STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075381	A. BUILDING _____ B. WING _____	**05/07/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WATER'S EDGE CENTER FOR HEALTH & REHAB	**111 CHURCH STREET MIDDLETOWN, CT 06457**

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 -** Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and review of facility documentation, the facility failed to ensure infection control practices were implemented as per Center for Disease Control and Prevention (CDC) guidelines. The findings include: Observation with the Director of Nurses (DNS) on 5/7/2020 at 10:00 AM identified a nurse aide garbed in an isolation gown and a surgical mask exit a resident's room located on the 3rd floor of the facility that was identified to be a room on contact precautions (room [ROOM NUMBER]), cross the hallway and enter another resident's room (room [ROOM NUMBER]) where the residents in that room were not on precautions. Interview with the DNS on 5/7/2020 at 10:00 AM identified that multiple rom changes had occurred on the unit the previous day in order to move and cohort all residents who were Covid-19 positive on the second floor. She further identified that as part of their personal protection equipment (PPE) optimization activities, staff wear the same gown and mask when caring for residents on that wing and for the residents who were pending, symptomatic or Covid-19 positive. The DNS further identified that she was unclear if the signage was accurate on the rooms due to all the changes, adding that all COVID-19 positive residents were already moved but symptomatic and COVID-19 pending were still on the unit. Inspection of 2 PPE carts outside resident's rooms identified as on droplet precautions lacked supplies of PPE. Interview with LPN #1 on 5/7/2020 at 10:15AM identified that all nursing staff kept the same gown on for an entire shift and cared for all the residents on that unit due to the gown shortage. The gown is worn for all care to the residents that would include high contact care such as resident's hygiene, toileting, transfers to and from bed to assistive equipment such as wheelchairs and changing of bed linen. Interview with the DNS on 5/7/2020 at 10:15 AM identified that it would be her expectation that staff change PPE if they had cared for a COVID-19 pending, symptomatic or COVID-19 positive Resident prior to caring for a Resident whose COVID-19 status was unknown or negative. Subsequent to this surveyors initial observations on the third floor unit, interview and observation with the DNS on 5/7/2020 at 11:15AM identified that residents residing in rooms 303, 304, 310, 311 were identified on as being on droplet precautions. The residents in those rooms were pending COVID-19 testing or exposed and at least one resident in each room was identified as symptomatic. Rooms 305, 306, 308, 309 housed residents not on precautions as they were asymptomatic, and their COVID-19 status was unknown. Education was provided to staff by the Infection Control Nurse concerning appropriate signage, adequate PPE and PPE disposal receptacles. CDC guidelines identify that high-contact residents care activities are activities that are at the highest risk of transmitting infectious pathogens, and include things like dressing, bathing or showering, transferring, providing hygiene, changing linens, assisting with toileting, device and wound care. Center for Disease Control and Prevention (CDC) guidance directs for extended use of isolation gowns consideration can be made to extend the use of isolation gowns (disposable or cloth) such that the same gown is worn by the same Health Care Professional when interacting with more than one patient known to be infected with the same infectious disease when these patients are housed in the same location (i.e., COVID-19 patients residing in an isolation cohort). Residents located in rooms 305, 306, 308 and 309 were not known to be infected and were cared for by staff wearing the same isolation gown and mask. The facility policy, Strategies to Optimize PPE, directs to extend the use of isolation gowns (disposable or cloth) such that the same gown is worn by the same Health Care Professional when interacting with more than one patient known to be infected with the same infectious disease when these patients are housed in the same location.

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.