STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075345	A. BUILDING _____ B. WING _____	**08/20/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
APPLE REHAB COCCOMO	**33 CONE AVE MERIDEN, CT 06450**

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 observation, review of facility documentation, facility policy and interview for 1 resident (Resident #1) who left the facility for a medical appointment, the facility failed to ensure a risk assessment was completed upon the residents return to ensure appropriate cohorting according to best practices to prevent the transmission of Covid 19 to non-infected residents. The findings include: Resident #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Facility documentation identified Resident #1 resided on Unit 300 (negative cohort) with a roommate. Facility documentation identified Resident #1 left the facility for a medial appointment on 8/19/20. Interview with LPN #1 on 8/20/20 at approximately 12:25 PM identified Resident #1 left the facility for a medical appointment and returned to his/her same room (in the negative cohort) after the appointment. LPN #1 recalled that she was on duty that day and filled out a risk assessment for Resident #1 upon his/her return and gave it to the supervisor on duty. Upon review of the form, it was noted to be a Covid 19 screening form, not the original risk assessment form developed by facility. Interview with the ADNS and Supervisor #1 on 8/20/20 at approximately 12:45 PM identified a risk assessment had not been completed upon Resident #1's return from the medical appointment on 8/19/20. Review of the facility's Covid-19 infection control policy identified transmission-based precautions may be instituted or discontinued by a physician, the infection control nurse, the DNS, ADNS or nursing supervisor. Residents who were confirmed or suspected of having Covid-19 should be placed in a private room or grouped together with other Covid-19 residents or suspected residents in order to reduce the risk of transmission to other Covid negative residents. Residents who have left the facility and did not have a risk assessment performed on return are considered suspected/exposed and should be placed on precautions. Dedicated staffing should be assigned to coordinate care to residents who are Covid-19 positive and/or on precautions to minimize exposure.

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