STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075158	A. BUILDING _____ B. WING _____	**05/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NEW LONDON SUB-ACUTE AND NURSING	**88 CLARK LANE WATERFORD, CT 06385**

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 -** Some	**Provide and implement an infection prevention and control program.** Based on observations, clinical record review, review of facility documentation, review of facility policy, and interviews, during an inspection in the kitchen and for five of five COVID 19 positive units, reviewed for infection prevention measures during the COVID 19 pandemic, the facility failed to ensure all staff were wearing masks while on duty within the facility, failed to ensure transmission based precaution signs were visible outside of COVID 19 suspected and positive resident rooms, failed to ensure adequate handwashing following contact with potentially contaminated surfaces, and/or failed to utilize effectual conservation re-usage measures of Personal Protective Equipment. The findings include: a. Observation in the kitchen on 5/5/2020 at 12:20 PM with Cook #1 identified Dietary Aide #1, during lunch service, had his/her surgical mask straps held in place by his/her ears, but the portion of the mask that should have been covering his/her nose and mouth had been pulled down below his/her chin. Cook #1 directed Dietary Aide #1 to appropriately reposition the mask, but after doing so, Dietary Aid #1 failed to wash his/her hands and was returning to work when Cook #1 stopped him/her. Cook #1 then directed Dietary Aide #1 to go wash his/her hands and that Cook #1 would fill in while he/she did so. Cook #1 identified that Dietary Aide #1 should have had his/her mask on but had just come back from 2 weeks leave and may not have known about the policy. Additionally, Cook #1 identified that he/she should have ensured that Dietary Aide #1 had been instructed on the mask placement policy and that Dietary #1 had failed to wash his/her hands until instructed. b. Observation and interview on 5/5/2020 at 2:07 PM with the Administrator and Nurse Aide (NA) #2 on the North unit identified NA #2 reaching under his/her face shield, adjusting his/her mask, removing his/her glasses to clean due to becoming fogged up and replacing. NA #2 continued to adjust his/her mask and glasses and was going into a Resident's room when he/she was stopped by the surveyor. NA #2 identified he/she should have washed his/her hands following adjustments to his/her personal protective equipment. c. Observation on 5/5/2020 at 11:38 AM identified bags of Tyvek suits in plastic bags on the floor in the front lobby. Interview and review of facility policy with Licensed Practical Nurse (LPN) #1 on 5/5/2020 at 11:45 AM identified that all staff must be wearing a mask to come into the building. On entrance, the facility provides one laundered Tyvek personal protection bodysuit for the entire day. LPN #1 identified that he/she goes down to one of five COVID 19 positive units and works until his/her lunch break. LPN #1 identified that when lunch time comes, he/she exits the unit, sanitizes his/her hands, goes through the locked door and sanitizes again. LPN #1 identified that it was the facility policy to go to the front lobby where all staff are screened every shift, remove his/her Tyvek bodysuit according to PPE guidelines, rolling it down and inside out, ensuring not to touch the contaminated outer layer. LPN #1 identified that he/she then marks his/her name on the plastic bag, inserts the Tyvek bodysuit and hands it to the screener. LPN #1 then locates his/her designated paper bag, removes his/her N95 mask and goggles and places the equipment inside the bag, puts on a new facility provided surgical mask and goes to break. On return from break the facility policy is to re-apply the now inside out, contaminated Tyvek bodysuit. LPN #1 identified that when putting the Tyvek bodysuit back on, it is impossible to do so in a sanitary manner to avoid contamination of the inside of the suit. LPN #1 identified that the facility does not have enough of a gown/Tyvek bodysuit supply, and that he/she is breaking infection control protocols when trying to replace her Tyvek bodysuit following his/her break. Additionally, the facility is utilizing reusable washable blue gowns when entering COVID 19 positive and presumptive rooms. These gowns are reused by all staff during a 24 hour time frame and are kept on a hook inside the COVID 19 positive/suspected resident room. LPN #1 identified that all COVID 19 positive and presumptive rooms do not have blue gowns to place on over facility staff Tyvek suits. Observation with the Administrator on 5/5/2020 at 1:15 PM identified Nurse Aide (NA) #1 attempting to re-apply her Tyvek bodysuit following his/her break. NA #1 identified that he/she was unable to do so without touching the contaminated outer portion of the rolled-up, inside out Tyvek bodysuit. The Administrator identified that he/she did not have a enough of a supply of PPE to provide each staff member with more than one suit per shift, that he/she had a conventional washer and dryer in the building and would attempt to provide additional washings between uses so that staff were provided with a clean Tyvek bodysuit following their breaks. Observation and interview with the Administrator and NA #2 on 5/5/2020 at 2:07 PM identified that not all the rooms had reusable, washable blue gowns for staff to use when entering Resident Rooms that are COVID 19 positive or COVID 19 suspected on the West and North Units. NA #2 identified that six out of thirteen COVID 19 positive or suspected rooms lacked blue gowns and that staff wound put on a short-sleeved hospital gown over their Tyvek bodysuit to tend to those residents. The Administrator identified that although he/she had more reusable blue gowns available to distribute, the staff had not made him aware they lacked the proper PPE equipment. Additionally, NA #2 identified that he/she had been using the same face shield and mask between COVID 19 positive/suspected residents and those who were not deemed positive/symptomatic, without the benefit of cleaning the face shield. The Administrator identified that the facility had an available count of approximately 50 gowns, 200 face shields, and 250 N95 masks, d. During a facility wide inspection with the Administrator on 5/5/2020 at 1:35 PM for five of five units, the facility failed to have enhanced droplet precaution signs for COVID 19 positive rooms on 17 out of 54 resident room doors and for 2 of 54 suspected COVID 19 positive doors. The Administrator identified that the only nursing manager that was currently available to work, was an MDS Coordinator. All other nursing managers were out ill. Review of facility COVID 19 employee Policy identified, in part, that all employees will wear masks while in the healthcare facility. Review of the facility limiting transmission of COVID 19 policy identified that facility should frequently review the CDC website dedicated to COVID 10 for health care professions and check the link for updates to guidance for using PPE.

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.