STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075070	A. BUILDING _____ B. WING _____	**05/27/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
APPLE REHAB SAYBROOK	**1775 BOSTON POST RD OLD SAYBROOK, CT 06475**

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 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of facility documentation, facility policy, and interviews, for 1 of 3 nursing units, the facility failed to maintain sufficient staffing to supervise residents and ensure measures to prevent the transmission of Covid 19 were implemented. The findings include: 1. Resident #1's [DIAGNOSES REDACTED]. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had severely impaired cognition, required extensive assistance with transfers and was independently mobile on the nursing unit. Resident #2's [DIAGNOSES REDACTED]. Resident #3's [DIAGNOSES REDACTED]. Observation on 5/27/20 at 3:50 PM identified Resident #1 seated at a table in the East Wing lounge with Resident #2 and Resident #3 (who share a room). Resident #1, 2 and 3 were without the benefit of a face mask, and Resident #1 was noted to be within three feet of Resident #2, who was noted to be within three feet of Resident #3. 2. Resident #4's [DIAGNOSES REDACTED]. The Annual MDS assessment dated [DATE] identified Resident #4 had moderately impaired cognition and was independent with transfers and ambulation. Observation on 5/27/20 at 3:52 PM identified Resident #4 came out of his/her room and walked down the hall to the nursing station using a two wheeled walker without the benefit of a face mask to the nursing station. LPN #1 was behind the desk at her medication cart, and no other staff were in the area. Resident #4 left the nurses desk and headed back the way toward his/her room. Interview with LPN #1 on 5/27/20 at 3:52 PM identified that the staffing for the unit included herself and NA #1, as well as a hospitality aid for 27 residents on the unit. LPN #1 identified that a staff member had called out sick and that no other staff members were available to be on the unit until 7:00 PM. Observation and interview with the Administrator on 5/27/20 at 4:05 PM identified that the facility policy directed residents should be wearing masks and maintaining social distancing if they come out of their rooms, and that if the resident had dementia, the staff should be redirecting the resident. Subsequent to surveyor inquiry, Resident #1 was assisted to return to his/her room by the Administrator (several rooms away from the lounge) where his/her face mask was stored on a table. Interview with NA #1 on 5/27/20 at 4:48 PM noted that although a hospitality aid was working on the unit with her, the hospitality aid was not allowed to physically assist residents in any way. NA #1 identified that it was only she and LPN #1 on the unit, and that if there had been a second nurse aide, she may have been able to redirect Resident #1, Resident 2, Resident 3 and Resident 4 to ensure they were wearing a face mask and maintaining social distancing. NA #1 identified that she could not oversee and redirect all 27 residents on the unit without another nurse aide while LPN #1 was passing medications.
F 0726 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.** Based on observation, review of facility documentation, facility policy, and interviews, the facility failed to ensure staff were appropriately educated on transmission based precautions, on donning and doffing Personal Protective Equipment (PPE), and on appropriate hand washing techniques during the COVID-19 pandemic. The findings include: During a review of the facility in-service education documentation, it was identified that the staff had not begun education and competencies for donning and doffing PPE until 5/14/20, five days following the facility's first case of COVID-19. Interview and review of facility educational records with the DNS on 5/27/20 at 2:41 PM identified that the facility did not have an Infection Control Nurse since approximately December of 2019, and that she was the staff member who was responsible for staff education regarding infection control. The DNS identified that the facility's first COVID-19 case occurred on 5/9/20, and the facility conducted a Point Prevalence Survey (PPS) on 5/19/20 and received the results on 5/21/20. The DNS identified that the following in-service education had been provided with the onset and continuation of the COVID-19 pandemic: 1. Although re-education on hand-washing techniques was conducted from 3/5/20 to 3/23/20, and was attended by 85 staff, competencies were not completed. 2. Enhanced and extended use of PPE education was conducted from 4/9/20 through 4/13/20, however, was only attended by 17 staff. 3. Education on universal masking while in the facility 4//9/20 through 4/13/20 was attended by only 18 staff. 