STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075232	A. BUILDING _____ B. WING _____	**05/21/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
COBALT LODGE HEALTH CARE & REH	**29 MIDDLE HADDAM RD COBALT, CT 06414**

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.** Based on observations and interviews with staff, the facility failed to ensure that appropriate infection control practices were implemented to prevent and control the spread of infection. The findings include: Observation on 5/21/20 at 9:15 AM identified that Registered Nurse (RN) #1 (nursing supervisor) was performing COVID-19 screening (screening questions and temperature readings) for individuals who entered the facility. RN #1 was noted to be wearing a cloth face mask at the time and then proceeded to enter the nursing unit with the cloth mask still in place. RN #1 approached Resident #1, and at face level with the resident, measured an area on the residents left arm. Resident #1 was not wearing a face mask at that time. Interview with RN #1 on 5/21/20 at 9:20 identified that she had not thought about wearing a surgical mask. RN #1 identified that she was aware she should be wearing a surgical mask while on the nursing unit and interacting with residents. RN #1 then donned a surgical mask. Interview with the Infection Control Nurse identified that the facility had an adequate supply of surgical masks, and all staff should be wearing surgical masks while on the nursing units. Review of the Center for disease control guidelines identified that health care providers should not be wearing cloth face coverings as they are not considered personal protective equipment because their capacity to protect against the COVID-19 virus is unknown.

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.