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 _____	**04/30/2020**

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 observations, review of facility documentation, review of facility policy, and interviews, the facility failed to ensure proper storage of disposable gowns and/or failed to ensure staff donned masks while in the building. The findings include: a. Observation on 4/30/20 at 5:30 AM identified Registered Nurse (RN) #1 opened the lobby door not wearing a mask, proceeded to talk with surveyor, and he/she then was walking through out facility without the benefit of a mask. Interview with RN #1 on 4/30/20 at 5:45 AM indicated he/she removed his/her mask after performing wound care and he/she usually keeps a mask on while in the facility. Subsequent to surveyor inquiry RN #1 donned a N-95 mask. Observation on 4/30/20 at 6:52 AM identified NA #2 entering the facility. He/she stopped to have temperature taken and proceeded to his/her unit without the benefit of a surgical mask or face covering. Observation with the DNS on 4/30/20 at 6:53 AM identified NA #2 entered the nurses station on Wing 200. NA #2 began donning his/her Tyvek coveralls while talking to other staff not 6 feet apart. NA #2 was not wearing a surgical mask. Interview with NA #2 on 4/30/20 at 6:55 AM with the DNS present indicated he/she kept the surgical and N-95 masks in the storage area next to wing 300. NA #2 identified he/she will go get it after he/she is done donning the Tyvek coveralls. NA #2 indicated he/she puts on his/her Tyvek coveralls first then obtains the masks. Observations on 4/30/20 from 6:56-7:05 AM identified the staff coming on for his/her shift being screened by the Administrator in the lobby. Temperatures were taken and questionnaires filled out. Once the staff completed the screening then proceeded to walk thru the building without the benefit of a mask or face covering. Interview with the DNS on 4/30/20 at 7:30 AM indicated all staff received education on the use of masks and donning masks after being screened. The DNS identified he/she would expect staff to put on a surgical mask as soon as they completed the screening process. The facility did not provide a staff mask use policy. b. Observation on 4/30/20 at 6:00 AM identified multiple yellow disposable paper gowns hanging on hooks on the outside of 7 resident entry rooms doors on wing 200. Interview with Nurse Aide (NA) #1 on 4/30/20 at 6:05 AMidentified the unit was not a designated Covid-19 unit. NA #1 indicated staff have been instructed by the Director of Nurses (DNS) to conserve the disposable yellow gowns by reusing them and staff hung them on the hooks on the outside of the resident room doors. Interview with Licensed Practical Nurse (LPN) #1 on 4/30/20 at 6:15 AM identified the unit had some residents positive, presumed positive, and some negative for Covid-19. LPN #1 indicated when he/she arrived at 11:00 PM last night the used disposable gowns were hanging on hooks outside of resident entry way doors. LPN #1 indicated he/she assumed that the 3-11 PM shift hung the used disposable gowns on the doors. LPN # 1 identified he/she was not touching them and left them hanging on the doors. Interview and observation with RN #1 on 4/30/20 at 6:25 AM on Wing 200 identified 7 resident rooms with multiple yellow disposable paper gowns hanging on hooks on the outside resident entry rooms. RN #1 could not explain why the used gowns were hanging on the resident room doors. In addition RN #1 identified it was not a safe infection control practice . A second observation on 4/30/20 at 6:50 AM on Wing 200 identified 7 resident rooms still had disposable used gowns hanging on the outside of the doors. Interview and observation on Wing 200 with the DNS on 4/30/20 at 6:51 AM identified multiple used disposable yellow gowns were still hanging on the outside of 7 resident rooms doors. The DNS indicated the gowns should not be hanging on the outside of the doors. The DNS identified he/she could not ensure staff nor residents would not accidently brush up against the contaminated gowns. The DNS indicated due to the national shortage of disposable gowns he/she instructed staff on the need to conserve the disposable gowns and re-use them. A review of the facility Infection prevent and control recommendations for patients with suspected or confirmed COVID-19 policy identified staff are to don gowns prior to entry into resident room, remove gown and perform hand hygiene before leaving the resident care environment, and after gown removal ensure that clothing and skin do not contact potentially contaminated surfaces that could result in possible transfer of microorganism to other residents. Subsequent to surveyor inquiry the Administrator and DNS provided a plan of action titled Infection/Prevention and use of PPE. The gowns on the 7 resident room doors were removed and all staff to be re-educated on hanging gowns behind the doors inside resident rooms. Staff will be re-educated to always wear surgical mask when entering the building.

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.