STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075397	A. BUILDING _____ B. WING _____	**05/02/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
REGALCARE AT NEW HAVEN	**181 CLIFTON STREET NEW HAVEN, CT 06513**

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 provide staff working on the COVID-19 designated area with an adequate number of gowns, failed to ensure the gowns maintained protection, failed to utilized gowns and the facility failed to maintain active surveillance to prevent the spread of infection amongst visitors and healthcare personal in accordance with the facilities infection prevention program for COVID-19 and the recommendations of the Center of Disease control(CDC) during a pandemic to ensure staff and residents were protected from the transmission of infection. The findings include: 1. Tour of the facility's supply storage areas, resident care areas, and laundry facility on 5/1/20 at 1:00 PM with the Director of Nursing (DON) identified the facility had a total count of twenty-four (24) washable gowns. A tour of the third floor designated to the care of residents with positive COVID-19 with the DON and Assistant Director of Nursing (ADON) on 5/1/20 at 2:00 PM identified seven (7) rooms with eighteen (18) positive COVID-19 residents and the unit was staffed with five (5) nurse aides and two (2) Licensed Practical Nurses (LPN). In an interview with LPN #1 on 5/1/20 at 2:20 PM, LPN #1 indicated that when working on the designated COVID-19 area she was provided with a washable gown at the beginning of the shift and it was the practice to wear the gown when caring for residents who were diagnosed with [REDACTED].#1 stated that the gown would be removed after care, hung in a designated room, and re-worn for the entire shift when performing care to the COVID-19 positive residents. LPN #1 indicated gowns there was a short supply in the facility. Interview with a Registered Nurse, RN #1, on 5/1/20 at 2:30 PM indicated the facility was short on personal protective equipment. RN #1 stated that the facility utilized washable gowns when caring for residents with positive COVID-19. RN #1 identified a single gown was used all shift by each staff, and because of being washed the gowns were falling apart, and the ties were broken. Observations of the area designated to store the washable gowns with LPN #1 on 5/1/20 at 2:45 PM identified hanging gowns. LPN #1 indicated the washable gowns were worn when caring for residents with positive COVID-19 [DIAGNOSES REDACTED]. An interview with the DON and Administrator on 5/1/20 at 3:30 PM indicated that a single washable gown was worn by each staff throughout the shift and the gowns were laundered at the end of each shift. The Administrator identified she thought there were more gowns available. The DON and Administrator were unable to provide documentation of the CDC recommendations on the use of gowns when caring for positive COVID-19 residents. 2. The survey team entered the facility on 5/2/20 at 11:25 AM, it was identified the front desk receptionist was unable to find the thermometer for the temperature screening process prior to entering the facilities work area. The receptionist placed a call to RN #1 who was working on the second-floor unit. RN #1 brought a no contact thermometer to the front desk. Interview with RN #1 at 11:40 AM prior to checking the temperatures of the survey team, identified he/she had the no contact thermometer on the second floor and had been checking the staff 's temperatures on the unit after they had filled out a surveillance questionnaire in a conference room before entering the work area. RN #1 was unable to identify why the facility staff members had not had their temperatures checked prior to entering the work area. Observations on 5/2/20 at 11:55 AM, identified RN #1 leaving the front desk area with the no contact thermometer to change the thermometer's batteries. RN #2 entered the facility at 11:58 AM and proceeded to walk toward the conference room. Interview with RN #2 identified he/she was going to the conference room to fill out a surveillance questionnaire followed by having his/her temperature checked on the unit. RN #2 was unable to identify why his/her temperature was not being checked prior to entering the work area. Subsequent to surveyor inquiry, RN #1 checked RN #2's temperature before entering the work area. Interview with RN #3 (Infection Prevention Nurse) at 12:45 PM, identified all facility staff members must have a temperature screening and fill out a surveillance questionnaire before entering the work area. RN #3 identified staff members had been having temperature screenings prior to entering the work area and was unable to identify why the process had not been conducted today. Interview with the Administrator on 5/2/20 at 12:40 PM, identified facility staff had been inserviced on active surveillance monitoring and maintaining appropriate transmission-based precautions. The Administrator indicated all staff and visitors should have had their temperature taken, and a completed a rveillance questionnaire prior to entering a nursing unit. Review of facility documentation identified that 10 facility employees did not have temperature screenings documented on 5/2/20. Subsequent to surveyor inquiry, facility employees had temperature screenings and were provided in-service education on the temperature screening process. Review of facility policy for Active Surveillance for Respiratory Infection among resident and healthcare personal, directed in part, that a temperature screening and surveillance questionnaire would be completed upon arrival to facility and prior to entering a work area.

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.