STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075380	A. BUILDING _____ B. WING _____	**05/21/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
APPLE REHAB CROMWELL	**156 BERLIN ROAD CROMWELL, CT 06416**

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, interviews, and review of facility documentation, the facility failed to ensure recommended infection control practices were implemented. The findings include: Observation of the West Wing unit with the Director of Nurses (DNS) on 5/21/20 at 12:46 PM identified Nurse Aide (NA) #1 entering a room with empty hands and immediately exiting the room with a cloth gown which NA #1 put on. NA #1 proceeded to the entrance of a resident room on the opposite side of the hall that had droplet precautions signage and an isolation cart outside the room. Interview with NA #1 on 5/21/20 at 12:47 PM identified that he/she was going to provide care for the resident. When asked where NA #1 had obtained the gown he/she had just put on, NA #1 identified that it was on a hook in the other room and that NAs use one gown all shift for all the residents on this unit who are on droplet precautions, and then at the end of the shift, the staff put the gown in the laundry if a washable gown or throw out if not washable. NA #1 further identified that this practice has been ongoing for a number of weeks. Interview with the DNS on 12:50 PM identified that ten residents on the unit were on droplet precautions, nine of these had been admitted from hospitals after two negative COVID-19 tests, and were to be quarantined on droplet precautions for fouteen days and gown reuse could be done. These residents were at varying times of the 14 days. The DNS further identified that one of the ten residents on droplet precautions on the unit was a resident who recently tested negative for COVID-19, and who had ongoing appointments in the community and would remain on droplet precautions due to recurring potential for exposure. After discussion of droplet precautions for exposed residents, The DNS identified that their may have been confusion related to use of the same gown between residents positive for COVID-19, and that no reuse of gowns should have occured. Interview with the Administrator, with the Assistant Director of Nurses (ADNS) present, on 5/21/20 at 1:20 PM identified that there had been some misunderstanding of recommendations and that the policy today is being revised to ensure no reuse of isolation gowns. Review of the state agency Interim Guidance to Nursing Homes dated 5/11/20 with the ADNS on 5/21/20 at 1:25 PM identified that in the exposed cohort, gowns and gloves must be changed between residents. The ADNS identified that gowns should have been changed for each resident in the exposed cohort unit.

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