STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075213	A. BUILDING _____ B. WING _____	07/02/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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)
F 0557 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, interviews, and review of facility documentation, for one of three residents reviewed for abuse, (Resident #1), the facility failed to ensure the resident was treated in a dignified manner. The findings include: a. Resident #1's [DIAGNOSES REDACTED]. The quarterly Minimum Data Set ((MDS) dated [DATE] identified Resident #1 had no cognitive impairment, no problems with mood, no behaviors, was independent in dressing, toilet use and personal hygiene after set up by one staff, and required transfer help of one staff for bathing. The care plan dated 3/31/20 identified a problem of diarrhea. Interventions included to record the duration and frequency of diarrhea, characteristics, consistency and quantity of stool. The care plan was revised on 5/5/20 with an intervention to transfer resident to emergency room (ER) for medical work-up on 5/5/20. The care plan identified no problem with behavioral outbursts until revision on 5/11/20 when the care plan was also updated to include incident of substantiated verbal abuse. A physician's orders [REDACTED]. Nurse's note dated 5/11/20 at 12:43 AM, written by Registered Nurse (RN) #1, identified around 6:00 PM, Resident #1 was observed in the hallway, self-propelling wheelchair displaying angry, disruptive behaviors as well as using profanities. Resident #1 complained that no aide came to his/her room when he/she called for help. According to nursing staff, the resident was earlier assisted to the bathroom. A few minutes later Resident #1 came out of the room asking for help, the assigned aide told Resident #1 to wait a few minutes as he/she was providing care for other resident. Resident #1 lashed out to nursing staff and started to yell, making a finger gesture, moving quickly in the wheelchair in the hallway, and kicking garbage cans in hallway. Resident #1 went to the second floor naked in hallway, demanding to have his/her old room back. Staff was not able to redirect the resident and staff heard him/her on phone to(NAME)Police. The writer intervened and told Resident #1 that his/her behavior was inappropriate and if continued he/she will be transferred to the hospital. Resident #1 calmed and went to another room where he/she has agreed to stay and sleep that night. The Administrator was updated on Resident #1's behavior. Resident #1 was to be seen by psychiatric Advanced Practice Registered Nurse (APRN) and Social Worker to address behavioral issues. A facility reportable event form dated 5/11/20 identified that on 5/10/20 a supervisor yelled at the resident, was rude and said was calling the police regarding an allegation of verbal abuse. Statement from RN #1 identified resident is rude and thinks he/she can yell at me. The supervisor was suspended, followed by termination. Investigation documentation for this reportable event identified that it was concluded that based on speaking in an unprofessional manner and raising his/her voice to a resident, that verbal abuse did occur. Interview with Resident #1 on 6/12/20 at 10:25 AM identified that he/she had been very upset as he/she had not been assisted to the bathroom in time and then soiled him/herself due to the [MEDICAL CONDITIONS]. Resident #1 identified he/she rarely needed assistance, except then due to the [MEDICAL CONDITIONS]. Resident #1 identified that he/she and the nurse went at it and that he/she went back to the floor he/she had previously resided in and stayed there. Resident #1 identified he/she had not seen the nurse since reporting this, and has had no issues since. Interview with RN #4 on 6/12/20 at 12:30 PM identified that RN #4 had investigated the incident and that when RN #1 was interviewed for the investigation, RN #1 identified that he/she would not be talked to in that manner by a resident. RN #4 further identified that RN #1 had concurred that he/she was arguing and yelling with the resident. RN #4 identified that verbal abuse was substantiated and RN #1 was terminated. Interview with RN #1 on 6/12/20 at 12:45 PM identified that he/she did tell the resident he/she would need to call the police if behavior continued, but did not yell at or argue with Resident #1. Interview with the DNS on 7/2/20 at 2:20 PM identified that nursing staff should not argue with residents, that is a nursing expectation. The facility policy for Resident Rights identified residents have the right to be treated with courtesy, consideration, and respect for the resident's dignity and individuality. The facility failed to ensure the resident was spoken to in a dignified manner.
