

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER 075366	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/12/2020
NAME OF PROVIDER OF SUPPLIER HAMDEN REHABILITATION & HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP 1270 SHERMAN LANE HAMDEN, CT 06514	
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, interviews, and review of facility documentation, the facility failed to ensure that facility staff had been tested for COVID 19 in accordance with State of Connecticut Executive Order 7AAA dated 6/17/20. The finding includes: Review on 8/12/20 of the staff schedules, 7/28/20 through 8/3/20 and the testing spreadsheets with the facility Administrator, identified 17 staff members had not been tested for COVID 19 and worked at least once during the period of 7/29 through 8/3/2020. Additional review with the Administrator on 8/12/2020 of the staff schedules 8/4/20 through 8/10/20 and testing spreadsheets identified 22 staff members had not been tested for COVID 19 and worked at least once during the period of 8/4/20 through 8/10/20. Interview with the Administrator on 8/12/20 at 2:00 PM identified it has been difficult to enforce mandatory testing because, although COVID 19 testing is offered to the employees twice per week in the facility, many staff have not been available to come in on the assigned testing days. The administrator identified the facility could not remove the staff who did not get tested from the schedule because they would not have enough staff to care for the residents.		
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.