STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075403	A. BUILDING _____ B. WING _____	05/18/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
APPLE REHAB WEST HAVEN	308 SAVIN AVENUE WEST HAVEN, CT 06516

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of facility policy, facility documentation, manufacturer recommendations and interviews, the facility failed to properly disinfect multi-use equipment including a glucometer and hoyer lifts, to prevent the spread of infection, including Covid 19 and bloodborne pathogens, between resident use. Additionally, the facility failed to ensure Covid 19 infected residents were cohorted appropriately to prevent the transmission of Covid 19 infection to non-infected residents, and the facility failed to ensure staff utilized Personal Protective Equipment (PPE) according to professional standards to prevent the transmission of Covid 19. The findings include: 1. Observation, interview and review of facility documentation identified the 2nd floor had a total of 6 residents that required blood glucose testing with the multi-use glucometer. Of those 6 residents, 1 resident had a [DIAGNOSES REDACTED]. Additionally, on the 3rd floor, 10 residents required blood glucose testing with the multi-use glucometer. Of those 10 residents, 8 residents had a [DIAGNOSES REDACTED]. a. Observation on 5/10/20 at 12:50 PM with RN #1 on the 2 East and West Units, and on the 3 East Unit identified the following: Licensed staff and non-licensed staff did not have access to the recommended EPA/PDI registered disinfectant detergent or germicide wipes on the unit or on the medication carts. Interview with RN #1 on 5/10/20 at 12:50 PM identified the facility did not have in stock, the EPA/PDI germicidal wipes to clean and disinfect multi-use glucometers. Further, RN #1 indicated although every medication cart and unit should have the recommended EPA/PDI germicide wipes, the facility has been out of the wipes for some time now. Interview with LPN #1 on 5/10/20 at 12:52 PM identified she is the nurse for 2 East and 2 West unit. LPN #1 indicated she had used the multi-use glucometer to perform blood sugar testing on 2 residents before lunch today. LPN #1 indicated she has been using alcohol prep pads to clean and disinfect the glucometer for approximately 2 weeks because the facility was out of the wipes due to a shortage. LPN #1 indicated she has also been using the alcohol prep pads to disinfect the multi-use thermometers and blood pressure machines for approximately 2 weeks. LPN #1 indicated although she was educated in the past to clean and disinfect the glucometer after each use with the EPA/PDI germicidal wipes, she decided to use the alcohol prep pads because she was not provided with the recommended wipes and thought that the alcohol prep pads were better than nothing. Interview with the 3 East unit charge nurse, (LPN #3) on 5/10/20 at 1:15 PM identified she does not have the EPA approved wipes for the glucometer on the medication cart, and when she finishes using the glucometer, she walks over to the 3 West unit and borrows the clorox wipes from the other medication cart. LPN #3 indicated she did not ask for the approved wipes because she knew the facility did not have them. Interview with the Infection Control Nurse, (RN #2) on 5/10/20 at 2:55 PM identified that although she was aware that the facility did not have the recommended EPA/PDI germicidal wipes for approximately 2 weeks, she was not aware that alcohol prep pads were being used to clean and disinfect the glucometers during that time. RN #2 indicated she did not notify the DPH that the facility could not obtain the recommended EPA/PDI germicidal wipes and could not identify what direction she provided to the nurses on the unit to properly disinfect the multiuse glucometers after each use. Interview with the Administrator on 5/10/20 at 2:58 PM identified she was aware that the facility did not have the recommended EPA/PDI germicidal wipes for approximately 3 to 4 weeks because they were on back order, although she could not answer why or if she had notified the corporate office that the facility was out of stock for 3 weeks. The Administrator indicated she had obtained some supplies from the corporate office on Friday 5/8/20 late in the evening including EPA/PDI germicidal wipes and hand sanitizer, which was brought to the facility that same evening and placed in the housekeeper office. The Administrator indicated she failed to distribute the EPA/PDI germicidal wipes to the units that night, Friday 5/8/20. Subsequent, to surveyor inquiry on 5/10/20 all 4 medication carts were supplied with the recommended EPA/PDI germicidal wipes. b. Observations on 5/11/20 at 11:40 AM with the DNS identified the medication cart on 2 East unit again did not have the recommended EPA/PDI germicidal wipes available. There was one container of the wipes available on the 2 West unit medication cart. Interview with LPN #4 on 5/11/20 at 11:41 AM identified she is the nurse for 2 East unit and 2 West unit. LPN #4 indicated that when she came in this morning, there was only one container of EPA/PDI germicidal wipes for use on the unit/medication carts, and it was located on the 2 West medication cart. Subsequent to surveyor inquiry, the DNS went into a back room and brought the container of EPA/PDI wipes out and placed it on the medication cart. Interview with the DNS on 5/11/20 at 11:42 AM indicated each medication cart should have a container of EPA/PDI germicidal wipes. Review of the facility Blood Glucose