F 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, interviews, and review of facility documentation, for one of three residents reviewed for abuse, (Resident #5), the facility failed to ensure the resident was free from neglect. The findings include: Resident #5's [DIAGNOSES REDACTED]. The care plan dated 5/7/20 identified Resident #5 was at risk for falls related to weakness and deconditioning, with interventions to encourage resident to call for assistance and keep call bell in reach. The care plan was revised on 5/9/20 with additional interventions added to obtain Physical Therapy (PT) consult for strength training and to provide assistance with toilet use after meals. physician's orders [REDACTED]. The admission Minimum Data Set ((MDS) dated [DATE] identified Resident #5 had moderate cognitive impairment, was totally dependent on two staff for bed mobility and transfers, was totally dependent on one staff for toilet use, and had one fall with no injury since the last assessment. The Care Plan was revised on 5/18/20 with an intervention added to occupy resident with meaningful distractions (music, coloring, television). Profile Care Plan Approaches identified a problem of falls/behavioral symptoms with approaches dated 5/21/20, bed lowered to floor; floor mats next to bed to keep resident safe if he/she attempt to place self on floor. Fall risk assessment dated [DATE] identified Resident #5 was at high risk for falls. Physical Therapy evaluation dated 5/25/20 identified Resident #5 was able to transfer using a slide board with moderate to maximum assist of two staff. Nurse's note written by Licensed Practical Nurse (LPN) #5, dated 6/8/20 at 2:19 PM identified: Resident rolls self on the floor, and Nurse Aide (NA) witnessed resident put self in bed. No injury, resident denies pain or discomfort. Will continue to monitor. Nurse's note written by Registered Nurse (RN) #3, dated 6/8/20 at 2:42 PM, identified: It was reported to this writer that resident placed self on landing mat beside bed. This writer went to assess the resident, resident was in bed laying down. No injuries noted, skin intact, resident has a care plan for sitting on the floor. Facility reportable event form dated 6/16/20, with time of incident 7:10 AM, identified the resident was found on floor next to bed. Facility reportable event form dated 6/16/20, with time of incident 8:30 AM, identified the resident was observed on floor in room with skin tear to left 2nd toe. An electronic reportable event form dated 6/16/20 identified Housekeeper #1 observed Resident #5 on the floor and observed the charge nurse tell the resident that he/she can get him/herself up and put him/herself back to bed. The reportable event form further identified that the resident required a slide-board and assistance of staff for transfer. Investigative documentation for the 6/16/20 reportable event identified Housekeeper #1's statement at 8:55 AM identified: At 7:10 AM on 6/16/20 Resident #5 was observed on the floor at his doorway naked, covered with a sheet, and feces was on the sheet. Housekeeper #1 went to the nurse's station and told

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.

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GOLDEN HILL REHAB PAVILION	2028 BRIDGEPORT AVE MILFORD, CT 06460

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F 0600 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) Licensed Practical Nurse (LPN) #3 and LPN #1 and was told that the resident had come out of his/her room to let someone know he/she needed his/her phone fixed. LPN #1 then hollered down the hall rudely and loudly I am not no phone tech, crawl yourself back to bed. Housekeeper #1 then asked LPN #3 to get a gait belt to assist the resident to bed. LPN #3 said Resident #5 was a Hoyer (mechanical lift), and told the resident to crawl back to bed because the bed is low enough. LPN #3 punched out, left the building, and left Resident #5 on the floor. LPN #1 then went to give another resident insulin and left Resident #5 on the floor. All the Nursing Assistants (NAs) were in rooms providing care while LPN #1 and LPN #3 were yelling at the resident to crawl back to bed, but NA #4 heard the commotion and came out to help Resident #5. Investigative documentation for the 6/16/20 reportable event, LPN #3's statement, identified: LPN #3 did see Resident #5 on the floor asking if he/she could get his/her phone fixed and LPN #3 did not help the resident. LPN #3 may have yelled to the resident to crawl back into bed, but does not remember if he/she said anything to the Resident. LPN #3 did not assist the resident, and knows that they (LPN #1 and LPN #3) should have helped the resident. The reason LPN #3 did not help was because LPN #1 said the resident had done this before. LPN #3 assumed the resident had crawled out of bed, did not determine if the resident had fallen, and did not notify the Registered Nurse (RN) supervisor. LPN #3 did not know if anyone had assisted the resident, when LPN #3 went by the room the resident was gone so LPN #3 thought Resident #5 had went back to bed. Investigative documentation for the 6/16/20 reportable event, LPN #1's statement, identified: The resident came out of the bed and put him/herself on the floor next to the bathroom and said his/her phone was not working, LPN #3 told the resident that LPN #3 would call to have the phone fixed, Resident #5 was given medications by LPN #1, and LPN #1 left the resident in bed with a gown on and sheet over him/her. Later on the resident was found on the floor, at 8:30 AM. LPN #1 had been told by the staff from the floor the resident was previously on that he/she had a care plan for crawling out of bed. Resident #5 usually crawled and puts himself/herself back to bed. Additional facility investigation interview notes dated 6/16/20 identified that LPN #1 did see Resident #5 lying on the floor at approximately 7:10 AM after the housekeeper came and told LPN #1 and LPN #3 that the resident was on the floor and wanted his/her phone fixed. The facility investigation interview further asked if LPN #1 or LPN #3 had assessed the resident at that time and the response was no and responses further identified that the RN was not notified. Investigative documentation for the 6/16/20 reportable event, NA #4's statement, identified: NA #4 had seen Resident #5 on the floor at approximately 7:10 AM on 6/16/20 and NA #4 had helped the resident in bed and provided care. When NA #4 left, the resident was in bed resting. Investigative documentation for the 6/16/20 reportable event, NA #5's statement, identified: he/she helped resident into the chair at approximately 8:30 AM with NA #6. Resident #5 was on the floor. Investigative documentation for the 6/16/20 reportable event, NA #6's statement, identified as a verbal interview with LPN #2 and NA #6, identified: he/she saw the resident at approximately 7:00 AM, maybe a little later. NA #6 observed the resident in bed sleeping, as he/she passed out linens. NA #6 also helped Resident #5 when he/she was on the floor around 8:30 AM with NA #5 and LPN #2, helped him/her into the wheelchair and NA#6 washed Resident #5 up for the day. Interview with RN #4 on 6/19/20 at 2:30 PM identified they had substantiated verbal abuse (by LPNs #1 and 3) towards Resident #5 for the 6/16/20 incident. Interview with Housekeeper #1 on 6/22/20 at 1:40 PM identified he/she did see and hear LPN #1 and LPN #3 tell Resident #5 to crawl back into bed, this was at 7:10 AM on 6/16/20. Housekeeper #1 went downstairs and asked the receptionist to find the Administrator. When the Administrator came in and Housekeeper #1 told him/her. Interview with LPN #3 on 7/2/20 at 9:14 AM identified LPN #3 was about to be leaving at the time of the incident and was not the primary nurse. LPN #3 saw Resident #5 on the floor with a gown on, not soiled, as LPN #3 was going to give medications. LPN #3 did not speak to the Resident. LPN #3 went to give the medications and when he/she returned did not see Resident #5, and thought someone had helped the resident. LPN #3 did not go into the room or check on the resident further and then LPN #3 left work. LPN #3 identified that at the time of the incident, the resident required a mechanical lift for transfers. LPN #3 identified that he/she did not speak to anyone about the resident at that time, but did see LPN #1 go to the resident and ask the resident why he/she was on the floor and the resident said it was because he/she wanted to have his/her phone fixed, and LPN #1 told the resident he/she would tell someone who could fix it, and then LPN #1 left the resident on the floor. LPN #3 was asked what a nurse should do when seeing a resident on the floor. LPN #3 identified that if he/she knew the resident was supposed to be assessed, he/she would have gotten the nursing supervisor. LPN #3 identified that he/she thought the resident was getting in and out of bed by him/herself. LPN #3 identified that the resident was seen by a nursing supervisor getting in and out of bed by him/herself when he/she was on a different floor. When asked about the resident's care plan, LPN #3 identified he/she thought it was care planned that the resident crawled out of bed and had a low bed and mats for this. Interview with NA #4 on 7/2/20 at 12:30 PM identified: On 6/16/20, he/she saw Resident #5 on the floor two times, once at 7:15 AM, and once at about 8:45 AM. NA #4 identified that at 7:15 AM, NA #4 was walking by the room, did not see anyone else, no nurses, no housekeeper, but did see the resident on the floor; then