STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075345	A. BUILDING _____ B. WING _____	**07/09/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
APPLE REHAB COCCOMO	**33 CONE AVE MERIDEN, CT 06450**

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 observation, review of facility documentation, facility policy and interview the facility failed to ensure residents were cohorted appropriately while receiving therapy in the gym to prevent the transmission of Covid 19 to non-infected residents. The findings include. Observation on 7/9/20 at 10:15 AM with the ADNS identified 3 resident's, who were on droplet precautions for exposure to Covid 19, were in the therapy gymr receiving therapy with 3 residents who were Covid 19 negative. Interview with the Director of Therapy on 7/9/20 at10:30 AM identified she received approval from her directors to give therapy to residents from different cohorts as long as they are kept 6 feet apart, were wearing masks, and staff cleaned the equipment between use. Interview with the ADNS and Administrator on 7/9/20 approximately 12:00 PM identified they were not aware residents from different cohorts were receiving therapy in the gym at the same time. Review of the facility's Covid-19 infection control policy identified transmission-based precautions may be instituted or discontinued by a physician, the infection control nurse, the DNS, ADNS or nursing supervisor. Residents who were confirmed or suspected of having Covid-19 should be placed in a private room or grouped together with other Covid-19 residents/ suspected residents in order to reduce the risk of transmission to other Covid negative residents. Dedicated staffing should be assigned to coordinate care to residents who are Covid-19 positive and/or on precautions to minimize exposure.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE