STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075417	A. BUILDING _____ B. WING _____	**05/07/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THREE RIVERS	**60 CROUCH AVENUE NORWICH, CT 06360**

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 observation, review of facility documentation, and interviews the facility failed to ensure effective infection prevention/control strategies included safe storage of liquid hand sanitizer supplies and failed to utilize eye protection as part of Personal Protective Equipment (PPE) when providing care for a resident on droplet transmission-based precautions. The findings include: During tour of the facility on 5/7/20 the facility's wall mounted liquid hand sanitizer dispensers were obserbed in limited quantity. The unit specified for transmission-based precautions had (1) dispenser on the wall near the double doors that entered the precautions unit without the benefit of another wall dispenser inside the unit. Further inspection of the unit identified three rooms with droplet transmission-based precautions. Outside the rooms were storage units for PPE supplies. On one of three storage units contained a (24) ounce bag of liquid hand sanitizer stored in an unsecure manner on top of the isolation unit, with the pour spout in the center of the bag opened. On three of three PPE storage units, 4-ounce bottles of liquid hand sanitizer with flip open caps were identified on the top or each unit. Observation of nursing staff on 5/7/20 from 8:40 AM to 8:55 AM identified two Certified Nursing Assistants (CNA), one nurse, and one staff from the maintenance department were present in the hallway of this unit. Three of three Residents on the unit remained in their rooms with the door to their rooms closed. Interview with the Director of Nursing Services (DNS) on 5/7/20 at 9:00 AM identified wall mounted liquid hand sanitizer dispensers were only placed in common areas where staff supervision was prevalent due to safety concern of the resident population related to the potential of misuse and drinking of the liquid. Subsequent observations of the transmission-based precautions unit on 5/7/20 from 9:10 AM to 9:40 identified the 4-ounce bottle of hand sanitizers which were stored on the top of the three units were a high touched surface used by several different staff. Subsequent interview with the DNS identified the facility had an ample supply of 4-ounce bottles of liquid hand sanitizer. She further identified staff will be encouraged to self-carry the smaller bottles in a pocket, label the bottles for single use, and ensure the liquid hand sanitizer was stored safely to prevent a resident from potential misuse. Interview with the Director of Maintenance on 5/7/20 at 9:35 AM identified the bag of sanitizer on the isolation unit is to be used in a wall mounted dispenser. Interview with CNA #1 at 9:36 AM identified she was unaware of why the open bag of sanitizer was on the isolation unit. Interview with RN #1 at 9:40 AM identified the open bag of sanitizer did not belong on the unit and removed it. Observation of staff use of PPE on 5/7/20 from 9:10 AM to 9:40 AM identified a lack of eye protection was worn by staff when providing care for three of three Residents on droplet transmission-based precautions. Interview with CNA #1 on 5/7/20 at 9:20 AM identified protective eye wear was required with droplet precautions while providing care. She identified there was once pair of goggles and one face shield available in the PPE storage units without a disinfectant wipe to sanitize between use. Without knowing who used the eye wear last and without a disinfectant wipe to clean the eye wear she was unwilling to use the eye wear as part of her PPE. Subsequent to surveyor inquiry and interview with RN #1 on 5/7/20 at 9:40 AM identified staff were provided eye wear for individual use, brown paper bags for storage of eyewear when not in use were provided, and the PPE storage units were stocked with disinfectant wipes.

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.