STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075388	A. BUILDING _____ B. WING _____	**05/21/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
APPLE REHAB AVON	**220 SCOVILLE ROAD AVON, CT 06001**

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 interviews and review of facility documentation, the facility failed to ensure infection control recommendations were implemented. The findings include: Interview with Registered Nurse (RN) #1 on 5/21/20 at 10:19 AM identified that he/she uses one disposable gown for COVID positive residents in the same room all shift and then wipes the gown with a bleach wipe after each use and keeps it hanging in the room for reuse that shift. Interview with RN #2, the Infection Preventionist, who was present for the interview with RN #1, identified that staff were to use the same disposable gown for the positive residents in the same room for the entire shift, but staff were not supposed to wipe the gowns with any disinfecting wipes. Interview with Nurse Aide (NA) #1 on 5/22/20 at 10:25 AM identified that one gown for each staff is used all shift for positive residents and he/she wipes the disposable gown with a disinfecting wipe between uses and hangs the gown in the room between uses. Interview with the Director of Nurses (DNS) on 5/22/20 at 10:42 AM identified that staff should not reuse gowns. The DNS further identified that this happend because there had been a misunderstanding of current expectations. The DNS identified that the facility does not have a policy that identified this specific issue.

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.