4. Education/competencies for donning and doffing PPE was not begun until 5/14/20. Competencies were completed with only 19 of 69 nursing staff. The DNS identified that this was the first time a PPE competency had been completed this year and since the onset of the COVID-19 pandemic. 5. The DNS identified that the last in-service given on transmission-based precautions this year, since the onset of COVID-19, was in the form of information sent from the facility's corporate office. The DNS identified that she had hung the information posters on the walls in early March, on every unit for the staff to read. Although the DNS did have a copy of the posters with a handwritten note at the bottom indicating that staff should read and sign, she could not identify if all staff had read and understood the information. The DNS identified that she had not completed any in-person education on transmission-based precautions. Interview with LPN #2 on 5/27/2020 at 4:15 PM identified that she could not recall the last time she had been trained on donning and doffing PPE, but it was before the previous Infection Control Nurse left in December of 2019. LPN #2 could not remember the last time anyone had observed her washing her hands and she could not recall the last time transmission based precautions were reviewed, but did receive an overview of the COVID-19 virus at the onset of the pandemic. Interview with the Administrator on 5/27/20 at 4:28 PM identified that appropriate in-service education and competencies should have been provided to the facility staff prior to the first COVID-19 case. The facility failed to adequately prepare for the Covid 19 pandemic by providing the necessary infection control education and competencies to all staff.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of facility documentation, facility policy and interviews, the facility failed to ensure universal masking of residents, failed to ensure social distancing of residents, and failed to ensure appropriate transmission based precaution signs were posted for 10 of 17 rooms on a COVID-19 positive unit. The findings include: 1. Resident #1's [DIAGNOSES REDACTED]. Resident #2's [DIAGNOSES REDACTED]. Resident #3's [DIAGNOSES REDACTED]. Observation on 5/27/20 at 3:50 PM identified Resident #1 seated at a table in the East Wing lounge with Resident #2 and Resident #3 (who share a room). Resident #1, 2 and 3 were without the benefit of a face mask, and Resident #1 was noted to be within three feet of Resident #2, who was noted to be within three feet of Resident #3. 2. Resident #4's [DIAGNOSES REDACTED]. Observation on 5/27/20 at 3:52 PM identified Resident #4 came out of his/her room and walked down the hall to the nursing station using a two wheeled walker without the benefit of a face mask to the nursing station. LPN #1 was behind the desk at her medication cart, and no other staff were in the area. Resident #4 left the nurses desk and headed back the way toward

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 -** Some	(continued... from page 1) his/her room. Interview with LPN #1 on 5/27/20 at 3:52 PM identified that the staffing for the unit included herself and NA #1, as well as a hospitality aid for 27 residents on the unit. LPN #1 identified that a staff member had called out sick and that no other staff members were available to be on the unit until 7:00 PM. Observation and interview with the Administrator on 5/27/20 at 4:05 PM identified that the facility policy directed residents should be wearing masks and maintaining social distancing if they come out of their rooms, and that if the resident had dementia, the staff should be redirecting the resident. Subsequent to surveyor inquiry, Resident #1 was assisted to return to his/her room by the Administrator (several rooms away from the lounge) where his/her face mask was stored on a table. Interview with NA #1 on 5/27/20 at 4:48 PM noted that although a hospitality aid was working on the unit with her, the hospitality aid was not allowed to physically assist residents in any way. NA #1 identified that it was only she and LPN #1 on the unit, and that if there had been a second nurse aide, she may have been able to redirect Resident #1, Resident 2, Resident 3 and Resident 4 to ensure they were wearing a face mask and maintaining social distancing. NA #1 identified that she could not oversee and redirect all 27 residents on the unit without another nurse aide while LPN #1 was passing medications. 3. Observation on 5/28/20 at 4:20 PM with the Administrator identified 10 of 17 rooms on the COVID-19 positive unit were lacking isolation signage. The Administrator identified that all COVID-19 positive rooms are required to have visible precaution signs present to identify the need to take appropriate precautions for COVID-19 positive residents. Subsequent to surveyor inquiry, the Administrator posted the required signage.