STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075244	A. BUILDING _____ B. WING _____	**05/13/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
AVON HEALTH CENTER	**652 WEST AVON RD AVON, CT 06001**

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 and interviews with staff, the facility failed to ensure that appropriate infection control practices were implemented to prevent and control the spread of infection. The findings include: The facility was previously cited for lapses in infection control practices noted during the 5/4/20 inspection. A) Interview with the Director of Nurses (DON) on 5/13/20 at 9:30 AM identified that Resident #1 had a positive COVID-19 result on 5/12/20 at 2:01 AM, Resident #1's roommate, Resident #2 had a negative COVID-19 result on 5/12/20 at 2:24 AM. The DON identified that as of 5/13/20 at 9:30 AM Resident #1 and Resident #2 remained in the same room (approximately 31 hours after the facility was made aware of Resident #1 and Resident #2's test results). The DON further identified that the facility was aware on 5/12/20 that Resident #1 was positive and in the room with Resident #2, and that priority is given to separate positive and negative residents. The DON further identified that it was not done on 5/12/20 because the facility had worked all day on other room changes and did not have time to move Resident #1 to the COVID designated unit. Observation on 5/13/20 at 10:30 identified that Resident #1 and Resident #2 were in the same room. The DON identified that Resident #1 would be moved to the COVID-19 positive unit as soon as possible. B) Interview with the DON on 5/13/20 at 9:40 AM identified that Resident #3 had a positive COVID-19 test on 5/11/20 at 10:00 PM, and Resident #4 had a negative COVID-19 test on 5/11/20 at 10:10 PM. The DON identified that as of 5/13/20 at 9:40 AM Resident #3 and Resident #4 remained in the same room, (approximately 36 hours after the facility was made aware of the test results). The DON stated that she could not explain why the resident's remained in the same room, and thought maybe it was an oversight on the part of the facility. Observation on 5/13/20 at 10:45 AM identified that Resident #3 and Resident #4 were in the same room. The DON identified that Resident #3 would be moving to the COVID-19 positive unit as soon as possible. Interview with the Medical Director on 5/13/2020 at 10:35 AM identified that COVID-19 positive residents and negative residents should not be in a room together, and should be separated as soon as possible. Interview with the administrator on 5/12/20 at 11:00 AM identified that the facility is to follow the Center for Disease Control (CDC) guidelines on COVID-19. Review of the CDC guidelines identified that residents that test positive for COVID-19 should be cohorted with other positive residents, and residents that test negative for COVID-19 should be cohorted with other negative residents. C) Interview and Observation on 5/13/20 at 9:30 AM with the staff development coordinator identified that a Nurse Aide was in a COVID-19 positive room without a face shield on. Interview with the NA identified that she did not like to wear the face shield because she cannot see well with it on. The staff development coordinator identified that it was facility policy to wear a face shield while in COVID-19 positive room, and the NA was educated. Review of CDC guidelines identified that individuals working with COVID-19 residents should wear eye protection. D) Interview and Observation on 5/13/20 at 9:20 AM identified a portable privacy screen at the entrance to the A unit. The screen was on wheels, and had a metal frame that had 3 panels with a curtain like material, the privacy screen had to be moved manually in order to enter the unit. The DON stated that the screen was in place as a barrier between the unit and the corridor leading to other units. The privacy screen was placed there because there are 4 patient rooms before the fire door, and closing the fire door would isolate those four rooms from the rest of the unit, so they decided to put up the portable privacy screen to provide a barrier from the unit and the corridor. The DON identified that the screen would be removed.

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.