STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075388	A. BUILDING _____ B. WING _____	**10/18/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
APPLE REHAB AVON	**220 SCOVILLE ROAD AVON, CT 06001**

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, review of facility documentation, 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: a. Observation on 10/18/20 identified that Nurse Aide #1 brought Resident #1 through the dining room and placed the resident outside at a table. Registered Nurse (RN) #1 was then noted to go outside and allow access to the courtyard to a visitor. The visitor sat down at the table across from Resident #1 and started their visit. RN #1 then re-entered the facility. At 11:10 AM, the visitor was noted to remove his/her facemask and place it below his/her chin exposing his/her nose and mouth. At 11:14 AM, Resident #1 was noted to remove his/her facemask, and place it below his/her chin leaving his/her nose and mouth exposed. At this time the Administrator was immediately notified by the surveyor and went outside. Upon re-entry into the building, the Administrator acknowledged that both the visitor and the resident had their face masks below their chin exposing their noses and mouths and that he/she had instructed them about the policy to have face masks on at all times while visiting. The surveyor then requested to see the visitor's screening documentation. The Administrator identified that the visitor had not been screened prior to the visit and promptly went outside and completed the visitor screening at 11:17 AM (17 minutes after the visit had started and 7 minutes after the visitor had removed his/her mask). The screening was completed and it was determined that the visitor was appropriate to have an outdoor visit. Interview with Nurse Aide (NA) #1 on 10/18/20 at 11:30 AM identified that the resident had told NA #1 that Resident #1 had an outdoor visit at 11:00 AM and the visitor had arrived, so NA #1 brought the resident outside and placed him/her at the table. Although NA #1 saw the visitor exiting the car, he/she did not screen the visitor because he/she thought someone else would do it. Interview with RN #1 on 10/18/20 at 11:38 AM identified that he/she had received a call from the visitor stating that he/she was in the parking lot waiting to be let into the courtyard for his/her visit. RN #1 identified that he/she entered the courtyard and let the visitor in, but did not screen the visitor because he/she thought that he/she only had to screen visitors for indoor visits. Interview with the Administrator on 10/18/20 at 11:45 AM identified that the visits are not supervised by staff unless there is a concern that either the resident or visitor would break infection control precautions. He/She further stated that there were no concerns with the visitation with the resident or family member prior to the current visit. He/She stated that he/she was the manager on duty on that day and was responsible for the outdoor visits and he was distracted by the surveyor and did not do the screening. He further identified that it is the facility practice to have the visitor ring the doorbell at the front of the facility to inform the staff that the visitor was here for the visit, but this visitor called the unit on the telephone instead. The Administrator stated that although he/she was responsible for the outdoor visits that day he/she could have asked staff to cover the screening. The Administrator further identified RN #1 should have completed the screening because he/she was the staff member that let the visitor into the courtyard. Review of the outdoor visit policy identified that visitors will be screened prior to the visit and face coverings (covering the mouth and nose) will be worn at all times. b. Observation and interview on 10/18/20 at 11:00 AM identified that NA #1 was exiting a room noted to be designated with a droplet precaution sign. Although NA #1 was wearing an isolation gown, a face mask, and gloves, he/she was lacking a face shield. Interview with NA #1 identified that he/she had been in the room providing the resident morning care. NA #1 further identified that he/she was aware that the resident was on droplet precautions, but he/she had forgotten his/her goggles and hadn't remembered to use them during the resident's care. Interview with RN #2 on 10/18/20 at 11:02 AM identified that the resident was on observation and was on droplet precautions because of a recent hospital stay. RN #2 further identified NA #1 should have been wearing eye protection while in the room. Review of the droplet precaution policy identified that eye protection must be worn when caring for a resident on droplet precautions. c. Review of staff screening conducted on 10/18/20 identified that the housekeeper's Covid-19 screening prior to the start of his/her shift reflected the temperature was recorded as 36.3 degrees Celsius (all other temperatures that morning were documented in Fahrenheit). The screener's signature at the bottom of the form was identified as the Dietary Aide. Interview with the Dietary Aide (DA) on 10/18/20 at 9:30 AM identified that he/she was in charge of the staff Covid-19 screenings that morning. He/She further identified that he/she had been trained and knew to contact someone in administration if someone had symptoms or a fever. Further interview with the DA identified that he/she did not know how to calculate Celsius into Fahrenheit and was unsure what the housekeeper's temperature was, and allowed the housekeeper to start his/her duties within the building. (Calculation converting Celsius to Fahrenheit identified that the housekeeper's temperature was 97.3 degrees Fahrenheit). Interview with the Administrator on 10/18/20 at 2:00 PM identified that the DA should have either found another thermometer that read Fahrenheit or sought assistance from the supervisor if he/she was unsure of the housekeeper's temperature. The Administrator identified that subsequent to surveyor inquiry, there were directions placed at the screening area on how to convert Celsius to Fahrenheit. Review of the staff screening policy identified that the screener must review the screening sheet prior to the staff member proceeding inside the building for a temperature above 100.3 degrees (Fahrenheit).
F 0886 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	Based on observations and interviews, the facility failed to ensure that staff testing was conducted in accordance to infection control standards of practice. The findings include: Observation in the resident dining room on 10/18/20 at 12:00 PM identified a refrigerator with a bright orange biohazard sticker on the door. The refrigerator was not locked and inside contained 2 specimen vials (containing a specimen) in a styrofoam vial container. Interview with the Administrator on 10/18/20 at 12:15 PM identified that although the residents are not using the dining room for dining purposes, the residents do use the dining room for activities and it is used a throughway for residents to attend outdoor visits. The Administrator further identified that the refrigerator was there because that is where the staff swabbed themselves for Covid-19, and then placed the vials with the specimen in the refrigerator. The Administrator identified that the staff has been self-swabbing since 8/29/20, and they swab themselves Monday through Friday when they are in the building for work. He/she further stated that the facility did not have a policy for staff testing but this was a procedure that was taught to them by their care partner. He/She stated that the supervisors have been trained and they have trained the staff members how to perform the Covid-19 swabs themselves. He/She stated that the testing was not supervised and he/she was unsure of the cleaning schedule in the testing area, or if more than one employee tests at a time. Also, he/she thought it was cleaned mid-day, but was unsure the area was disinfected between each staff swab. Interview with the Infection Control Nurse (ICN) on 10/19/20 at 12:45 PM identified that there is no policy on staff testing, but that the facility follows the Center for Disease Control guidelines. He/She further identified that the specimen refrigerator should be locked and not in a patient accessible area. He/She stated that none of the staff are supervised when they self-swab, and he/she was unsure about the disinfection of the area after the staff self-swab. The ICN stated that if staff requests help with swabbing it is provided by another staff member who would be wearing a face shield, gloves and a mask. Review of the Centers for Disease Control (CDC) guidelines for staff testing include the facility should establish who is responsible for specimen

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.

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F 0886 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) collection from the staff, specimen collection should be performed one individual at a time with the door closed, and no other individuals present. The staff should not wait in the room where another individual is being swabbed and surfaces within 6 feet of where the specimen collection was performed should be cleaned and disinfected using an EPA approved disinfectant at least hourly, and a terminal cleaning of the area should be performed at the end of each day that testing was performed. The CDC also recommends any staff performing swabbing use eye protection, a mask, gloves and an isolation gown. An action plan for staff testing was requested by the State Agency on 10/19/20 that included developing a policy on staff testing, having the staff testing be supervised by a trained employee, having the staff testing in a non-resident area, wearing appropriate personal protective equipment during the testing, and proper disinfection of the testing area during and after use.