

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER <b>075244</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED <b>05/04/2020</b>
NAME OF PROVIDER OF SUPPLIER <b>AVON HEALTH CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP <b>652 WEST AVON RD AVON, CT 06001</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</b> - Minimal harm or potential for actual harm  <b>Residents Affected</b> - Few	<b>Provide and implement an infection prevention and control program.</b>  Based on clinical record review, facility documentation, interviews, observations and policy review, the facility failed to ensure that precautions were taken for a resident who had a pending COVID-19 test that was in the same room as a COVID-19 resident, and that face shields were stored in an appropriate manner. The findings include: a) Tour of the facility, observation and interview with the Director of Nurses (DON) on 5/3/20 at 9:15 AM identified a droplet precaution sign outside of a resident room. The curtain between the two residents was not drawn. The DON identified that a resident in that room had been placed on droplet precautions, as he/she had a pending COVID-19 test taken over the weekend due to a change in mental status. The DON further identified that the roommate had recently had a negative COVID-19 test. The DON further identified that the curtain should have been drawn around the COVID-19 pending resident. Subsequent to surveyor inquiry the curtain was pulled around the COVID pending resident. Subsequent to surveyor inquiry, the facility started immediately education to staff. Review of the facility COVID-19 precautions guidelines identified that a resident with a COVID pending test should have the curtain drawn around them at all times.		

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.