STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075415	A. BUILDING _____ B. WING _____	**04/30/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
COUNTRYSIDE MANOR OF BRISTOL	**1660 STAFFORD AVENUE BRISTOL, CT 06010**

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 observation and interview, the facility failed to maintain adequate infection control practices. The findings include: An observation at 11:00 AM identified two staff from a transportation service company removed Resident #1 from his/her bedroom on a Covid 19 positive wing of the facility. Resident #1, who tested positive for Covid 19, was taken to the facility exit through a non-infected wing of the facility without he benefit of a facial covering. An interview with the facility ' s Infection Control Nurse on 4/30/19 at 11:39 AM identified Resident #1 was being discharged to another facility. The Infection Control Nurse further identified facility staff have been educated on the proper use of personal protective equipment and should have masked Resident #1 prior to exiting his/her bedroom. She identified the transportation staff could have been instructed to use an exit in the building that would not go through the non-infected unit. An interview with the facility ' s Director of Nursing on 4/30/20 at 12:10 PM identified staff did not notice the transportation staff entering the unit until they had Resident #1 on the gurney and were wheeling him/her down the hall. She identified the transportation staff announce themselves at the front entrance and should have check in with staff on the nursing unit, but sometimes do not. She further identified the facility staff should have been aware and either administered a face covering to Resident #1 and/or instructed the transportation staff to utilize the exit on the Covid 19 positive unit. Although the facility had an infection control policy related to Covid 19, the policy failed to identify a procedure for exiting positive residents from the facility.

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