with assistance of three other staff, two aides and one nurse supervisor, the resident was lifted up to a wheelchair using a sheet, and then into bed. NA #4 identified the second incident at about 8:45 AM was when he/she heard a noise, possibly the resident calling out, and went to see what it was and found the resident in the room on the floor and called the nurse. NA #4 identified that all the staff were in other rooms. NA #4 identified that Resident #5 was then lifted just like at 7:15 AM, using a sheet and four staff. NA #4 identified the resident was in a gown at the time of both incidents, and not soiled. Interview with the Director of Nurses (DNS) on 7/2/20 at 2:30 PM identified that if an LPN sees a resident on the floor, the LPN should get the RN, and after RN assessment, the resident should be assisted in getting up. Interview with LPN #1 on 7/3/20 at 11:50 AM identified: When Resident #5 was transferred to the unit from the 2nd floor, LPN #4 told LPN #1 he/she had a care plan, he/she crawls around on the floor, then the same day the nurse who is now the DNS identified Resident #5 crawls on the floor all the time, and this is care planned. Resident #5 was a mechanical lift but transferred him/herself to chair or floor whenever he/she wanted. On 6/16/20, Resident #5 came out at about 7:15 AM, when he/she was about to give him/her medication. Resident #5 was sitting on the floor just inside the exit door to his/her room. When he/she was sitting on the floor, he/she said his/her phone was broke. LPN #1 told the resident that he/she would get staff to fix his/her phone, and LPN #1 left while the resident was on the floor. LPN #1 went back later and brought Resident #5's medications and gave him/her the medications, around 7:30 AM or so; at this time the resident was in bed with two therapy staff with him/her. LPN #1 left the resident with the therapy staff. Then at 8:30 AM one NA came to say the Administrator wanted to see him/her in the resident's room. LPN #1 went right away to the room, the Administrator was there, and LPN #2 and two NAs and other staff lifted the resident with a sheet, and LPN #1 put the wheelchair under the resident. Then the supervisor, RN #3, said that the housekeeper said LPN #1 said to the resident get off the floor while cursing at the resident. LPN #1 identified he/she did tell the Resident to get back into bed, but did not swear. LPN #2 asked LPN #1 for a statement and as LPN #1 was starting to write the statement, a resident wanted a pain medication, so LPN #1 gave it, and then the Administrator came and got LPN #1 to go and finished the statement in the Administrator ' s office. LPN #1 was asked why LPN #1 did not call the supervisor when seeing the resident on the floor. LPN #1 answered, he/she did not think Resident #5 fell , but thought he/she put himself on the floor. LPN #1 received report from two nurses who both said he/she crawled and had a care plan. Observation and interview on 7/2/20 at 12:20 PM with the Administrator identified Resident #5's baseline was some confusion. Resident #5 was observed sitting at bedside eating from tray table and then Resident indicated he/she was done eating and was observed laying down and sitting back up twice without assistance or difficulty. Staff then lowered the bed, mats were in place. Statement provided by facility on 7/3/20, identified as an addendum by NA #4 to clarify incident regarding Resident #5, dated 7/3/20, 3:15 PM, reflected: On 6/16/20 at 7:15 AM, NA #4 heard a resident yelling. NA #4 called out to the nurse, LPN #1, that the resident was on the floor. NA #4 didn't hear a response back from the nurse. The resident was getting agitated and when NA #5 came in the room we helped the resident get back in his/her chair and assisted him/her to bed. NA #4 provided care to the resident. Statement provided by facility on 7/3/20, identified as an addendum by NA #5 to clarify incident regarding Resident #5, dated 7/3/20, 3:20 PM, stated: On 6/16/20 at around 7:15 AM, NA #5 heard NA #4 calling for help. NA #5 observed Resident #5 was trying to get up and was agitated. NA #4 and NA #5 helped the resident to get back in his/her chair and assisted him/her back to bed. NA #5 provided care to the resident. NA #5 did not hear any of the nurse's conversations. NA #5 had never seen Resident #5 crawling around on the floor and had never heard of anyone referencing him/her crawling around on the floor. The facility policy for Abuse identified the facility will protect their residents from abuse by anyone, including staff; and will develop and implement policies and procedures to aid the facility in preventing abuse, neglect, or mistreatment of [REDACTED].#5's needs were not neglected and failed to ensure Resident #5 received care in a timely manner.
