| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **075274** | A. BUILDING _____ B. WING _____ | **04/26/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **WESTERN REHABILITATION CARE CENTER** | **107 OSBORNE STREET DANBURY, CT 06810** |

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<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | **Provide and implement an infection prevention and control program.**<br><br>Based on observation, interviews and review of facility documentation, the facility failed to ensure that acceptable infection control practices were implemented. The findings include: An interview with the day supervisor on 4/26/2020 at 10:30 AM identified that the third floor of the facility was considered the Covid-19 positive unit and that residents who were Covid-19 positive were all moved to that unit. She further identified that the staff on the third floor utilized shoe covers, protective caps, gowns, gloves, N95 masks and face shields as personal protective equipment when working on Covid-19 unit. Interview with LPN #1 on 4/26/2020 at 10:50 AM identified that there were twenty-two residents on her side of the third floor unit with eight residents who've tested positive for Covid-19. The eight residents occupied 4 semi-private rooms on the unit. She identified that some of the Covid-19 positive residents were independent, but others required assistance with personal care. LPN #1 further identified that at the start of the shift she was provided a gown, gloves, boot covers, a protective cap, a surgical mask and a face shield. She was previously issued an N95 mask that she also wears underneath the surgical mask. She further identified that she would put on all provided personal protective equipment prior to entering the 3rd floor Covid-19 unit. In addition, she noted that when she provided care to a resident she would wash her hands, put on new gloves and proceed to provide care to the resident, identifying that she would not change her gown, surgical mask, booties or protective cap prior to providing care to the next resident. LPN #1 clarified that the same process was done when going from a Covid-19 positive resident to a resident who was not demonstrating any symptoms and who was not tested as the whole unit was on precautions. She further identified that the nurse aides were following the same process when providing care to a resident on the Covid-19 unit. LPN #2 on 4/26/2020 at 11:00 AM identified that there were twenty-eight residents on her side of the third floor and four residents had tested positive for Covid-19. The four residents occupied two semi-private rooms. LPN #2 further identified that at the start of the shift she was provided a gown, gloves, boot covers, a protective cap, a surgical mask and a face shield. She was previously issued a N95 mask that she also wears underneath the surgical mask. She further stated that she would put on all provided personal protective equipment prior to entering the 3rd floor Covid-19 unit. In addition, LPN #2 identified that when she provided care to a resident she would wash her hands, put on new gloves and proceed to provide care to the next resident, identifying that she would not change her gown, surgical mask, booties or protective cap prior to providing care to the next resident but would remove her gloves, wash and put on new gloves. LPN #2 also noted the same process was done when going from a Covid-19 positive resident to a resident who was not demonstrating any symptoms and who was not tested as the whole unit was on precautions. LPN #2 further identified that the CNAs were following the same process in the provision of care to all residents on the unit. An interview with the DNS on 4/26/2020 at 12:00 PM identified that she was not aware that LPN #1 and LPN #2 did not change PPE in between providing care to Covid-19 positive residents and residents presumed to be positive but were asymptomatic. The DNS further, indicated that when moving from providing care to a Covid-19 positive resident to a resident who had no symptoms and had not been tested for Covid-19, the expectation was that PPE would be changed to maintain infection control practice. According to CDC guidance a trash can should be positioned near the exit inside the resident's room to make it easy for staff to discard PPE, prior to exiting the room, or before providing care for another resident in the same room. |

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.