interviews for infection control review, the facility failed to ensure infection control standards related to COVID-19 were followed, in accordance with CDC guidelines The findings include: a. Interview and facility policy review with the Administrator on 9/21/2020 at 10 AM identified although the facility Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) Policy directed the use of Personal Protective Equipment (PPE), and listed the use of gloves and gowns and eye protection, the Policy did not direct use of masks. The Administrator indicated that the Policy should direct staff use of masks for COVID-19 suspected or confirmed residents. b. Interview and facility documentation review with the Administrator and the DON on 9/21/2020 at 10 AM identified the COVID-19 line list was a one page form with all residents listed by unit. The form was color coded to identify COVID-19 status: pink for quarantine, green for COVID-19 exposed, purple for COVID-19 positive, and teal for COVID-19. Additional review of the form identified the room numbers were coded green for exposed room and purple for COVID-19 positive, and the resident names were pink for quarantine. No names were teal for COVID-19 positive. The facility identified that although they used the form for a resident COVID-19 line list, they were unable to provide a line list that identified if the residents were COVID-19 positive or exposed, the date of the positive or exposure and symptoms. Additional review of the form identified that although the resident in rooms [ROOM NUMBERS] were on precautions, the form was not coded to identify precautions were required. In addition, room [ROOM NUMBER] was listed as green to identify precautions were required, but interview identified the resident in room [ROOM NUMBER] was not on precautions. Interview identified the form should clearly identify which residents/rooms required precautions for COVID-19. Although no facility policy was provided for line lists, however interview with the DON identified the expectation was that an accurate line list should be maintained for tracking COVID-19 status. c. Interview and facility documentation review with the Administrator and the DON on 9/21/2020 at 10 AM identified the Migeon Lane nursing unit had both COVID-19 negative and suspected/exposed residents. The COVID-19 suspected/exposed resident ' s rooms were mixed in-between the COVID-19 negative resident rooms; there were one or two negative rooms between each room with COVID-19 suspected/exposed residents. Interview identified that although the COVID-19 suspected/exposed residents should be cohorted together by areas of the facility or unit, and the facility had 16 empty beds, the Administrator and DON were unable to explain why the suspected/exposed resident rooms were mixed in-between the COVID-19 negative resident rooms. The DON indicated that although they had discussed with staff potential resident room changes, potential room changes were not discussed with residents. Review of CDC Guidelines Responding to COVID-19 in Nursing Homes, Resident Cohorting, (https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-responding.html) directed in part, to create a location of COVID-19 care unit and create a staffing plan. Ideally the unit should be physically separated from other rooms or units without confirmed COVID-19; the COVID-19 care unit could be a separate floor, wing or cluster of rooms. Assign dedicated staff to work only on the COVID-19 unit. d. Interview with the DON and NA #1 on 9/21/2020 at 11:25 AM identified she worked on the Migeon Lane nursing unit with suspected/exposed COVID-19 residents with two other NAs. NA #1 stated that the three NAs work together to provide care for all residents, and did not have individual resident assignments. She indicated that it did not matter which residents they provided care for first as all the suspected/exposed COVID-19 residents had signs posted outside their room. She further indicated that it was common for staff to work together on the unit and not have individual resident assignments. Interview with the DON and LPN #1 (charge nurse on Migeon Lane) on 9/21/2020 at 11:35 AM identified the NAs should have their own individual assignments and they should provide care to the suspected/exposed COVID-19 residents last. Interview with the DON, NA #2, and NA #3 on 9/21/2020 at 11:45 AM identified they were working on Migeon Lane with NA #1, they were working together and did not have individual resident assignments. NA #2 and NA #3 indicated that the Infection Control Nurse (ICN)had told them that it did not matter which residents they provided care for first or last; it did not matter if the resident was on COVID-19 precautions or not, as long as they wore their PPE, washed their hands. They indicated that the ICN had instructed them that they should assume all residents had COVID-19. The DON indicated that the NAs should have individual assignments and should provide care for suspected/exposed COVID-19 residents last. No facility policy was provided for surveyor review regarding NA assignments and sequence of resident care for COVID-19 negative and suspected/exposed residents. Review of CDC Guidelines Responding to COVID-19 in Nursing Homes, Resident Cohorting, (https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-responding.html) directed in part, to create a location of COVID-19 care unit and create a staffing plan. Ideally the unit should be physically separated from other rooms or units without confirmed COVID-19; the COVID-19 care unit could be a separate floor, wing or cluster of rooms. Assign dedicated staff to work only on the COVID-19 unit. Review of CDC Guidelines, Responding to Coronavirus (COVID-19) in Nursing Homes, directed in part to assign dedicated Health Care Personnel (HCP) to work only on the COVID-19 care unit. At a minimum this should include the primary nursing assistants (NAs) and nurses assigned to care for these residents.
