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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A COVID-19 Focused Survey was conducted on May 1 and 2, 2020 at RegalCare at New Haven to determine compliance with 42 CFR Part 483 Requirements for Long Term Care Facilities, including proper infection prevention and control practices to prevent the development and transmission of COVID-19.	F 000		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify	F 880		5/20/20

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

Electronically Signed | 05/15/2020

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 1	F 880		

possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 2	F 880		

This REQUIREMENT is not met as evidenced by:
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

1). There we no residents identified to be affected by this practice.

2). All residents have the potential to be affected by the same practice.

3). Systemic changes that the facility will provide to prevent reoccurrence are: Administrator obtained additional gowns on 5/1/2020.

Staff will be re-educated on the appropriate reuse/use techniques for Personal Protective Equipment (PPE).

4). To monitor the corrective action: weekly audits will be conducted, finding will be reviewing at our weekly COVID-19 task force meeting

5). The corrective measure will be in effect by May 20, 2020 and will be monitored by the ADNS/ INC and INC

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 3 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 COVID-19. LPN #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 diagnosis and that one (1) gown was worn for the entire shift. 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	F 880	Designee F.880, Part 2: 1). There we no residents identified to be affected by this practice. 2). All residents have the potential to be affected by the same practice. 3). Systemic changes that the facility will provide to prevent reoccurrence are: staff will be re-educated on not reporting to the unit until the surveillance questionnaire is completed and temperature and O2 stats are taken. 4). To monitor the corrective action: weekly audits will be conducted, findings will be reviewing at our weekly COVID-19 task force meeting 5). The corrective measure will be in effect by May 20, 2020 and will be monitored by the ADNS/ INC and INC Designee	

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 4	F 880		

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

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

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 5 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.	F 880		