Monitoring via Glucometer policy directed to disinfect the glucometer with (germicidal wipes) after each use. Review of the manufacturer's guidelines for the Assure Platinum Blood Glucose Monitoring System identified cleaning and disinfecting can be completed by using a commercially available EPA-registered disinfectant detergent or germicide wipe. 2. Observation on the 3rd floor identified 9 residents required the hoyer lift for transfers. Of those 9 residents, 7 residents had a [DIAGNOSES REDACTED]. Observation on the 3rd floor on 5/10/20 at 1:55 PM identified a nurse aide came out of a resident room (a resident with a [DIAGNOSES REDACTED]. The observation identified the hoyer lift was not disinfected or wiped down after its use. Additionally, a short time later, another nurse aide took the hoyer lift from the hallway and brought it into the room of a resident who did not have Covid 19 infection and used the lift to transfer the resident. The observation identified the hoyer lift was not disinfected or sanitized before transferring the resident who did not have Covid 19 infection. Observation on the 3rd floor on 5/11/20 between 11:45 AM and 12:05 PM identified two nurse aides exited a resident room (the resident had a [DIAGNOSES REDACTED]. The observation identified the hoyer lift was not disinfected or wiped down after its use. Interview with NA #1 on 5/11/20 at 12:10 PM identified she is assigned on the 3 East and 3 West units. NA #1 identified she had transferred 2 residents out of bed to the wheelchair with the hoyer lift this morning. NA #1 indicated she did not wipe down, clean or disinfect the hoyer lift before or after use. NA #1 indicated although she worked yesterday and used the hoyer lift on both residents infected with Covid 19 and residents who did not have Covid 19, she did not clean or disinfect the hoyer lift yesterday either. Interview with NA #2 on 5/11/20 at 12:15 PM identified she was assigned to 3 residents on the 3 West unit that she transferred with the hoyer lift. NA #2 indicated she did not clean or disinfect the hoyer lift before or after its use. NA #2 indicated she worked yesterday and used the hoyer lift to transfer residents. NA #2 identified she did not clean or disinfect the hoyer lift yesterday 5/10/20. Interview with NA #3 on 5/11/20 at 1:55 PM identified she was assigned to 1 resident on the 3 East unit that she used the hoyer lift to transfer out of bed to the wheelchair. NA #3 indicated she did not clean or disinfect the hoyer lift before or after its use today or yesterday because she did not have the supplies to do so. Interview with NA #4 on 5/11/20 at 2:03 PM identified she was assigned to 1 resident on the 3 West unit that she used the hoyer lift to transfer out of bed to the wheelchair. NA #4 indicated she did not clean or disinfect the hoyer lift. Interview with NA #5 on 5/11/20 at 2:11 PM identified she was assigned to 2 residents on the 3 East unit that she had used the hoyer lift to transfer out of bed to the wheelchair. NA #5 indicated she did not clean or disinfect the hoyer lift between its use. Interview with the DNS on 5/11/20 at 11:42 AM identified that the hoyer lift should be cleaned with the EPA/PDI wipes after each use. Although requested, a policy on the cleaning and disinfecting of the hoyer lift was not provided/available. Additionally, the manufacturer recommendations for the hoyer lift was not provided/available. Review of the Interim Infection Prevention and Control Recommendations for

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.

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) Patients With Suspected or Confirmed Coronavirus Disease policy identified transmission-based precautions are designed for patients documented or suspected to be infected with highly transmissible microorganisms for which additional precautions beyond standard precautions are needed to interrupt transmission in the facility. Directions for patient-care equipment and instruments/devices the following: Handle patient-care equipment and instruments/devices according to standard precautions. If common use of equipment for multiple patients is unavoidable, clean and disinfect such equipment before use on another patient according to manufacturer's guidelines. 3. Observation on 5/10/20 with RN #2, the Administrator and the DNS identified the following: The 2 East unit had a census of 16 residents. Twelve residents had confirmed Covid 19 infection and 4 residents did not have confirmed Covid 19 infection. The observation identified that the Covid 19 infected resident's rooms were intermingled on the unit with non-infected resident rooms, with some non-infected resident room's located in-between 2 rooms with confirmed Covid 19 infected residents. The 2 West unit had a census of 11 residents. One resident had confirmed Covid 19 infection, 10 residents did not have confirmed Covid 19 infection, and one resident had Covid 19 test results pending. The 3 East unit had a census of 19 residents. Fifteen residents had confirmed Covid 19 infection, 4 residents did not have confirmed Covid 19 infection, and one resident had Covid 19 test results pending. The observation identified that the Covid 19 infected resident's rooms were intermingled on the unit with non-infected resident rooms with some non-infected resident room's located in-between 2 rooms with confirmed Covid 19 infected residents. The 3 West unit has a census of 20 residents. Fifteen residents had confirmed Covid 19 infection, 5 residents did not have confirmed Covid 19 