

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER <b>075106</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED <b>10/08/2020</b>
NAME OF PROVIDER OF SUPPLIER <b>MIDDLESEX HEALTH CARE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP <b>100 RANDOLPH RD MIDDLETOWN, CT 06457</b>	
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  <b>Level of harm - Minimal harm or potential for actual harm</b>  <b>Residents Affected - Few</b>	<p><b>Provide and implement an infection prevention and control program.</b></p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b></p> <p>Based on observations, clinical record review, review of facility documentation, review of facility policy, and interviews reviewed for Infection Control Practices, the facility failed to ensure staff was compliant with recommendations from the Center for Disease Control (CDC) and the facility's practices in donning appropriate personal protective equipment and [MEDICATION NAME] social distancing placing residents and staff at risk during the COVID 19 pandemic. The findings include: A tour of the facility on 10/8/2020 at 11:00 AM with the Assistant Director of Nursing Service (ADNS) identified the following: 1) OT #1 providing therapy to Resident #1 in the resident's room on the observation unit. OT #1 was less than 6 feet from Resident #1 and was without the benefits of wearing eye/face protection. 2) NA #1 and NA #2 seated together in a room on 2 West Bay (charting room). NA#1 and NA #2 were seated less than 6 feet apart and both NA's were without the benefit of wearing facemask's or eye protection. Observation of the room with the ADNS identified that the size of the room did not allow 6 feet social distancing for 2 staff. A review of Resident #1's clinical record indicated the resident resided in a room on the Observation unit. Signage at the entrance to Resident #1's room identified to wear a face mask and a face shield at all times. Resident #1's clinical records indicated Resident #1 was admitted to the facility on [DATE]. Further review of the Resident's record identified a social service note dated 9/30/20 that indicated Resident #1 had an outdoor visit scheduled for 10/11/20 once the Resident is off quarantine and precautions. In an interview with OT #1 on 10/8/20 at 11:30 AM, OT #1 indicated it was her practice to wear eye protection along with mask, gown and gloves when providing care for residents. OT #1 indicated she usually wore contact lens but was wearing her personal eye glasses on the day of observation. OT #1 further stated she and thought she had eye protection in place. Subsequent to the surveyor's inquiry OT #1 was provided with appropriate eye/face protection. An interview with the DNS on 10/8/20 at 11:40 AM indicated it was the practice of the staff and expectation that all staff wore full protective equipment when entering rooms of Residents on quarantine. In an interview with NA #2 on 10/8/20 at 11:45 AM NA #2 indicated she was informed by the facility that staff should always wear masks when in the facility except when on break and able to remain 6 feet apart and while having lunch. NA #2 indicated she should be wearing her mask but stated she needed to breathe. An interview with the ADNS on 10/8/20 at 11:45 AM indicated it was the expectation that staff wore masks while in the charting room as chairs were less than 6 feet apart and did not allow for social distancing. Review of facility documentation of the recommendations on use of Protective Personal Equipment when caring for patients with confirmed or suspected COVID 19 identified acceptable personal equipment included facemask's, non- sterile gloves, isolation gown and face shield or goggles. Facility Staff did not adhere to the CDC recommendations and the facility's practice in the use of appropriate PPE and social distancing.</p>		
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.