STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075089	A. BUILDING _____ B. WING _____	**06/28/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
APPLE REHAB MIDDLETOWN	**600 HIGHLAND AVE MIDDLETOWN, CT 06457**

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, facility policy, and interview during a COVID 19 Focused survey, the facility failed to ensure that personal protective equipment (PPE) was cleaned and stored per policy and Center for Disease Control (CDC) guidelines in order to prevent the spread of infection. The finding includes: A: Observation on 6/28/2020 at 10:45 AM identified Dietary Aide (DA) DA#1 walking from the kitchen hallway wearing a faceshield. DA#1 then removed her faceshield, without wearing gloves, touching the front and lower right corner of the faceshield. DA #1 then threw her uncontained faceshield on a storage rack where staff store their faceshields in brown paper bags. DA #1 proceeded to exit the building without utilizing hand sanitizer, located 2 feet from the shelf, or washing her hands after touching her contaminated face shield. Upon return from outside the building DA #1 removed her uncontained face shield from the shelf without the benefit of hand sanitizer use and glove application. Interview with DA #1 on 6/28/2020 at 10:52 AM identified that the shelf is where their PPE is stored when they are not wearing them, and that her faceshield should have been stored properly in a bag after wiping it down with appropriate wipes. DA #1 indicated that she was not aware that she had contaminated her hands or that her faceshield should be stored in a bag when not in use. B: Observation on 6/28/2020 at 10:46 AM identified DA #2 walking from the kitchen hallway wearing a faceshield. DA #2 then removed her face shield by grabbing the outside of the shield without the benefit of wearing a glove, attempted to fold the mask like a clamshell touching the outside of the mask. DA#2 then attempted tostore the uncontained mask between properly stored faceshields in brown paper bags. In the process she disrupted three bags, contaminating all three of them, when they fell to the floor. DA #2 then again took her mask and threw it on the shelf without placing the mask in a paper bag. DA #2 then exited the building without utilizing hand sanitizer, located 2 feet from the shelf, or washing her hands, after making contact with the contaminated mask. DA #2 then returned a few minutes later, removed her contaminated mask off of the shelf and then cleansed her hands with hand sanitizer. Interview with DA #2 on 6/28/2020 at 10:54 AM indicated that she was not aware that her shield should be wiped down and stored in a bag, and she was not aware that she had contaminated three storage bags on the shelves. According to the DNS the facility goes not have a a policy for storage of PPE in use, however the facility followed CDC guidelines by storing the materials in a safe location. The shelf was provided near the reception desk with paper bags to store the masks/shields. The DNS further stated, that the dietary aides had been inserviced prior on proper storage and removal of PPE. Review of facility documentation for Covid updates dated 6/5/2020 identified that faceshields would be stored on the shelf by the reception desk (already disinfected) in a labeled paper bag at the end of the employees work day. C: Observation on 6/28/2020 at 11:10 AM identified noted two used/soiled face shields placed on top of PPE carts outside of room North 128, one used/soiled face shield resting on top of PPE cart outside room North 126, and two soiled face shields on top of PPE cart outside room North 130. Interview with Nursing Assistant (NA) #1 at this time identified that the dirty faceshields were left over from the night shift but he did not know by who. He indicated bleach wipes were not available on the unit for him to wipe cleanse the face shields with. NA #1 further identified that dirty faceshields should be cleaned and stored properly in bags if used by an employee and not left on top of PPE carts. Interview with the Director of Nursing DNS on 6/28/2020 at 11:15 AM identified that soiled face shields should not be stored on top of PPE carts and she did not know why they had been stored on the PPE carts.

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.