STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075366	A. BUILDING _____ B. WING _____	**08/12/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HAMDEN REHABILITATION & HEALTH CARE CENTER	**1270 SHERMAN LANE HAMDEN, CT 06514**

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 observation, interviews, and review of facility documentation, the facility failed to ensure that facility staff had been tested for COVID 19 in accordance with State of Connecticut Executive Order 7AAA dated 6/17/20. The finding includes: Review on 8/12/20 of the staff schedules, 7/28/20 through 8/3/20 and the testing spreadsheets with the facility Administrator, identified 17 staff members had not been tested for COVID 19 and worked at least once during the period of 7/29 through 8/3/2020. Additional review with the Administrator on 8/12/2020 of the staff schedules 8/4/20 through 8/10/20 and testing spreadsheets identified 22 staff members had not been tested for COVID 19 and worked at least once during the period of 8/4/20 through 8/10/20. Interview with the Administrator on 8/12/20 at 2:00 PM identified it has been difficult to enforce mandatory testing because, although COVID 19 testing is offered to the employees twice per week in the facility, many staff have not been available to come in on the assigned testing days. The administrator identified the facility could not remove the staff who did not get tested from the schedule because they would not have enough staff to care for the residents.

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