F 0607 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.**

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F 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) Based on interviews and review of facility documentation, for one of four nursing staff reviewed, (Nurse Aide (NA) #1), the facility failed to ensure training for abuse had occurred, failed to ensure required background screening was completed, and failed to ensure nurse aide certification was verified. The findings include: A New Hire File Checklist form for NA #1 identified date of hire was 4/10/20. The checklist was not completed except for Name: NA #1, Position: CNA (Certified Nurse Aide) and Date of Hire: 4/10/20. Included in this checklist and blank, were items for abuse training, criminal background check and license/certification check. The personnel record/employee file for NA#1 failed to reflect required background screening or Nurse Aide certification. Documentation for Abuse training was not provided. A check of the state Nurse Aide Certification Registry on 6/22/20 failed to identify NA#1 was a Certified Nurse Aide. Review of staffing dated 5/10/20 identified NA #1 worked the 3:00PM to 11:00PM shift. Review of facility documentation identified NA #1 was separated from facility employment on 5/15/20 for insubordination and violation of cell phone policy. Interview with the Administrator on 7/2/20 at 12:20 PM identified the person responsible for ensuring screening for hiring was the Business Office Manager. Interview with the Business Office Manager on 7/2/20 at 12:45 PM identified the Business Office Manager is responsible for sending information to the corporate office and then corporate office does the screening checks, and when approved, corporate will send information to the facility and the facility hires the staff person. The Business Office Manager identified that he/she did not send NA #1 's information to corporate, so NA #1 was not screened. The Business Office Manager further identified that NA #1 was hired without having screening, should not have been hired without screening, and that this had happened because this was a slip-up during a mass hiring that was done due to the pandemic. The facility policy for Hiring identified: Where appropriate, background investigations may be conducted on persons making application for employment with this facility and on current employees. Facility policy for Abuse Prevention Program identified: Administration will conduct employee background checks. The policy further identified: Administration will require staff training/orientation programs that include such topics as abuse prevention, identification and reporting of abuse, stress management and handling verbally or physically aggressive resident behavior.
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, interviews, and review of facility documentation, for one of three residents reviewed for abuse, (Resident #5), the facility failed to ensure an Registered Nurse (RN) assessment prior to being moved after a potential fall. The findings include: Resident #5's [DIAGNOSES REDACTED]. The care plan dated 5/7/20 identified Resident #5 was at risk for falls related to weakness and deconditioning, with interventions to encourage resident to call for assistance and keep call bell in reach. The care plan was revised on 5/9/20 with additional interventions added to obtain Physical Therapy (PT) consult for strength training and to provide toileting assistance after meals. physician's orders [REDACTED]. The admission Minimum Data Set ((MDS) dated [DATE] identified Resident #5 had moderate cognitive impairment, was totally dependent on two staff for bed mobility and transfers, was totally dependent on one staff for toilet use, and had one fall with no injury since the last assessment. The Care Plan was revised on 5/18/20 with intervention added to occupy resident with meaningful distractions (music, coloring, television). Profile Care Plan Approaches identified a problem of falls/behavioral symptoms with approaches dated 5/21/20, bed lowered to floor; floor mats next to bed to keep resident safe if he/she attempt to place self on floor. Fall risk assessment dated [DATE] identified Resident #5 was at high risk for falls. Physical Therapy evaluation dated 5/25/20 identified Resident #5 was able to transfer using a slide board with moderate to maximum assist of two staff. Nurse's note written by Licensed Practical Nurse (LPN) #5, dated 6/8/20, 2:19 PM identified: Resident rolls self on the floor, and NA witnessed resident put self in bed. No injury, resident denies pain or discomfort. Will continue to monitor. Nurse's note written by Registered Nurse (RN) #3, dated 6/8/20, 2:42 PM, identified: It was reported to this writer that resident placed self