STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075246	A. BUILDING _____ B. WING _____	**05/10/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WHITNEY REHABILITATION CARE CENTER	**2798 WHITNEY AVENUE HAMDEN, CT 06518**

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 observation, review of facility documentation, and interviews reviewed for infection prevention and control strategies, the facility failed to ensure food contact areas of meal service carts were cleaned and sanitized in accordance with facility protocols, and the facility failed to ensure strategies to prevent potential cross contamination of facility laundry were implemented. The findings include: 1. On 5/10/20 at 9:20 AM dietary Staff #1 was observed cleaning meal service carts. Staff #1 identified after the meal carts were emptied the carts were cleaned and sanitized. She was observed removing a cloth towel from a red bucket used for the sanitizing step of cart cleaning. Interview with Staff #1 identified she prepared the solution in the red bucket at 9:00 AM. Subsequent to Surveyor inquiry a sanitation range test of the solution in the red bucket identified a non-reactive test. The test strip dipped into the solution failed to change color. Dietary Staff #2 assisted with the testing of the solution and to verify the test strip was accurate she dispensed a cupful of sanitation solution into a cup and the strip changed to a green color. The change to green identified the test solution was within sanitation range of 150-200 parts per million (PPM). Interview with Staff #1 identified she had prepared the red bucket with warm water and a little bit of bleach. Observation of the sanitizer dispensing system with Staff #2 identified the instructions for use were posted on the wall next to the system faucet. The instructions were further identified written in English and Spanish with step by step pictured directions. Interview and review of facility documentation with the facility's Administrator on 5/10/20 at 11 AM identified the sanitizer dispenser utilized for kitchen cleaning was a device that premixed the sanitation solution with warm water. Staff #1 was re-educated on the three-step protocol of cleaning the meal carts after offloading and cart sanitation before reuse. 2. Observation of personal protective equipment (PPE) utilized by laundry staff on 5/10/20 at 9:50 AM identified several concerns with the potential for cross contamination of soiled PPE to clean linens. Interview with Staff #3 identified she wore a surgical mask throughout the day. The N95 mask was worn when moving dirty laundry from the laundry shoot out of the plastic bags, and into a washer. She identified the N95 was stored in a plastic bag and she retrieved the plastic bag from the clean linen area. She placed the top strap of the two-strap N95 mask over her head and over her surgical mask. She entered the dirty laundry room and removed a washable isolation gown from the handle of a wash machine and put on the gown. The gown was observed tied loosely at the neck and inside out. Staff #3 identified she reused the gown throughout the day. With gloves on both hands Staff #3 demonstrated how the soiled laundry was removed from the plastic bags, sorted, and a load of whites were placed in the washer for cleaning. She then removed the gown that turned right side out over the soiled gloves and hung the gown on the handle of the machine that was just loaded. RN #1 arrived as Staff #1 was removing the gown. Staff #3 was provided immediate re-education of soiled glove removal and hand hygiene before gown removal. RN #1 assisted Staff #3 with obtaining clean PPE. Interview with the facility Administrator and the Director of Nursing Services on 5/10/20 identified laundry staff would be provided re-education on PPE donning and doffing. 3. Observation and interview with RN #1 on 5/10/20 at 11:20 AM identified a nursing unit that was designated for Residents diagnosed with [REDACTED]. The unit was further identified as a COVID-19 cohort unit with droplet transmission-based precautions implemented. In the hallway between two resident rooms a linen cart was identified without the benefit of a cover. Further inspection of the linen cart identified the top shelf stored disposable incontinence briefs of various sizes, oral care products of sponge swabs and mouth wash. A pair of nail clippers and other nail care products were stored. Next to the personal care items an open box of gloves and a roll of plastic bags were stored. The bottom two shelves of the cart contained clean linens, johnnies, and clothing protectors. On top of the cart was another stack of clean bed linen without benefit of a cover. Interview with RN #1 on 5/10/20 at 11:25 AM identified the facility was experiencing a shortage of carts due to the closure of units for infection prevention and control secondary to the COVID-19 outbreak. She identified stocking a linen cart with personal care items was not a typical practice and the extra linen on top of the cart prevented use of the protective cover intended to enclose the cart in accordance with infection control standards.

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.