STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075231	A. BUILDING _____ B. WING _____	**05/25/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
APPLE REHAB COLCHESTER	**36 BROADWAY STREET COLCHESTER, CT 06415**

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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, a review of facilty documentation, and interviews, for two sampled residents (Resident #1 , and Resident #2), reviewed for infection control, the facilty failed to conduct a safety assessment to determine the appropriateness for the use of surgical or cloth face mask and/or failed to provide residents with a face mask when outside of a resident room. The findings include: Resident (R) #1 was admitted to the facilty on 7/21/19 with [DIAGNOSES REDACTED]. R #2 was admitted to the facilty on 7/12/19 with [DIAGNOSES REDACTED]. Observation on 5/25/20 at 8:40 AM on the dementia unit identified R #1 and R #2 sitting in the hallway across from the nurses'station without the benefit of a cloth or surgical facemask. Interview with LPN #1 on 5/25/20 at 8:40 AM identified R#1 and R#2 were never provided face masks to wear outside of their rooms. Additionally, LPN#1 identified many of the residents on the unit would not tolerate a facemask and he/she did not know if each resident was assessed to wear a mask. Furthermore, LPN #1 indicated the staff were not educated to provide each resident a mask when they were outside of their rooms, and because there were no new admission, the same staff, and no visitors, LPN #1 indicated the resident were low risk for COVID-19. Interview with RN #1 (Nurse Supervisor) on 5/25/20 at 8:45 AM identified residents on the rehab unit had not been assessed for appropriateness/safety to wear masks and/or provided with masks to wear when they come out of their rooms. Additionally, RN #1 identified on the rehabilitation unit, residents are redirected back to their rooms and because there are no visitors, or admissions on the rehab unit and the staff always wear masks, that the residents had little risk for COVID-19 and are permitted to be in the hallway without a mask. Interview with the Administrator on 5/25/20 at 9:54 AM identified the facilty had not implemented a process to assess resident masking when residents were out of the room. Additionally, the Administrator indicated the facilities approach has been to redirect the resident back to her room or socially distance when out of the room. Review of a plan of correction dated 5/25/20 identified residents would be assessed to determine their ability to tolerate a mask. Residents who could not tolerate a mask would be socially distanced. Additionally, care plans would be updated, and staff and residents would be educated. Although requested the facilty did not provide a resident masking policy. Review of the CDC guidelines Core Practices directed in part that residents should wear a cloth face covering or facemask if tolerated when they leave their room including procedures outside of the facilty. Cloth face covering should not be placed on anyone who has trouble breathing, is unconscious, incapacitated, or otherwise unable to remove the mask without assistance.

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.