on landing mat beside bed. This writer went to assess the resident, resident was in bed laying down. No injuries noted, skin intact, resident has a care plan for sitting on the floor. An electronic reportable event form dated 6/16/20 identified Housekeeper #1 observed the resident on the floor and observed the charge nurse tell the resident that he/she can get him/herself up and put him/herself back to bed. The reportable event form further identified that the resident required a slide-board and assistance of staff for transfer. Interview with LPN #3 on 7/2/20 at 9:14 AM identified LPN #3 was about to be leaving at the time of the incident and was not the primary nurse. LPN #3 saw Resident #5 on the floor with a gown on, as LPN #3 was going to give medications. LPN #3 went to give the medications and when he/she returned did not see Resident #5, and thought someone had helped the resident. LPN #3 did not go into the room or check on the resident further and then LPN #3 left work. LPN #3 identified that at the time of the incident, the resident required a mechanical lift for transfers. LPN #3 identified that he/she did not speak to anyone about the resident at that time, but did see LPN #1 go to the resident and ask the resident why he/she was on the floor and the resident said it was because he/she wanted to have his/her phone fixed, and LPN #1 told the resident he/she would tell someone who could fix it, and then LPN #1 left the resident on the floor. LPN #3 was asked what a nurse should do when seeing a resident on the floor. LPN #3 identified that if he/she knew the resident was supposed to be assessed, he/she would have gotten the nursing supervisor. LPN #3 identified that he/she thought the resident was getting in and out of bed by him/herself. LPN #3 identified that the resident was seen by a nursing supervisor getting in and out of bed by him/herself when he/she was on a different floor. Interview with the Director of Nurses (DNS) on 7/2/20 at 2:30 PM identified that if an LPN sees a resident on the floor, the LPN should get the RN, and after RN assessment, the resident should be assisted in getting up. Interview with LPN #1 on 7/3/20 at 11:50 AM identified: When Resident #5 was transferred to the unit from the 2nd floor, LPN #4 told LPN #1 Resident #5 had a care plan, he/she crawls around on the floor. Resident #5 was a mechanical lift but transferred him/herself to chair or floor whenever he/she wanted. On 6/16/20, Resident #5 came out at about 7:15 AM, when LPN #1 was about to give him/her medication. Resident #5 was sitting on the floor just inside the exit door to his/her room. When he/she was sitting on the floor, he/she said his/her phone was broke. LPN #1 told the resident that he/she would get staff to fix his/her phone, and LPN #1 left while the resident was on the floor. LPN #1 was asked why LPN #1 did not call the supervisor when seeing the resident on the floor. LPN #1 answered, I told them, I did not think he/she fell , I thought Resident #5 put him/herself on the floor. Statement provided by facility on 7/3/20, identified as an addendum by NA #4 to clarify incident regarding Resident #5, dated 7/3/20, 3:15 PM, reflected: On 6/16/20 at 7:15 AM, NA #4 heard a resident yelling. NA #4 called out to the nurse, LPN #1, that the resident was on the floor. NA #4 didn't hear a response back from the nurse. The resident was getting agitated and when NA #5 came in the room they helped the resident get back in his/her chair and assisted him/her to bed. NA #4 provided care to the resident. Statement provided by facility on 7/3/20, identified as an addendum by NA #5 to clarify incident regarding Resident #5, dated 7/3/20, 3:20 PM, reflected: On 6/16/20 at around 7:15 AM, NA #5 heard NA #4 calling for help. NA #5 observed Resident #5 was trying to get up and was agitated. NA #4 and NA #5 helped the resident to get back in his/her chair and assisted him/her back to bed. NA #5 provided care to the resident. NA #5 did not hear any of the nurse's conversations. NA #5 had never seen Resident #5 crawling around on the floor and had never heard of anyone referencing him/her crawling around on the floor. After NA #5 assisted NA #4, NA #5 proceeded with his/her rounds. Interview and record review with the DNS on 6/22/20 at 12:59 AM identified that the resident should have been assessed by an RN prior to being assisted up from a potential fall, and did not have an assessment prior to being assisted up after being found on the floor on 6/16/20 at 7:10 AM. The DNS identified that the reason this occurred was, according to the LPNs involved, (LPNs #1 and #3) the LPNs did not know this was required. The facility policy for Fall Management did not identify need for RN assessment before moving a resident after a fall or potential fall.
F 0726 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.** Based on review of facility documentation and interviews, for three of three nurses reviewed, (Registered Nurse (RN) #1, Licensed Practical Nurse (LPN) #1, and LPN #3), the facility failed to ensure required performance evaluations were completed. The findings include: Personnel Records/ Employee File documentation identified the following dates of hire: LPN #1: On or about 1/2/2015, as date of hire was not clearly documented in the record. LPN #3: 1/13/2006. RN #1: On or about

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075213	A. BUILDING _____ B. WING _____	**07/02/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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)
F 0726 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 3) 4/19/17 or 5/4/17, as date of hire is not clearly documented in the record. Performance evaluation and/or competencies were not reflected in the records. Interview with the Administrator on 6/19/20 at 2:54 PM identified the facility did not find evaluations for nursing staff and the facility would be completing these now. The Administrator further identified that these staff have worked at the facility for greater than one year and evaluations should have been completed. Interview with RN #4 on 6/19/20 at 2:58 PM identified that performance evaluations for nursing staff should be done annually. The facility policy for Performance Appraisals identified that all employees shall have performance evaluations annually.
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 interviews and review of facility documentation, the facility failed to ensure thorough implementation of the Legionella Water Management program, failed to ensure required water management meetings were completed and documented, and/or failed to address recommendations from the state agency regarding a Legionella concern. The findings include: Documentation from the Department of Public Health to the facility Director of Nursing and Corporate Staff #1 sent on 11/12/19 at 6:21 PM identified: Based on CDC recommendations and current public health practice the following was recommended: 1. Conduct clinical active prospective surveillance. If a suspect Legionnaires' disease case(s) (i.e. patient with pneumonia of unknown etiology) is identified, test for Legionella using the urine [MEDICATION NAME] test and when possible collect sputum or other lower respiratory secretions for Legionella culture. You need to specifically request Legionella Culture on the lab request form. 2. Review your existing Water Management Program WMP. 3. Conduct an environmental assessment - (CDC Environmental Assessment). 4. Consider temporizing measures at your facility, such as the installation of 0.2 micron point-of-use filters any shower-heads or sink/tub faucets intended for use. 5. Create an environmental water sampling plan that includes testing (culturing) water samples for Legionella, as well as testing physical and chemical parameters (temperature, disinfection residual levels, and pH). The sampling locations may differ from those locations tested during routine surveillance. Sample locations should correlate with case patient(s) travel path through the facility, as well as key physical plant locations. Please view CDC Guidance for environmental sampling or contact us for further guidance if you have questions about this. 6. Environmental water samples should be analyzed by a lab that participates in the CDC Elite program and has been certified by the CT DPH Environmental Laboratory Certification program. Click here for List of Approved Laboratories for Legionella Testing. 7. Remediate/ decontaminate possible environmental source(s) when identified - see CDC guidance for decontamination. Facility documentation provided related to Water Management Program and/or Legionella consisted of: Water tested for Legionella 6/3/19 -- no Legionella isolated. Water tested for Legionella 11/12/19 - no Legionella isolated. Water tested for Legionella - 3/4/20 -- no Legionella isolated. Water temperature logs provided for sinks from January 2019 to June 2020, reflected lowest temperatures logged were 105 degrees Farhenheit. Safety Committee meeting notes dated 6/18/18, with no reference to water management, did include sign-in sheet. Safety Committee meeting agenda dated 3/19/20, with agenda item of Water Management, did not include a sign in sheet. Interview with the Administrator on 6/12/20 at 10:15 AM identified that he/she has been at the facility since February 2020 and was not aware of issues related to water management, Legionella concerns or any related issues. The Administrator further identified that all Legionella testing had been negative. Interview with the Director of Maintenance on 6/12/20 at 10:45 AM identified he/she had worked at the facility as Maintenance Director for the past two and a half years and identified there have been no concerns related to Legionella or any other water issues. The Director of Maintenance identified that any water leaks were fixed immediately with no issues reported. Interview with the Administrator on 6/12/20 identified the facility had no additional documentation related to a water management program or legionella. Interview with the Administrator on 6/18/20 at 1:40 PM identified that he/she was not aware of any recommendations from the Department of Public Health regarding Legionella concerns, or of any email with recommendations from the Department of Public Health to the facility Director of Nursing and Corporate Staff #1. Facility Water Management Program identified that the program included (in part) specific measures to control the introduction and/or spread of legionella, a system to monitor control limits, and documentation of the program. The policy further identified that the Water Management Program will be reviewed at least once a year.