STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075211	A. BUILDING _____ B. WING _____	04/27/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
APPLE REHAB ROCKY HILL	45 ELM STREET ROCKY HILL, CT 06067

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** - Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of facility documentation and staff interviews, the facility failed to ensure COVID-19 infection prevention protocols were consistently implemented. The findings include: a. During a tour of the facility on 4/26/20 at 10:00 AM, observation on two separate units identified the doors of Rooms #5, #6, #7, #8, #10, #12, #13, #14, #15, #16, #17, #18, #20, #21, #23, #34, #35, #40, #41, #42, #46, #48, #40, #51, #55, and #57 were noted to have droplet precaution signs posted outside each door, without the benefit of each bedroom door being closed, per CDC guidelines. Review of the facility COVID-19 tracking tool and facility floor plan dated 4/27/20 identified the rooms listed above were isolation rooms for COVID-19 positive residents that required droplet precautions. Interview with Licensed Practical Nurse (LPN) #1 on 4/27/20 at 10:00 AM identified she did not know the reason the doors were not in the closed position. LPN #1 further identified the doors should have been closed and indicated they may have initially been opened by Nurse Aides (NA) or Housekeeping staff who forgot to close them after leaving the room. LPN #1 subsequently closed the doors of the COVID-19 positive resident rooms and indicated those residents were safe to have the door closed with monitoring and checks. Review of the policy for Infection Prevention and Control Recommendations for patients with suspected or confirmed Coronavirus disease failed to identify the doors of COVID-19 positive residents should remain closed, despite CDC guidelines. b. Further observation during tour identified Personal Protective Equipment (PPE) disposal bins and soiled gown disposal bins located in the hallways, outside the COVID-19 positive resident rooms on all units. Observation on 4/27/20 at 11:15 AM identified a droplet precaution sign was by the door of Resident #1's room and a clean PPE disposal bin was located against the wall, directly to the left side of the door. The PPE disposal bin was also noted to be outside of Resident #1's room with a dirty PPE disposal bin beside it that contained dirty hospital gowns that staff had used as PPE when caring for COVID-19 positive residents. Additionally, the clean linen cart that contained sheets and towels was directly beside the opened dirty hospital gown disposal container. Interview with LPN #1 on 4/27/20 at 10:00 AM identified staff were educated to place the PPE disposal bins inside the resident's room (not outside of the rooms) and staff were required to remove PPE prior to leaving the room. LPN #1 further identified she did not know the reason some rooms had PPE disposal bins in the room and others had the bins outside of the room. Interview with LPN #3 on 4/27/20 at 11:20 AM identified staff remove gowns inside the room and roll the gowns up in a ball, exit the room and place them in the container outside the room. Interview with the Corporate Nurse identified all PPE disposal carts should be stored inside the resident's rooms and staff should remove PPE and place in the bin prior to leaving the room. Additionally, the Corporate Nurse indicated this practice would be implemented 4/27/20. Review of the facilty policy for droplet precautions identified to apply PPE before entering the room and to remove gloves and other PPE prior to leaving the resident care area. c. Observation of LPN #2 on 4/27/20 identified LPN #2 was standing in the hallway with a hospital gown over a white full body isolation suit. The lower aspect of the arms of the suit were exposed. Interview with LPN #2 at that time identified the facilty provided her with the suit to wear each day on the unit and was instructed to reuse the suit for several day. Additionally, LPN #2 identified because there are no gowns available, a hospital gown is worn over the suit when caring for COVID-19 positive residents and only the hospital gown is removed after providing care. Further, LPN #2 indicated she removes the gown at the end of the shift, places the suit in a paper bag, carries it to her car and brings the same suit back to work the next day for reuse. Interview with the Administrator on 4/27/20 at 12:25 PM identified some staff are more comfortable taking their PPE with them and know that it belongs to them. Interview with Corporate Registered Nurse (RN) #2 identified a process would be developed to store reusable PPE in the facility and not in staff's personal vehicle. Although requested, the facilty was unable to provide a policy related to reuse of isolation suits. d. Observation on 4/27/20 at 11:40 AM identified a droplet precaution sign posted on the door frame of Resident #18's room. There was no PPE disposal bin inside Resident #18's room and there was no PPE equipment cart outside the room. Interview with LPN #2 at 11:40 AM identified Resident #18 did not require isolation precautions and had tested negative for COVID-19 and she forgot to remove the droplet precaution sign. Review of the COVID tracking sheet identified Resident #18 was COVID-19 positive and review of the laboratory report dated 4/23/20 identified Resident #18 was positive for COVID-19 virus (despite LPN #2 identifying Resident #18 was COVID-19 negative. Interview on 4/27/2020 at 11:45 with NA #1 and NA #2 identified they did not know if Resident #18 required droplet