STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075060	A. BUILDING _____ B. WING _____	**05/21/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SALMON BROOK REHAB AND NURSING	**72 SALMON BROOK DRIVE GLASTONBURY, CT 06033**

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 clinical record review, facility documentation, interviews and policy review, for one of four residents reviewed for a change in condition, (Resident #1), the facility failed to ensure that the physician was notified once a change in condition was identified. The findings include: Resident #1 had [DIAGNOSES REDACTED]. A quarterly Minimum (MDS) data set [DATE] identified that the resident had severe cognitive impairment and required extensive assistance with activities of daily living. Review of physician orders [REDACTED]. Review of a nurse's note dated [DATE] at 4:11 PM identified that the resident was noted with blood tinged sputum on the inside of mouth. Upon exam the mouth was clean, and no bleeding was noted. Review of a nurse's note dated [DATE] at 8:47 AM identified that the nurse was called to the resident's room by a Nurse Aide and another nurse because the resident was not breathing right. The resident was unresponsive, had difficulty breathing, then vomited blood tinged emesis. The resident had no vital signs, respirations ceased, and the resident was pronounced deceased at 5:25 AM. Review of a death certificate dated [DATE] and signed by the medical director identified that the cause of death was cardiopulmonary arrest and COVID-19. Interview with the speech therapist on [DATE] at 12:50 PM identified that on [DATE] she noted the resident had crusted blood on his/her lips and teeth. She swabbed the resident's mouth, noted blood tinged sputum, and notified RN #1. Interview with Registered Nurse (RN) #1 on [DATE] at 1:00 PM identified that on [DATE] she was notified that the speech therapist was treating the patient and noted blood in his/her sputum. RN #1 assessed the resident who had stable vital signs and no active source of bleeding in the mouth area. She identified that if her assessment had identified active bleeding she would have contacted the physician. Interview with RN #2 on [DATE] at 1:35 PM identified that she was the nursing supervisor on [DATE] when the resident expired. When she entered the room the resident was unresponsive and having difficulty breathing. She started an assessment, attempted to obtain vital signs, felt a faint radial pulse and was unable to obtain a blood pressure. The resident then vomited blood tinged emesis. RN #2 stated that while RN #3 stayed in the room with the resident she had gone to call 911, but before she made the call the resident was noted with no pulse, and pronounced deceased . Interview with the Advanced Practice Registered Nurse (APRN) #1 on [DATE] at 1:45 PM identified that he would expect to be notified if blood was visible in the mouth. He further stated that he would have assessed the resident as he was in the building that day, and would have put interventions in place if his assessment deemed appropriate to do so. The APRN stated that this resident's bleeding most likely had nothing to do with his/her death as the resident had COVID-19, his/her health status was declining and towards the end of life, and COVID-19 was the cause of death. Review of the change of condition in resident status policy identified that the facility will notify the physician when there is a change in the resident's condition.
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 observations and interviews with staff, the facility failed to ensure that appropriate infection control practices were implemented to prevent and control the spread of infection. The findings include: a. Observation of Laundry Worker #1 on 5/20/20 at 10:30 AM identified him exiting the employee break area and onto the COVID-19 negative nursing unit wearing a cloth mask. He then removed the cloth mask and entered the laundry room. The laundry worked failed to wear the appropriate Personal Protective Equipment (PPE) which was a surgical mask. b. Observation and interview and on 5/20/20 at 11:05 AM in the dietary department identified the cook preparing green beans with her surgical mask hanging off of her right ear and not covering her nose or mouth. Interview with the cook identified that although she was aware that she should be wearing a mask while preparing food, she removed it because it was making her too hot. Interview with the DD on 5/20/20 at 11:07 AM identified that the cook should be wearing a face mask at all times. Interview with the DON on 5/20/20 at 10:42 AM identified that all staff should be wearing a surgical mask at all times, and cloth masks are not to be used. She further identified that there are enough surgical masks available, and if staff need a mask, they just need to ask for one. Review of Center for disease control guidelines identified that all health care workers should be wearing a face mask at all times while in the facility. Cloth face masks are not appropriate for health care staff and are not considered Personal Protective Equipment because their capability to protect health care workers is unknown. c. Observation and interview with the DON on the COVID-19 designated unit on 5/20/20 at 11:45 AM identified an open waste basket in an alcove with a used blue disposable gown and a white Tyvek suit that were overflowing out of the waste basket. Along side the basket were bins with lids on them designated for disposal of PPE, but the user would have to lift the lid of the bin to place the isolation gown into the bin. Interview with the DON identified that the gowns should have been disposed of in a covered isolation bin, and the bin should have a foot pedal so the user does not have to touch the bin when disposing of the gown. The DON identified that the facility had isolation bins with foot pedals and she would put them into use. d. Observation and interview of the COVID-19 designated unit on 5/20/20 at 11:50 AM with the DON identified an alcove off of the resident unit with a yellow isolation gown hanging from the door frame. The DON identified that it was unclear when the gown was hung there, but all isolation gowns should be removed before leaving a resident's room and should not be hanging on the door. Review of CDC guidelines identified that disposable gowns should be disposed of in a dedicated container for waste or linen. e) Observation and interview with the DON on 5/20/20 at 1:00 PM identified that the facility was re-using face shields. The staff clean the face shields with alcohol wipes and place them in brown paper bags. Observation with the DON of the alcohol wipes used to disinfect the face shields identified that the facility was using micro-kill plus wipes with an [MEDICATION NAME] alcohol content of 41.58%. The label on the wipes did not identify that it was effective against [DIAGNOSES REDACTED] or human [MEDICAL CONDITION]. The alcohol wipes were not listed as an approved Environmental Protective Agency (EPA) approved disinfectant for the human [MEDICAL CONDITION]. Interview with the DON on 5/20/20 at 1:15 PM identified that she thought that the alcohol wipes had an alcohol concentration of 70% or more, and did not realize that the alcohol concentration was only 41.58 %. The DON further identified that the Center for Disease Control (CDC) guidelines required a disinfectant to be 70% or more alcohol concentration. The DON identified that they would be in-servicing the staff to use a different disinfectant with a higher alcohol concentration of 72.5 % and that was listed as effective against the human [MEDICAL CONDITION]. Review of the CDC guidelines identified that alcohol solutions with at least 70 % alcohol concentration may be used as a disinfectant against the human [MEDICAL CONDITION]. The CDC further recommended to carefully wipe the outside of the face shield with an EPA registered hospital disinfectant solution.

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.