STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075153	A. BUILDING _____ B. WING _____	**09/04/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
VILLA AT STAMFORD, THE	**88 ROCKRIMMON ROAD STAMFORD, CT 06903**

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 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observation, review of policy, and interviews the facility failed utilize hair restraints in accordance with policy and standard of infection control practice. The findings include: Observation in the kitchen area on 9/4/20 at 9:45AM identified Dietary Staff #1 without a hair restraint or beard guard, Dietary Staff #2 without a beard guard and Dietary Staff #3 without a hair restraint. Interview on 9/4/20 at 9:45AM with Dietary Staff #3 identified she was rushing and had forgotten to put on the hair restraint. Interview on 9/4/20 at 10:15 AM with the Administrator identified staff should be wearing hair restraints while in the kitchen area. The facility policy for maintaining a safe and sanitary dietary department directed that hair be styled so it does not touch the collar and hair restraints are required to cover all hair. The facility failed to ensure the kitchen was maintained in a safe and sanitary manner with the use of hair restraints.
F 0886 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	Based on review of facility documentation, facility policy, and interviews the facility failed to conduct staff testing based on established requirements. The findings include: Facility documentation dated 7/7/20 identified Resident #1 tested positive for COVID 19. Interview with the DNS on 9/4/20 identified Covid 19 staff testing dated 7/7/20 through 7/28/20 indicated of the 137 total staff, 17 staff had not completed weekly testing for Covid 19 for 2 consecutive weeks. Additionally, of the 17 staff who were not tested weekly between 7/7/20 through 7/28/20, 9 staff members worked at least one shift beyond the last required weekly test date of 7/21/20. Interview with the DNS and RN #1 on 9/4/20 at 11:55 AM identified some staff had been on vacation and obtaining test results for staff working at alternate sites had been a challenge at times, however, most staff were tested on ce after returning from vacation on 7/28/20. Review of the State of Connecticut Department of Public Health Covid-19 infection control and testing guidance for nursing homes identified: CDC recommends repeat testing of all previously negative staff and resident until no new cases of Covid-19 are identified for 14 days. CMS similarly recommends weekly testing of all staff and testing of all resident until all residents test negative. Consistent with CDC and CMS, DPH also recommends weekly retesting of previously negative resident and staff until no new cases are identified for 14 days. Nursing Homes should document their testing plans, as well as dates and testing results. To conform with CMS guidance, nursing homes that do not have a plan in place should immediately begin to develop a strategy to implement regular testing of staff. DPH is available to assist nursing homes in formulating their plans.

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.