STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075407	A. BUILDING _____ B. WING _____	**05/27/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THE RESERVOIR	**1 EMILY WAY WEST HARTFORD, CT 06117**

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.** Based on observations, review of facility documentation and interviews for 6 residents who were identified to be potentially exposed to COVID-19 (Resident #1, Resident #2, Resident #3, Resident #4, Resident #5, and Resident #6), the facility failed to post isolation precaution signage and utilize Personal Protective Equipment (PPE) according to Centers for Disease Control (CDC) guidelines. The findings include: On 5/17/20 at 9:00 AM, observation and interview with the Administrator identified the facility had designated a group of rooms on the first floor as the Exposed Cohort Unit. Exposed residents are those residents who were roommates of COVID-19 positive residents who undergo a 14 day quarantine or are symptomatic residents with a high clinical suspicion for COVID-19, awaiting testing results. Observation on 5/17/20 at 9:15 AM identified the rooms of Resident #1, Resident #2, Resident #3, Resident #4, Resident #5, and Resident #6 were designated as the Exposed Unit and the entrance to that side of the unit or the room of those residents were without the benefit of signage to identify that the residents were on contact/droplet precautions. Additionally, only 1 Personal Protection Equipment (PPE) storage bin was observed in the area, and when opened, failed to identify the presence of isolation gowns. Interview with LPN #1 on 5/17/20 at 9:15 AM identified all the residents on her assignment were considered exposed and that she and the NA assigned to that side of the unit would wash their hands and change gloves between residents, but would wear the same gown to provide care to each resident as part of the extended use policy for isolation gowns. Interview with the acting DNS/Infection Preventionist on 5/17/20 at 9:15 AM identified that Residents #1, Resident #2, Resident #3, Resident #4, Resident #5, and Resident #6 were residents that have been identified as exposed residents. The State of Connecticut Department of Public Health blast fax entitled COVID-19 Point Prevalence Survey testing and cohosting in Nursing Homes (Interim Guidance - May 11, 2020) directs that in the exposed cohort, gowns and gloves must be changed between residents, extended use of facemask/respirator and eye protection is acceptable. 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 who the facility identified as exposed are not be considered infected. The facility failed to post signage related to droplet precautions and failed to utilize PPE per CDC guidelines when providing care to the residents exposed to COVID-19.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE