| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | **075213** | A. BUILDING _____ B. WING _____ | **04/14/2020** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
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| **GOLDEN HILL REHAB PAVILION** | **2028 BRIDGEPORT AVE MILFORD, CT 06460** |

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) |
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| F 0580<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**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.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 of 2 residents (Resident #2) reviewed for notification of change in condition, the facility failed to ensure that the resident's Conservator of Person (COP) was notified when the resident's condition changed, including orders for diagnostic testing, out of facility transfers, and changes in medications. The findings include: Resident #2 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The nurse's note dated [DATE] at 9:29 PM identified Resident #2 was seen by the physician and new orders were obtained for a chest x-ray, EKG, and blood work to be drawn on Monday. The nurse's note failed to reflect that the resident's COP was notified of the new orders. The nurse's note dated [DATE] at 1:46 PM identified the chest x-ray result was abnormal and the APRN was notified. The APRN gave new order to send Resident #2 to the emergency room for a CT Scan of the chest. The nurse's note failed to reflect that the COP was notified of the chest x-ray result or the new order to transfer the resident to the hospital. The nurses note indicated a message was left for the Conservator of Estate to return call to the facility. The nurse's note dated [DATE] at 2:17 PM identified Resident #2 was transferred to the hospital at 1:10 PM. The nurse's note dated [DATE] at 8:30 PM identified Resident #2 returned to the facility from the hospital after being evaluated for a positive PPD (a skin test to check for [MEDICAL CONDITION]). The initial chest x-ray prior to transfer to the hospital identified a right lower lung effusion. The chest x-ray performed at the hospital indicated a negative result, no consolidation/infiltrates noted. The APRN and DNS were made aware of Resident #2's returned to the facility. The nurse's note failed to reflect that the COP was notified of Resident #2's returned to the facility.<br>The nurse's note dated [DATE] at 2:48 AM identified LPN #7 explained to Resident #2 that a urinalysis was needed and Resident #2 refused. The nurse's note failed to reflect that the COP was notified of Resident #2's refusal of the urinalysis or the order for the urinalysis. The nurse's note dated [DATE] at 12:53 PM identified Resident #2 refused the ordered blood work. The nurse's note failed to reflect that the COP was notified of Resident #2's refusal of blood work.<br>The MDS dated [DATE] identified Resident #2 had mildly impaired cognition and required extensive assistance with personal hygiene. A physician's orders [REDACTED].#2 is on skilled care for observation related to presumptive Coronavirus, [MEDICAL CONDITION] monitoring, and droplet precautions. The nurse's note dated [DATE] at 3:16 PM identified Resident #2 was found on the floor at approximately 2:00 PM. The nurse's note identified a message was left for the Conservator of Estate to call the facility. The nurse's note failed to reflect that the Conservator of Estate was notified or updated regarding the fall. The nurse's note failed to reflect that the COP was notified of the fall. The nurse's note dated [DATE] at 4:00 PM identified RN #2 was called to the resident's room regarding Resident #2 temperature of 101.4 F and observed with shallow breathing. Lungs were clear to auscultation. The APRN was notified with new orders to administer oxygen as needed when oxygen saturation is < 92%, obtain a chest x-ray, swab for influenza and obtain blood work. The nurse's note identified a message was left for the COP to call the facility. The nurse's note failed to reflect that the COP was notified or updated regarding the resident's fever, shallow breathing, and new orders. A physician's orders [REDACTED].< 92% on room air. The nurse's note dated [DATE] at 10:00 PM identified new orders for [MEDICATION NAME] (medication used to treat infection) 400 mg by mouth every day for 10 days. The nurse's note identified a message was left for the Conservator to call for update. The nurse's note failed to reflect that the COP was notified or updated regarding the chest x-ray result and new order. A physician's orders [REDACTED]. The nurse's note dated [DATE] at 9:02 AM identified Resident #2 is on antibiotic for pneumonia, is on droplet precautions, influenza swab was done, and Resident #2 refused blood work. Oxygen is in place. The nurse's note failed to reflect that the COP was notified of the antibiotic order, droplet precautions, influenza swab being obtained, and Resident #2's refusal of blood work. The nurse's note dated [DATE] at 6:32 PM identified Resident #2 was alert, had a dry cough noted, no labored breathing, oxygen saturation 94% with oxygen via nasal cannula, lung sounds diminished in all fields, and temperature 100.2 F. Resident #2 denied body aches, headache, gastro-intestinal upset, droplet precautions maintained, and COVID-19 test pending. The nurse's note failed to reflect that the COP was notified of the new order for COVID-19 test, or that the test was pending. The care plan, updated on [DATE], identified Resident #2 is at risk for respiratory complications related to a possible exposure to COVID -19 and related to increase risk factors and advanced age. On [DATE] Resident #2 tested positive for COVID-19. Interventions included to complete respiratory risk assessments and monitor respiratory status for at least 14 days or as ordered. Isolate in room, medications as ordered. Notify the physician for transfer to hospital as with any acute respiratory illness. Use principles of infection control and universal/standard precautions. The nurse's note recorded as a late entry on [DATE] at 12:41 PM identified a note dated [DATE] at 12:25 PM identified RN #1 was called to unit at 9:25 AM and identified Resident #2 was lying in bed without respiration, and staff are unable to obtain apical pulse. Resident #2 is a full code, 911 was initiated, chest compression/air high flow started. At 9:40 AM, 911 in the building, chest leads placed by 911 personnel and indicated asystole. EMS call to Medical Director at approximately 9:45 AM, 911 personnel pronounced Resident #2 expired. The APRN was notified, call placed to conservator and message left with request for call back. Call placed again to Conservator of Estate and Conservator of Person and updated on Resident #2 status. An interview and clinical record review with RN #1 on [DATE] at 3:35 PM indicated he/she notified both Conservator of Estate and Conservator of Person when Resident #2 expired. RN #1 indicated he/she notified both conservators because the names in the chart listed both parties as the conservators. RN #1 indicated when there is a change in resident condition the nurses should notify the responsible party/families. RN #1indicated the nurses are responsible to follow up with making sure the responsible party/families are updated. An interview with LPN #1 on [DATE] at 9:32 AM identified it is his/her usual practice to notify the family when there is a change in resident condition. LPN #1 indicated he/she usually will follow through during the shift to make sure that the families are aware of what is going on with their loved ones. An interview with LPN #2 on [DATE] at 10:06 AM identified he/she notified RN #1 regarding Resident #2's temperature of 100.2 F. Additionally, LPN #2 indciated RN #1 performed the Covid-19 test on the resident. LPN #2 indicated he/she did not notify the resident's family regarding the temperature of 100.2 F due to the facility protocol that read 100.4 F and above is considered a temperature. LPN #2 identified the Conservator of Estate is for finance, and Conservator of Person is responsible for medical issues. LPN #2 indicated the nurses are responsible to notify the supervisor and the responsible party with change in resident condition. An interview with LPN #4 on [DATE] at 11:04 AM identified he/she left a message for the Conservator of Estate to call the facility and he/she informed the in-coming nurse to notify the conservator that Resident #2 was found on the floor. LPN #4 indicated that he/she is aware of the difference between Conservator of Estate/Person and that on [DATE] the COP was not listed on the face sheet, only one person was listed and that was the Conservator of Estate. An interview with LPN #5 on [DATE] at 11:49 AM identified if he/she did not document that the family was notified of the refusal of blood work, that means he/she did not call or notify the family. LPN #5 indicated that the APRN was notified. LPN #5 indicated the facility protocol is to notify the family or conservator with new orders and change in resident condition. An interview with RN #3 on [DATE] at 1:43 PM indicated he/she is an agency nurse. RN #3 indicated he/she spoke to the Conservator of Person when Resident #2 returned from the hospital, however, he/she does not know why the conversation was not documented. An interview with RN #6 on [DATE] at 2:38 PM indicated he/she called the COP and left a message to call facility for an update regarding Resident #2's temperature of 101.4 F, new orders for a chest x-ray, flu swab, and blood work. RN #6 indicated no call was returned from the COP. An interview with Person #7 on [DATE] at 3:05 PM indicated he/she is the COP for Resident #2. Person #7 indicated he/she received only 2 calls from the facility since Resident #2 was admitted . The two calls were on [DATE] and [DATE]. Person #7 indicated he/she received a phone call on [DATE] from a Greenwich number which was unfamiliar, and he/she did not answer. Person #7 indicated on [DATE] around 11:25 AM he/she received a call from that same number from Greenwich that he/she had received on [DATE]. Person #7 indicated he/she received 3 consecutive calls from the Greenwich number and answered the phone the third time. Person #7 indicated that a male nurse informed him/her that they were calling from the facility to report that Resident #2 has died . Person #7 indicated he/she asked the nurse what happened and was Resident #2 sick. The nurse indicated that when he/she went into the room Resident #2 was unresponsive and although staff attempted to resuscitate, and called 911, the resident died . Review of the Facility Change in a Resident's Condition or Status policy identified the facility shall promptly notify the resident, his or her attending physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.). Unless otherwise instructed by the resident, a nurse will notify the resident's representative when: The resident is involved in any accident or incident that results in an injury including injuries of an unknown source; there is a significant change in the resident's physical, mental, or psychosocial status; a decision has been made to discharge the resident from the facility; and/or it is necessary to transfer the resident to a hospital/treatment center. The facility failed to notify Resident #2's COP when the resident had changes in his/her medical condition, was placed on oxygen, was sent to the hospital for evaluation and returned, was tested for Covid 19, and was placed on antibiotic for infection. |

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| 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.