STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075181	A. BUILDING _____ B. WING _____	**07/29/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
APPLE REHAB WATERTOWN	**35 BUNKER HILL RD WATERTOWN, CT 06795**

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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, review of facility documentation, observations and interviews, for two sampled resident (Resident #1 and #2) who were recently admitted and under a fourteen (14) day period of quarantine on the observation unit, the facility failed to utilize proper personal protective equipment (PPE), ensure proper resident cohorting and failed to implement infection control measures during an aerosolized treatment. The findings include Resident #1's [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. A facility training document dated 5/22/20 identified an N95 mask was needed for aerosolized procedures on COVID-19 positive or suspected positive residents. Observations of Resident #1's room on 7/29/20 at 10:30 AM identified the entrance door was open and the privacy curtain was pulled back between Resident #1 and the roommate (Resident #2) beds, both residents were recently admitted to the facility and on a fourteen (14) day quarantine unit, to be observe for signs and/or symptoms of COVID-19. Upon further observations Resident #1 was noted to be receiving a nebulizer treatment administered by the 7AM-3PM charge nurse, Licensed Practical Nurse (LPN) #1. Although LPN #1 was wearing a surgical mask, she was not wearing the recommended personal protective equipment for use during an aerosolized breathing treatment, which included an N95 mask, face shield and gown. Interview with the Director of Nursing (DON) on 7/29/20 at 11:20 PM identified LPN #1 should have been wearing an N95 mask, a gown and a face shield. The DON stated she had been monitoring physician's orders [REDACTED].#1. Interview with LPN #1 on 7/29/20 at 11:55 AM identified she thought she only needed full droplet precaution PPE when giving direct care. LPN #1 indicated direct care would include assisting a resident with eating, bathing, and getting dressed, and not administering medication. LPN #1 failed to wear the appropriate personal protective equipment, create a barrier between Resident #1 and Resident #2 during the aerosolized treatment and failed to close the door to the resident room while the treatment was administered.

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.