STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075365	A. BUILDING _____ B. WING _____	**05/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CURTIS HOME ST ELIZABETH CENTER	**380 CROWN STREET MERIDEN, CT 06450**

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 observations, review of facility documentation, and interviews, the facility failed to ensure staff members adhered to infection control practice during a pandemic by wearing the N95 mask in a manner that optimized effectiveness of the mask and the facility failed to adhere to infection control practice during a pandemic by placing a resident exposed to another resident diagnosed with [REDACTED]. The findings include: 1. Observations during the tour of the facility's B Wing on 5/5/20 at 11:55 AM with RN #1 (Infection control specialist) and CDC representatives identified Housekeeper #1, Housekeeper #2 and a Nurse Aide (NA) #2 wearing N95 masks with a surgical mask in place under the N95 mask. NA #1 was noted wearing a KN95 mask with a surgical mask in place under the KN95 mask and Housekeeper #3 was noted wearing a fabric mask under the N95 mask. The facility was divided into of two (2) wings. The B wing housed five (5) of the fourteen (14) COVID positive residents and the remaining nine (9) COVID positive residents were housed on the A Wing. In an interview with NA #1 on 5/5/20 at 12:15 PM, NA #1 stated she wore a second mask for her added protection and could not recall if the facility addressed wearing a second mask along with the N95 or KN95. NA #1 indicated she provided care for residents who were positive COVID-19. In an interview with the 7-3 charge nurse, Licensed Practical Nurse, LPN #1 on 5/5/20 at 12:20 PM, LPN #1 indicated the facility did not provide education on using a surgical mask with the N95. An interview with Housekeeper #3 indicated she was in-serviced on handwashing and social distancing but was not in-serviced on the process of applying a mask. Housekeeper # 3 stated her job included cleaning high touched areas including areas in the rooms occupied by residents with positive COVID-19. Subsequent to the observations CDC Representative #1 informed NA #1, NA #2, and LPN #1, RN #1 and other staff present that to obtain an optimal fit for the protection of staff and residents, the N95 masks should not be worn with another mask placed between the N95 and the skin. The CDC representative identified that this action would compromise the safety of staff and residents. A review of the facility's COVID-19 educational offerings documentation indicated staff completed personal protective equipment competency validation 4/24/20 through 4/28/20. An interview with RN #1 on 5/5/20 at 2:30 PM indicated staff were in-serviced on techniques of donning and doffing and RN #1 stated staff should not be wearing any other masks between the skin and the N95 mask. 2. Observations during the tour of the A Wing and interview with RN #1 (infection control specialist) on 5/5/20 at 12:30 PM identified two (2) names on the entrance to a residents' room. Resident #1 was occupying bed #1 and bed #2 was unmade. Entrance to Resident #1's room was without the benefit of isolation precaution signs and an isolation cart. RN #1 stated Resident #2 was admitted to the hospital after displaying symptoms of COVID-19 and was subsequently diagnosed with [REDACTED].#2's clinical record dated 4/21/20 identified the resident was found in respiratory distress, cyanotic, with an oxygen saturation level in the 60's and was sent to the emergency department for further evaluation. A review of the facility's COVID out-break line list identified Resident #2 was diagnosed with [REDACTED]. Review of Resident #1's clinical record with RN #1 identified the nurse's note dated 4/16/20 at 2:40 PM Resident #1 had a runny nose, cough and was given Tylenol for a temperature of 99.2. The nurse's note dated 4/17/20 indicated Resident #1 reported feeling crummy, had a productive cough and was given Tylenol and [MEDICATION NAME]. The nurse's note dated 4/27/20 at 2:05 PM indicated Resident #1 had a body temperature of 100.1, a cough, and the oxygen level was increased from three (3) to four (4) liters to maintain an oxygen saturation level of 92%. Review of the nurse's notes from 3/14/20 through 5/5/20 with RN #1 failed to identify Resident #1 was tested , placed on precautions for presumed or exposure to COVID-19. In an interview with RN #1 (Infection control specialist) on 5/5/20 at 3:00 PM, RN #1 stated she was unsure the reason Resident #1 was not placed on droplet precautions and Resident #1 should have been on droplet and contact precautions at the time the facility was informed Resident #2 was diagnosed with [REDACTED].

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.