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 _____	**07/08/2020**

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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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: Interview with the Director of Nurses (DON) on 7/8/20 at 9:05 AM identified that the optometrist had come to the facility on [DATE]. The DON identified that there were a total of eight (8) residents seen by the optometrist on 7/7/20. He further identified that there were 2 residents that were in need of seeing the optometrist because of an acute condition that needed to be evaluated by the optometrist, one resident had a puffy, painful eye and the other resident had weeping eyes. The other six (6) residents were seen for routine eye exams and were not examined because of an acute or emergent situation. The DON identified that he was aware that consultants should only be allowed in the facility for those residents experiencing an emergent problem, but that the other six residents were scheduled for routine exams because the optometrist was going to be in the building. Review of the CDC guidelines identify to restrict visits from healthcare providers such as those providing elective consultations.

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.