F 0885 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	Based on facility documentation review, facility policy review, and interviews infection control review, the facility failed to ensure requierd Agencies were notified of a staff member who tested positive for COVID-19. The findings include: Interview with the Administrator and the DON on 9/21/2020 at 1:15 PM identified Dietary Aide (DA) #1 tested positive for COVID-19 on 9/5/2020 and was removed from the work schedule. Interview identified DA #1 had traveled to a family party in New York on or about 8/30/2020. When the facility was notified by the lab of the positive COVID-19 results on 9/5/2020, DA #1 was working in the facility and was sent home. The dietary department was directed reeducated regarding sanitization and directed to re-sanitize the kitchen, and housekeeping to re-sanitize bed tables, bed railing and other surfaces that the employee may have had contact with (door handles, etc). Group dining was stopped for and residents monitored every shift for seven (7) days. The Administrator identified that any co-workers DA #1 had worked with were allowed to continue to work with screening prior to each shift for any COVID-19 symptoms. The Administrator indicated that although she entered the information on the DPH report, DPH Epidemiology was not notified, and DPH FLIS was not notified of the staff member ' s positive test results, she assumed the lab notified DPH Epidemiology. The facility did not provide documentation for surveyor review that the CDC was notified of the positive result. Review of facility COVID-19 Facility Exposure Management Policy, dated 3/16/2020, directed in part to immediately notify the health department about anyone with COVID-19. Review of CMS Interim Final Ruel Updating Requirements for Notification of Confirmed and Suspected COVID-19 Cases Among Residents and Staff in Nursing Homes, directed in part, regulation required Long Term Care facilities to have written standards to include when and who possible incidents of communicable disease or infections should be reported, such as to local/state health authorities. In an effort to support surveillance of COVID-19 cases, added to infection control requirements provisions to establish reporting for confirmed or suspected COVID-19 cases. The facility must report information about COVID-19 suspected and confirmed COVID-19 infections among residents and staff. Provide the information

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.

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F 0885 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	(continued... from page 1) no less than weekly to the CDC.
F 0886 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	Based on observations, facility documentation review, facility policy review, and interviews for infection control review,the facility failed to ensure residents and resident ' s responsible parties/family members were updated weekly regarding the facilities ' COVID-19 status. The findings include: a. Interview and review of facility documentation with the Administrator on 9/21/2020 at 10:55 AM identified the Social Worker provides COVID-19 facility updates to families weekly via e-mail and the Infection Control Nurse provides weekly COVID-19 facility updates to the residents. Interview and review of facility documentation review with the Director of Social Services (DSS) on 9/21/2020 at 11:55 AM identified the last COVID-19 facility status weekly update that was sent to families was on 9/4/2020. Additional interview and facility documentation review with the Administrator and DSS on 9/21/2020 at 12:30 PM identified that although she sent weekly emails to resident families, she does not include the COVID-19 status of the facility (resident or staff incidence of COVID-19 in the building). Review of email dated 6/28/2020 identified DSS communicated the facility had no positive or exposed COVID-19 cases and if that changed, she would notify the families. Review of email dated 8/28/2020 identified DSS communicated to the families that the facility was COVID-19 negative at the time. Although the DSS indicated that the families should be updated weekly, she was unable to provide documentation that resident family members were updated weekly and indicated that she would start to do so. The facility did not provide a policy regarding family notification, however interview with the Administrator identified the expectation was that weekly updates would be provided to the resident ' s family/responsible party. b. Interview with the Administrator and the DON on 9/21/2020 at 1;15 PM identified that although the facility had a staff member test positive for COVID-19 on 9/5/2020, the facility was unable to provide documentation that the residents were updated on the COVID-19 status in the facility. Interview further identified that although residents should be updated weekly of the COVID-19 status in the facility, the facility was unable to provide documentation that the residents were updated weekly regarding the COVID-19 status in the facility. Although the facility did not provide a policy for surveyor review regarding weekly resident updates for the facility COVID-19 status, interview with the Administrator identified the residents should be updated weekly. c. Interview and facility documentation review with the Administrator and DON on 9/21/2020 at 12:10 PM identified the facility performed weekly resident COVID-19 testing, and also testing 100% of their staff for COVID-19 weekly. Review of facility documentation identified that weekly staff testing was missing for the following staff: LPN #1 had no COVID-19 test for the weeks of 8/26/2020, and had worked in the facility during that time. NA #1 had no COVID-19 test for the weeks of 8/30 and 9/6/2020, and had worked in the facility during that time. NA #3 had no COVID-19 test for the weeks of 8/30, 9/6, and 9/13/2020 and had worked in the facility during that time. P.T. #1 had no COVID-19 test for the weeks of 8/30, 9/6 and 9/13/202, and had worked in the facility during that time. Interview identified staff should be tested if they are working. Interview further identified that although the contracted lab staff are in the facility weekly for resident blood draws, the Administrator identified that she had no COVID-19 testing information for the lab staff. The wound physician/Physician #1 was in the facility weekly, the last facility visit was on 9/17/2020 and the DON indicated she had no COVID-19 test results at all for Physician #1. The DON indicated that the contracted radiology vendor had not provided any COVID-19 test information for staff that had been in the facility for resident x-rays. Additional information received identified eight additional staff members had COVID-19 testing not obtained between 8/26 and 9/16/202, although they worked during the time they were not tested . Review of State of CT Executive Order 7AAA directed in part, to require that a private or municipal nursing home facility, beginning not later than the week starting June 14, 2020, shall weekly test members of the nursing home facility staff for COVID-19 who have not previously tested positive for COVID-19, and shall continue such weekly testing for the duration of the public health and civil preparedness emergency, or until testing identifies no new cases of COVID-19 among residents or staff over at least 14 days since the most recent positive result, whichever occurs first.