STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075265	A. BUILDING _____ B. WING _____	**09/03/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ELIM PARK BAPTIST HOME, INC	**140 COOK HILL RD CHESHIRE, CT 06410**

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 0886 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	Based on review of facility documentation, the facility failed to ensure that staff testing for COVID-19 was conducted in accordance with CMS and CDC guidance. The findings include: Interview with the Director of Nursing Services (DNS) on 9/3/20 at 9:30 AM indicated that the facility was testing all staff in accordance with the guidance and noted that the facility was COVID-19 free. The DNS further identified that she/he felt it was very important to continue staff testing in order to decrease the risk of staff resident transmission. Interview with the Administrator on 9/3/20 at 10:00 AM identified that all the staff were tested on a weekly basis to prevent COVID-19 from entering the facility. The Administrator identified that this is very important to prevent a resurgence of COVID-19. Interview on 9/3/20 at 10:20 AM with the Infection Control Nurse (LPN #1) indicated she/he performed staff testing and was responsible for ensuring that all staff members were tested on a weekly basis. LPN #1 provided a spread sheet with all employee names and the dates of their testing during 8/16/20 through 8/29/20. Interview with the DNS on 9/3/20 at 11:00 AM identified the facility had a staff member that tested positive in June 2020 but did not have any current staff or residents that were positive for COVID-19. The DNS identified that she reviewed the employee testing list on a weekly basis to ensure that all the staff were tested . The DNS further noted that the staff were very good about getting tested on a weekly basis on their scheduled day and time and if an employee was going to be off on their scheduled testing day, then the staff member was supposed get tested on the previous day. The DNS indicated weekly testing of COVID-19 was done by LPN #1 with oversight from the Infection Preventionist RN #1. Review of the employee roster on 9/3/20 with the DNS and LPN #1 identified that during the week of 8/16/20 through 8/22/20 seven employees were not tested for COVID-19 and during the week of 8/23/20 through 8/29/20 thirty-one employees were not tested for COVID-19. Further review noted that all of the employees not tested had worked at least once during the period of 8/16/20 through 8/29/20 and thereafter. Further interview with the DNS on 9/3/20 at 2:00 PM indicated she/he did not realize that many employees were not tested during the week of 8/23 through 8/29/20. The DNS was unable to explain why these staff members were not tested . Further interview with LPN #1 on 9/3/20 at 2:05 PM identified she/he had double checked all the test results and confirmed that the data provided was accurate. LPN #1 indicated that during the week of 8/23 through 8/29/20 she/he was out sick a few days and could not explain why there were 31 employees who were not tested . Further interview with the Administrator on 9/3/20 at 2:20 PM identified she/he was not aware that they were not 100% compliant, but identified that it is a priority to have all the employees tested weekly because they are the ones that would be bringing COVID-19 into the facility and spreading COVID-19 to the residents. A review of the facility's testing report for weekly testing on 9/3/20 identified that for the week of 8/16/20 through 8/22/20 the facility staff testing completion rate was 80% and during the week of 8/23 through 8/29/20 was 60.6%. The facility had a total of 34 employees (none of which had previously tested positive for COVID-19) that were actively working in the nursing home between 8/16 through 8/29/20 and thereafter. The facility failed to conduct staff testing in accordance with CMS guidance, Executive Order 7AAA and Blast Fax 2020-87. The facility policy on Resident and staff testing was requested but not provided.

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.