STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075339	A. BUILDING _____ B. WING _____	**05/27/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LORD CHAMBERLAIN NURSING & REHABILITATION CENTER	**7003 MAIN STREET STRATFORD, CT 06614**

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 0580 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility policy and interview for 1 resident (Resident #1) reviewed for notification of change, the facility failed to ensure the resident representative was notified in a timely manner when the resident experienced a change in condition. The findings include: Resident #1's [DIAGNOSES REDACTED]. The annual MDS dated [DATE] identified Resident #1 had severely impaired cognition, required limited assistance with personal hygiene and was independent with ambulation and eating. The care plan dated 3/4/20 and revised on 5/1/20 identified Resident #1 tested positive for COVID-19. Interventions included to continue respiratory monitoring with temperature every shift, place on droplet precautions, encourage frequent hand washing, good respiratory hygiene and to wear mask to contain respiratory droplets. physician's orders [REDACTED]. Keep oxygen saturation above 92% and call the physician immediately and as needed. physician's orders [REDACTED]. A nurse's note dated 5/1/20 at 12:05 AM identified Resident #1's oxygen saturation was 84%, oxygen was applied and subsequent oxygen saturation was 92% on 5 liters oxygen via nasal cannula. Temperature was recorded as 102.8 F, and Tylenol and cold compresses were administered/implemented. At 10:00 PM the resident's temperature was recorded as 101.8 F. Further review failed to reflect Resident #1's representative was notified of the medical changes in the resident's condition or the initiation of oxygen therapy. Interview with the DNS on 6/5/20 at 10:25 AM identified the charge nurse who initiated the oxygen therapy should have notified the resident representative or requested the RN supervisor to call resident representative. Additionally, the DNS identified RN #3 was educated to ensure the resident representative is notified with any change in condition in a timely manner. Multiple attempts to contact RN #3 were unsuccessful. Review of the facility's policy for Resident Change of Condition identified the resident and his/her representative will be notified in a timely manner of resident's status and plan of care as directed by the physician.

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.