STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075390	A. BUILDING _____ B. WING _____	**05/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BEACON BROOK HEALTH CENTER	**89 WIED DRIVE NAUGATUCK, CT 06770**

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 observations and interviews with staff, the facility failed to ensure that appropriate infection control practices were implemented to prevent and control the spread of infection. The findings include: a) Observation on 5/5/20 at 8:45 AM identified that the doors that separated the nursing unit to the lobby were open, and that on the right and left side of the entry door to the unit there were two rooms with droplet precaution signs. Interview with the infection control nurse on 5/5/20 at 11:40 AM identified that the doors to the unit should have been closed to create a barrier from the nursing unit to the lobby. b) Observation on the facility tour on 5/5/20 at 10:00 AM identified that a room had a droplet precaution sign on the outside of a door. Observation of the room identified that there were two residents in the room and the privacy curtain was not drawn. Interview and review of the facility line list with the Infection Control Nurse (ICN) on 5/5/20 at 11:30 AM identified that one of the residents had a pending COVID-19 test that was taken on 5/2/20, but the roommate was asymptomatic. The ICN identified that if no other room was available for cohorting the COVID-19 pending resident, the privacy curtain should be drawn between the two residents. c) Observation of another room on the facility tour on 5/5/20 at 10:10 AM identified a droplet precaution sign on the door with two residents in the room with the privacy curtain not drawn. Interview with the ICN on 5/5/20 at 11:40 AM identified that there was a droplet precaution sign on the door because a resident in that room had a pending COVID-19 test on 5/2/20, but the roommate was asymptomatic. Review of the line list with the ICN failed to reflect that this resident had a pending test. The ICN further identified that she did not know why this resident was not on the line list, and further identified that she was unsure if any beds were available to cohort, and was unable to state why this was not considered when the resident became a pending status on 5/2/20. The ICN further identified that the privacy curtain should be drawn between the two residents if a room to cohort was not available. The ICN, Assistant Director of Nurses, and the corporate nurse identified that if room changes are available, pending residents and asymptomatic residents should be cohorted. They further stated that they would be looking into a room change for these residents if there were beds available, and would be reviewing the line list to ensure that all residents are on the list and properly cohorted. d) Observation on 5/5/20 at 10:00 AM identified a therapist in a room with a droplet precaution sign on the door. The therapist was wearing a short sleeve(NAME)over her short sleeve scrub top. As the therapist was leaving the room she took off the(NAME)with her bare hands, placed it in a garbage bag and brought it down to the soiled utility room. Interview with the therapist on 5/5/20 at 10:05 AM identified that she should have had a long sleeve isolation gown on underneath her(NAME) and she should have removed the(NAME)before removing her gloves. Interview with the ICN on 5/5/20 at 11:45 AM identified that the therapist should have had a long sleeve isolation gown on underneath the(NAME)and she should have removed the(NAME)before removing her gloves. e) Observation upon entering the COVID-19 designated unit on 5/5/20 identified a yellow disposable isolation gown and hairnet hanging off of the bulletin board at the entrance to the unit, and a Tyvek suit hanging from the other side of the bulletin board. Across from the bulletin board by the time clock, there were a number of Tyvek coverall suits hanging on the wall. Further observation identified a staff member doffed a Tyvek coverall suit and hung it on hook with another Tyvek suit. Interview with the ADNS on 5/5/20 at 10:45 AM identified that the isolation gown and Tyvek suit should not be hung on the bulletin board after use. The isolation gown should have been discarded after use and the Tyvek suit should have been disinfected and hung up with the other suits. She further identified that the staff member should not have hung her Tyvek suit on top of another Tyvek suit as the suits on the wall were clean. The ADNS identified that the facility is using the suits on the COVID-19 designated unit and after use the staff are wiping each other down using bleach wipes, and hanging them in the alcove by the time clock for future use. The ADNS was unsure if the suits should be stored there. The ADNS identified that this was the practice they had been directed to use. However, the facility had just received updated information from the state epidemiology department that stated the suits were now designated for one use only. The facility would be changing their practices, and all staff would be in-serviced on current storage and use of Tyvek suits.

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