precautions. Interview with LPN #2 identified she does not have a master line list of who is positive or negative and LPN #1 indicated the Infection Control Nurse provides an updated copy of the line list to the units but did not know where to find it. Interview with the Corporate RN on 4/27/2020 at 11:50AM identified Resident #18 was COVID-19 positive and should be maintained on droplet precautions, with an isolation set up outside of the room, and disposal bins inside of the room. Interview with the Infection Preventionist on 4/28/20 at 11:53 AM identified she updates a facilty map daily with the COVID-19 status of residents and distributes a copy to each nurse so they can give report to NA's. A line list is kept in a binder on each unit and the nurse can update the list with new residents who have symptoms. Review of the policy for Interim Infection Prevention and Control recommendations for suspected or confirmed cases of [MEDICAL CONDITION] disease identified appropriate or a combination of transmission-based precautions will be instituted for all patients with known or suspected to be infected. e.Observation of LA (Laundry Aide) #1 on 4/27/20 at 12:10 AM identified LA #1 was wearing vinyl gloves to both hands while wheeling a linen cart down the hall. LA #1 proceeded to push open the double doors on the Nursing unit with her gloved hands and moved the cart through the door. LA #1 opened the clean PPE cart located in the hallway using her soiled gloved hands, removed the soiled gloves, and began to don the new gloves without the benefit of handwashing. Interview with LA #1 at that time identified she had just delivered laundry to a resident in a COVID positive room and did not change her gloves or wash her hands. LA # 1 indicated she should have changed her gloves and washed her hands after leaving the COVID positive room and further indicated she does not change her gloves between every patient room because sometimes she cannot find gloves. Additionally, LA #1 indicated she wears a surgical mask and a hospital gown in all the rooms but does not utilize a faceshield or eye goggles. LA #1 also identified that she has no process for which room she enters first (entering COVID free rooms before COVID positive rooms) and delivers laundry to which ever room she comes to first, regardless of resident COVID status. Interview with the Director of Housekeeping (DOH) on 4/27/20 at 12:15 PM identified LA #1 should wear a laundry gown, surgical mask, gloves, and face shield and should wash hands between rooms. Additionally, the DOH identified there was no process in place to prioritize delivery of laundry to COVID positive or negative residents. Interview with the Administrator on 4/27/20 at 12:30 PM identified ancillary staff should not enter COVID positive rooms. f. Observation of an unoccupied (vacant) resident room on 4/27/20 at 10:15 AM identified the room door was in the open position and the two beds in the room were unmade. There was no sign on the bed or door indicating the room was cleaned. Interview with the Director of Housekeeping on 4/27/20 at 10:55 AM identified the room had been terminally cleaned on 4/24/20 and after the room was cleaned the NA's were told to make the beds and the Receptionist was supposed to call her when the beds were made so the DOH could close the door and seal the clean room with a sticker. The DOH identified she did not know the reason that process was not followed and indicated she would have the room recleaned.

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 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 1) g. 1) Resident #4 was admitted to the facilty on 10/4/16. A physician order [REDACTED]. The lab result dated 4/23/20 identified Resident #4 was positive for COVID-19. 2) Resident #5 (Resident #4's roommate) was admitted to the facility on [DATE]. A physician order [REDACTED]. The lab results dated 4/23/20 identified Resident #5 tested negative for COVID-19. Review of the facilty map dated 4/27/20 and observation on 427/20 at 10:55 AM identified room [ROOM NUMBER] and room [ROOM NUMBER] were unoccupied/vacant. Interview with the Director of Housekeeping on 4/27/20 at 10:45 AM identified both rooms were terminally cleaned on 4/24/20 in the morning. Review of the nurse's notes from 4/23/20 to 4/27/20 failed to identify Resident #4 (who tested negative for COVID-19) or Resident #5 (who tested positive for COVID-19) was offered a room change and cohorted appropriately. Interview with the DNS and RN #1 identified they were not verbally made aware that the positive and negative COVID-19 residents were cohorted, however indicated they both receive the updated COVID-19 status of all residents daily via an E-mail. Additionally, RN #1 indicated if there was a positive and negative resident, they should not be cohorted together if there was the availability to move one of the residents into a private room. Subsequent to surveyor inquiry, a nurse's note dated 4/27/20 at 1:00 PM identified the facilty spoke with Resident #5's Conservatory of Person about a room change (due to the resident's COVID-19 negative status) and Resident #5 was subsequently moved from room [ROOM NUMBER] to room [ROOM NUMBER] (a private room). Review of the facilty policy for Interim Infection Prevention and Control recommendationsed for suspected or confirmed cases of [MEDICAL CONDITION] disease, place COVID positive residents in a private room or with another positive resident. If the COVID positive resident had a roommate, isolate the roommate for 14 days and until the test results are received, if tested .