STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075402	A. BUILDING _____ B. WING _____	**07/25/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MANSFIELD CENTER FOR NURSING AND REHABILITATION	**100 WARREN CIRCLE MANSFIELD, CT 06268**

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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation, observations, and interviews for two sampled Residents (R#2, and R#4) reviewed for infection control practices, the facility failed to ensure the reuse of Person Protective Equipment (PPE) was conducted in accordance with current standards and failed to ensure high touch electronic devices were stored in a clean/sanitary manner. The findings include: 1. On 7/25/20 review of clinical records identified Resident #2 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The admission minimum data set ((MDS) dated [DATE] identified R#1 with severe cognitive impairment (BIMS of 7) and required limited assistance of one with activities of daily living (ADL). Record review identified Resident #4 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. An admission nursing assessment identified R#4 presented with moderate cognitive impairment and required extensive assistance of two for ADL. During a tour of the facility on 7/25/20 at 10:55 AM supply carts were identified in the hallway outside the door of the rooms where R #2 and R#4 resided. Signs were posted above the supply carts that identified the resident required transmission-based standard and droplet precautions. The instructions further identified that staff were required to wear a mask, face shield, isolation gown, and gloves prior to entering the resident rooms. Several brown paper bags were observed on top of the two carts. The bags were labeled with a name and contained a face shield. Interview with RN #2 on 7/25/20 at 11:00 AM identified the labeling ensured the face shield was assigned to an individual staff member for use in the isolation rooms, and it was to be cleaned after exiting the isolation rooms and stored in a bag for reuse. Further observation identified several yellow disposable isolation gowns hanging on top of each other inside the rooms of Residents #2 and #4. RN #2 identified the gowns were taken off (doffed) after use and were hanging in the resident rooms for reuse. She identified the gowns were reused (donned) and doffed by staff several times throughout the shift and replaced if soiled during the shift. Review of the facility's Quarantine and Observations of Residents procedures dated 5/28/20 identified all newly admitted Residents to the facility would be placed in a private room under a fourteen-day specialized quarantine due to possible Coronavirus Disease 2019 (COVID-19) exposure. Interview and review of the facility's PPE supplies with the Infection Prevention Nurse (IPN) on 7/25/20 at 11:30 AM identified the practice of gown reuse was to optimize the facility supplies based on Centers for Disease Control and Prevention (CDC) guidelines that were utilized to develop the facility's procedures dated 5/28/20. Review of the updated CDC guidelines for optimizing supply of PPE dated 7/16/20 identified disposable gowns were not typically doffed and reused because the ties and fasteners may break during doffing. The updated guidelines identified the risk of self-contamination while re-donning an isolation gown was unknown and was therefore not a recommended infection control standard of practice. The facility failed to ensure that disposable isolation gowns were discarded following each use to prevent the transmission of infection. 2. During a tour of the facility on 7/25/20 at 10:45 AM identified staff used a handheld electronic touch screen device for clinical record documentation. Observations identified the devices to be stored on top of the clean linen carts on the North One and East One nursing units. Interview and review of the policy on Cleaning and Disinfecting Touch Screens for Laptops and iPads with the Infection Control Nurse on 7/25/20 at 11:30 AM identified touchscreen devices were to be disinfected frequently to minimize the potential for spreading infections. The policy specified the disinfectant product that was to be utilized to sanitize the devices and identified that the device was to be stored in the nursing lounge by the iPad charging stations.

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.