STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075263	A. BUILDING _____ B. WING _____	04/28/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AUTUMN LAKE HEALTHCARE AT CROMWELL	385 MAIN STREET CROMWELL, CT 06416

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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interviews, the facility failed to ensure that acceptable infection control practices were implemented. The findings include: Observation on 4/28/2020 at 12:15 PM identified that the Director of Nurses donned an N95 mask on top of a surgical mask. Observations and interview on 4/28/2020 at 12:20 PM with the DNS identified two residents in a room on contact precautions. The DNS identified that the Resident on the door side of the room was Covid-19 positive (Resident #1) and the resident on the window side was exposed and not currently exhibiting symptoms (Resident #2). The curtain was drawn between Resident #1 and Resident #2 but Resident #1's privacy curtain did not surround the entire bed and Resident #1 was also without the benefit of a mask. Further observation on 4/28/2020 at 12:25 PM identified that Resident #2 on the window side of the room was observed ambulating past Resident #1 and entering the bathroom in the room without the benefit of a mask. In addition, the door of the room was opened and subsequent to surveyor inquiry, the residents' room door was closed. Observations during the tour of Elm unit on 4/28/2020 from12:20 PM to12:45 PM identified four staff members wearing surgical masks under their N95 masks, one staff member identified herself as a certified nursing assistant (CNA). In addition, a sign posted on an office door in the main corridor on the Elm unit identified the following: Do the five: 1) wash hands often , 2) cough into your elbow, 3) don't touch your face, 4) stay 3 feet apart, and 5) if sick stay home. Additional observations identified three additional residents' rooms scattered throughout Elm unit that had residents on contact precautions for either suspected, pending or Covid-19 positive and lacked the benefit of the doors being closed as recommended per CDC guidance. Interview with the Assistant Director of Nurses (ADNS) identified that the residents in those rooms did not have any safety concerns that would preclude door closure. Subsequent to the observations and interviews, the doors were closed for each room identified. Interview with the DNS on 4/28/2020 at 12:45 PM identified that the procedure for N95 mask conservation included wiping the inside of mask after each use with an alcohol wipe and to store in a paper bag. Observations during the unit tour on the secured unit on 4/28/2020 at 1:15 PM identified six residents in the hallway without the benefit of a mask or being 6 feet apart. An interview with LPN#1 on the unit identified that they did not offer the residents a mask as they would not wear them. Subsequent to being interviewed about two residents seated next to each other, LPN #1 proceeded to escort one of the residents to his/her room. Interview with the DNS on 4/28/2020 at 1:20 PM identified that the residents were primarily dementia residents and based on the facility knowledge of the behaviors, they did not attempt to place on a mask on the residents. The Infection Preventionist identified that social distancing was 6 feet apart and that efforts should be made to conform to this guidance. Continued observations and interview with the Infection Preventionist on 4/28/2020 at 1:30 PM on the Covid-19 unit identified that gowns were being conserved by the utilization of one gown per staff member each shift when caring for the residents. Upon entry to the unit, gowns were hung on hangers directly in contact with each other on a small coat rack. There were six gowns hanging on that rack with a face shield also on the same hanger with the interior of the face mask towards the used gown. Interview with LPN #2 identified that when she comes in she choses one of the gowns on the rack and then uses the cleaned face mask that would be hanging on the gown. She further stated that she now realizes that the face mask would be contaminated by the way it was stored and she would have had difficulties donning the used gown without contaminating herself. Interview with the Infection Preventionist on 4/28/2020 at 1:35 PM identified that the face masks as they were stored were contaminated and when observing the gown storage, she also identified that donning the gowns would likely cause cross contamination. The US Food and Drug administration (FDA) defines an N95 respirator as a respiratory protective device designed to achieve a very close facial fit and very efficient filtration of airborne particles. The N95 mask is designed to sit directly against the face so that there is not a leakage of air in/out of the circumference of the mask. Center for Disease Control and Prevention (CDC) educational materials on donning the N95 mask does not allow a surgical mask to be donned first. Current data per the CDC suggest person-to-person transmission most commonly happens during close exposure to a person infected with [MEDICAL CONDITION] that causes COVID-19, primarily via respiratory droplets produced when the infected person speaks, coughs, or sneezes. Until more is known about how COVID-19 spreads, OSHA recommends using a combination of standard precautions, contact precautions, airborne precautions, and eye protection (e.g., goggles, face shields) to protect healthcare workers with exposure to [MEDICAL CONDITION]. A component of airborne precautions is to ensure appropriate patient placement in an airborne infection isolation room (AIIR) constructed according to the Guideline for Isolation Precautions. In settings where Airborne Precautions cannot be implemented due to limited engineering resources, masking the patient and placing the patient in a private room with the door closed will reduce the likelihood of airborne transmission. AS of 4/20/2020, the facility had not provided requested documents. The facility failed to follow current guidance for Long term care facilities in regards to providing masks for residents of they are likely to be closer than 6 feet apart and/or ambulating in the hallways on a unit as well as not closing doors to resident rooms with known Covid-19 in order to maximize airborne precautions. The facility did not store gowns and face shields in accordance with CDC guidance that would avoid cross contamination and potential exposure to Covid-19. Additionally, the facility did not don N-95 masks or post information as per CDC guidelines.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE