STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075222	A. BUILDING _____ B. WING _____	**10/08/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CHESHIRE REGIONAL REHAB CENTER	**745 HIGHLAND AVENUE CHESHIRE, CT 06410**

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, the facility failed to adhere to infection control practice by not screening visitors. The findings include: Upon entering the facility on 10/8/20 at 09:30 AM, two visitors (a state inspector and one National Guardsman) were waiting in the lobby for the facility's Administrator and the Director of Nursing to arrive to be escorted into the facility and to the nursing units. Receptionist #1 completed both visitor's temperatures and wrote them on each individual screening forms and placed the forms in a box without the benefit of asking the screening questions or having the visitors answer to the questions on the screening form. Interview with The Administrator on 10/8/20 at 9:38 AM identified everyone including staff, administration, vendors, and visitors are to be screened before entering the facility. This includes taking the individuals temperature and asking questions related to current health status and exposure to Covid-19. The Administrator immediately completed an in-service with Receptionist #1. Receptionist #1 identified that s/he was covering for the regular receptionist who is on vacation and was not aware that s/he needed to ensure that the questions on the screening form needed to be asked and answered.

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