infection, and one resident had refused Covid 19 testing. The observation identified that the Covid 19 infected resident's rooms were intermingled on the unit with non-infected resident rooms with some non-infected resident room's located in-between 2 rooms with confirmed Covid 19 infected residents. Interview with RN #2 on 5/10/20 at 2:55 PM identified the facility has been reviewing the residents with confirmed Covid 19 infection, and had moved 1 resident from the 2nd floor to the 3rd floor approximately 3 weeks ago. Interview with the Administrator on 5/10/20 at 2:58 PM indicated tomorrow, Monday 5/11/20, the facility will have a department head meeting regarding the cohorting strategy for the Covid 19 infected residents. The Administrator indicated the facility plan was to make the 3rd floor a Covid 19 unit, utilize the 2 West for asymptomatic and negative residents, and utilize the 2 East unit for residents who have recovered from and considered to be presumptive for Covid 19 infection. Review of facility Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (Covid-19) policy identified transmission-based precautions are designed for patients documented or suspected to be infected with highly transmissible microorganisms for which additional precautions beyond standard precautions are needed to interrupt transmission in the facility. Resident(s) are placed in a private room or cohorted with another Covid positive resident. Review of the facility Isolation Precautions policy identified it is the policy of this facility to prevent the spread of infection when necessary through the use of isolation precautions. Droplet precautions: Private room is desirable. The door may remain open. If a private room is not available, place the resident in a room with another who has the same infection, but with no other infection (cohorting). Reviewing of the facility Cohorting of Patients identified if the facility has positive Covid 19 resident(s), transmission-based precautions are initiated. Resident(s) are placed in a private room or cohorted with another Covid positive resident. Residents will be cohorted either as positive together or negative together based on the availability of beds on a unit. Residents will be as much as possible cohorted based on infection on one area of the unit as feasible by the facility to accommodate needs of the resident and maintain infection control practices. Although the facility had a total capacity of 90 beds and had a census of 65 beds, which left 25 beds empty and available, staff failed to ensure residents with confirmed Covid 19 infection were cohorted away from non-infected residents to prevent the spread of Covid 19 infection to other resident's. 4. Observation on 5/18/20 at 12:16 PM identified NA #1 exited from the 2 East unit, (Covid 19 positive unit) and entered the 2 West unit (Covid 19 negative unit) wearing the same PPE gown. Additionally, NA #1 was wearing a surgical mask under an N-95 mask. Interview with NA #1 on 5/18/20 at 12:16 PM identified she had been out of work from 4/17/20 until 5/18/20 and today was her first day back to work. NA #1 identified her assignment is on 2 East, the confirmed Covid 19 unit. NA #1 indicated she came over to the 2 West unit to help assist with passing out the coffee/tea/juice and condiments for lunch. NA #1 indicated she was not in-serviced regarding the correct way of wearing the masks or that she could cross contaminate by going between the confirmed Covid 19 unit and the negative unit. NA #1 identified she changed her PPE gown on the positive Covid 19 unit prior to coming to the negative unit. Observation on 5/18/20 at 12:30 PM identified NA #2 was wearing non-skid socks over her shoes followed by a clear plastic bag. Interview with NA #2 on 5/18/29 at 12:30 PM identified this is what the facility had the employees were wearing. NA #2 indicated she did not ask the supervisor for proper PPE shoe covers. Observation on 5/18/20 at 12:53 PM identified NA #3 exited from the 2 East confirmed Covid 19 unit with a blue PPE gown and entered the 2 West negative unit. Interview on 5/18/20 at 12:53 PM with NA #3 identified she is part time and a float nurse aide. NA #3 identified that the other nurse aides gave her an assignment with 2 residents on the negative unit and 5 residents on the confirmed Covid 19 unit. NA #3 indicated she was not in-serviced regarding cross contamination going from the confirmed Covid 19 unit to a negative unit with the same PPE gown. Observation on 5/18/20 at 1:25 PM identified NA #4 with non-skid socks on over her sneakers. Interview with NA #4 on 5/18/20 at 1:25 PM identified she was assigned to the 3 West unit, the (confirmed Covid 19 unit). NA #4 indicated she put the non-skid socks on over her sneakers to protect her sneakers. NA #4 indicated she did not ask the supervisor for PPE shoe covers. Observation on 5/18/20 at 1:42 PM on 2 East (confirmed Covid 19 unit) identified Housekeeper #1 proceeding down the hall with gloves on and a large bag of garbage. Housekeeper #1 was observed punching a code onto the code panel and opening the door with a gloved hand to the utility room. Interview with Housekeeper #1 on 5/18/20 at 1:42 PM identified she was in the process of disposing garbage from her cart and that was her usual practice. Subsequent to surveyor inquiry Housekeeper #1 disinfected the code panel and door handle. Observation on 5/18/20 at 2:00 PM identified Housekeeper #1 exited the 2 East (confirmed Covid 19 unit), and without the benefit of hand washing or changing