STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075268	A. BUILDING _____ B. WING _____	**04/20/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
TRINITY HILL CARE CENTER	**151 HILLSIDE AVE HARTFORD, CT 06106**

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, staff interviews, a review of the facilities policies and procedures, the facility failed to ensure proper Personal Protective Equipment (PPE) was worn, and/or failed to ensure proper donning and doffing of PPE, and/or failed to ensure handwashing was conducted in accordance with infection control standards and the facilities policies and procedures. The findings include: Observation on 4/20/2020 at 9:25 AM with the Director of Nursing (DNS) identified LPN #1 exited a COVID 19 positive resident room, with a two piece nylon outfit, and an untied short sleeved hospital gown that was worn over the nylon outfit. LPN #1 stepped into the hallway, and the hospital gown was noted to be hanging off his/her left shoulder. LPN #1 proceeded to adjust the hospital gown onto his/her shoulder with the gloves that were worn during care while in the resident's room. LPN #1, then touched the medication cart with his/her contaminated PPE and picked up three intravenous (IV) bags from the medication cart. LPN #1 punctured each IV bag to insert the tubing and placed them in the drawer within the medication cart. LPN #1 did not doff her PPE upon exiting the resident's room and failed to wash her hands. Interview with LPN #1 on 4/20/2020 at 9:40 AM identified the two piece nylon outfit was her personal item that she had been wearing in the facility. LPN #1 indicated she rotated wearing her personal outfit with the facility approved one-piece jumpsuit. LPN #1 further indicated she should have tied her gown before entering the room, doffed before moving onto the next task, and washed her hands following removal of the PPE and did not. a. Interview with the DNS on 4/20/20 at 9:42 AM identified she was not aware LPN #1 was wearing his/her own personal clothing, as it was not a facility approved uniform, or part of Personal Protective Equipment. The DNS directed LPN #1 to remove her personal covering, and to don facility approved PPE. b. Furthermore, the DNS indicated the hospital gown should have been secured at the time of donning to prevent a breech in infection control practices. c. Lastly, the DNS identified LPN#1 should have doffed the PPE upon exiting the room and wash her hands before moving to the medication cart to resume her tasks. The DNS indicated LPN #1 did not follow infection control guidelines for donning and doffing PPE, and did not follow the facility policy for handwashing. Subsequent to the surveyors observation Corporate Nurse #1 provided LPN #1 with proper infection control education as it related to handwashing, personal protective equipment, donning and doffing, and general infection control practices. Review of the facility COVID 19 Response Plan, directed in part that Personal Protective Equipment (PPE) would be utilized by clinical staff in the delivery of patient care as directed by the facilities policies and procedure for contact, droplet or other precautions. Review of the facility policy for donning and doffing of Personal Protective Equipment in part directed that when putting on a gown and/or apron the staff member would fasten the gown in the back of the neck and at the waist. The policy further directed that after doffing PPE the staff member would clean and dry their hands thoroughly. Review of the Personal Protective Equipment policy for COVID 19 Affected Units in part directed to change hospital gowns, perform hand hygiene and apply new gloves between residents. After care had been performed, gloves and the hospital gown are to be removed and placed in the dirty linen container in the residents room. Review of facility policy entitled Handwashing directed in part, that the goal of handwashing was to prevent the spread of infection. Employees should wash their hands before and after each resident contact. The policy further directed that hand sanitizer would be utilized after contact with a resident and before exiting the resident's 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.