PPE, entered 2 West (negative unit). Interview with Housekeeper #1 indicated she was in-serviced to use 1 Tyvek coverall for both units for the whole shift. Interview on 5/18/20 at 2:05 PM with the ADNS identified she was not aware that nurse aides were moving between the Covid positive and Covid negative units, or that they were wearing non-skid socks for shoe covers. Additionally, the ADNS indicated she was not aware that the housekeeper was using only 1 Tyvek coverall between the confirmed Covid 19 unit and the negative unit, for the whole shift. The ADNS was unable provide documentation that nursing staff or housekeeping staff had been educated on standard infection control protocols. Interview with the Administrator on 5/18/20 at 2:15 PM identified she was not aware that the nurse aides were moving between the positive and negative units or that they were wearing non-skid socks for shoe covers. Further, the Administrator indicated she was not aware the housekeeper was using only 1 Tyvek coverall between the positive and negative unites for the whole shift. Review of the Use of Coveralls during the COVID 19 Pandemic dated 5/1/20 identified DuPont Tyvek coveralls are currently being used as PPE during the care of patients with suspected or confirmed COVID 19. DuPont Tyvek 400 coveralls are indicated for single-use. They are not intended for reuse and DuPont does not recommend washing and disinfecting them. The DPH does not recommend reuse. Review of DuPont Considerations for Healthcare, First Responders, and Occupational Health Professionals on the Disinfecting and Reuse of Tyvek Garments during the COVID-19 Pandemic identified the following; Tyvek industrial protective garments are single-use products and not intended for reuse. DuPont does not recommend washing or disinfecting garments for reuse. Tyvek protective coveralls are for single use only and are to be discarded after each use. Although extended use and reuse of PPE may have the potential benefit of conserving limited supplies of disposable PPE, concerns about these practices have been raised during pervious pandemic outbreaks where adequate PPE supplies could not be obtained. To date there is no available method for decontamination and reuse of a disposable Tyvek garment that meets the following criteria: Is harmless to the user, ensures original performance properties, removed [MEDICAL CONDITION] threat, does not compromise the integrity of both the garment fabric and trim components. 5. Observation on 5/18/20 at 12:00 PM through 2:00 PM with the Administrator and the ADNS identified the following: The 3 East unit had a census of 14 residents. Two residents had confirmed Covid 19 infection and 12 residents did not have confirmed Covid 19 infection. The observation identified that the Covid 19 infected resident's rooms were intermingled on the unit with non-infected resident rooms with some non-infected resident room's located in-between 2 rooms with confirmed Covid 19 infected residents. Interview with the DNS on 5/18/20 at 2:10 PM identified the facility had reviewed the residents with confirmed Covid 19 infection, and had moved residents from the 3 East unit to the 3 West unit which was a dedicated Covid 19 unit. However, the ADNS was unable to explain why 2 residents with confirmed Covid 19 infection remained on the dedicated negative unit. Interview with the Administrator on 5/18/20 at 2:15 PM indicated the facility plan was to make the 3 West unit a Covid 19 unit, utilize the 3 East unit for asymptomatic and negative residents. The Administrator indicated she did not know why the 2 residents with

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) confirmed Covid 19 infection were left on the 3 East unit, which is consider the negative unit. Although the facility had 3 empty beds located on the 3 West unit and 4 empty beds located on the 2 East unit which are considered to be dedicated for Covid 19 infected residents, staff failed to ensure 2 remaining residents who had confirmed Covid 19 infection were cohorted away from non-infected residents on the dedicated negative unit to prevent the spread of Covid 19 infection. Review of facility Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (Covid-19) policy identified transmission-based precautions are designed for patients documented or suspected to be infected with highly transmissible microorganisms for which additional precautions beyond standard precautions are needed to interrupt transmission in the facility. Resident(s) are placed in a private room or cohorted with another Covid positive resident. Review of the facility Isolation Precautions policy identified it is the policy of this facility to prevent the spread of infection when necessary through the use of isolation precautions. Droplet precautions: Private room is desirable. The door may remain open. If a private room is not available, place the resident in a room with another who has the same infection, but with no other infection (cohorting). Reviewing of the facility Cohorting of Patients identified if the facility has positive Covid 19 resident(s). Transmission based precautions are initiated. Resident(s) placed in a private room or cohorted with another Covid positive resident. Residents will be cohorted either as positive together or negative together based on the availability of beds on a unit. Residents will be as much as possible cohorted based on infection on one area of the unit as feasible by the facility to accommodate needs of the resident and maintain infection control practices.