STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075381	A. BUILDING _____ B. WING _____	08/26/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WATER'S EDGE CENTER FOR HEALTH & REHAB	**111 CHURCH STREET MIDDLETOWN, CT 06457**

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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews and a review of the facility documentation for three of five residents (Resident #2, #3, and #4), reviewed for droplet precautions, the facility failed to ensure infection control practices were followed for residents during rehabilitation services, and failed to ensure proper personal protective equipment was utilized by a therapist during a therapy session in accordance with current infection control guidelines for individuals under investigation for COVID -19. The findings include: 1.Resident #2 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A physician order [REDACTED]. The resident care plan dated 8/25/20 identified Resident #2 required transmission-based precautions upon admission/readmission relating to unknown COVID-19 status or potential COVID-19 exposure. Interventions directed contact/droplet precautions. 2. Resident #3 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A physician order [REDACTED]. The resident care plan dated 8/20/20 identified Resident #3 required transmission-based precautions upon admission/readmission related to unknown COVID-19 status or potential COVID-19 exposure. Interventions directed contact/droplet precautions. 3. Resident #4 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A physician order [REDACTED]. Observation during the tour of the facility with RN #1 (Infection Preventionist), on 8/26/20 at 9:55 AM identified Resident #2, #3 and #4 were located in the rehabilitation gym. Resident #2 was walking in the middle of the gym with a hemi walker assisted by OTA #1. OTA #1 supported Resident #2's arm with one hand, and utilized a gait belt with his other hand, while another therapist was closely following Resident #2 with a wheelchair. Resident #2 had a face mask on, and OTA #1 was wearing an N95 mask and goggles. Resident #3 was sitting in his/her wheelchair close to the exit door and was performing upper body exercise with COTA #1. Resident #3 had a face mask on, and COTA #1 had a N95 mask and goggles on. Resident #4 was sitting in his/her wheelchair by the window and resting. Resident #4 had a face mask on. Interview with RN #1 at the time of observation identified that Resident #2 and Resident #3 were on 14-day quarantine and required transmission-based precautions and Resident #4 did not require transmission-based precautions. Further observation identified Resident #4 ambulating in the hallway on 8/26/20 at 10:01 AM. Interview with PT #1 on 8/26/20 at 10:17 AM identified she transported Resident #4 to the rehabilitation gym at approximately 9:25 AM from the COVID negative unit. PT #1 indicated Resident #4 was brought to the gym to perform a balance and a walking test. PT #1 identified the tests were conducted with the treatment and Resident #4 was resting when Resident #2 and Resident #3 were brought into the gym. PT #1 indicated during this time she was filling out Resident #4's discharge paperwork and then they were going to walk back to Resident #4's room. PT #1 indicated since Resident #4 was from the non-observation unit, she saw him/her first. PT #1 identified the rehabilitation director made the schedule for residents to be seen for the day and it was up to the therapist how they scheduled the treatment sessions. PT #1 indicated she did not know the schedule for Resident #2 and Resident #3. Interview with COTA #1 on 8/26/20 at 10:39 AM identified she brought Resident #3 into the rehabilitation gym around 9:45 AM for treatment from the observation unit. Resident #3 was tentatively scheduled for that time and COTA #1 assumed residents from the non-observation unit were already finished with their therapy. COTA #1 identified when she entered the gym with Resident #3 from the observation unit, Resident #4 from the non-observation unit was still in the gym. COTA #1 indicated she saw Resident #4 sitting with the walker in front of him/her and getting ready to leave, however she was focused on Resident #3 and directed her attention to Resident #3. COTA #1 identified she was aware she had to start therapy with non-exposed residents first. COTA #1 identified it was poor judgement on her part that Resident #4 was in the gym with Resident #2 and #3. COTA #1 indicated she should have waited for Resident #4 to leave the gym before bringing Resident #3 into the gym for treatment. Interview with OTA #1 on 8/26/20 at 10:55 AM identified he was treating Resident #2 and he/she resided on the observation unit. OTA #1 indicated as he brought Resident #2 into the gym around 9:45 AM, Resident #4 was in the gym. COTA #1 identified he knew Resident #4 resided on a non-observation unit. OTA #1 indicated that if he came into the gym and was able to distance residents 6 feet apart and there was enough space for social distancing than he could treat residents from the observation unit and non-observation unit in the gym at the same time. Interview with the Director of Nursing (DON) and RN #1 on 8/26/20 at 11:09 AM identified Resident #4 was finishing up his/her therapy session when Resident #2 and Resident #3 were brought into the gym. RN #1 indicated there was an overlap of about 10 minutes while residents from the observation unit and resident from non-observation unit where in the gym. The DON indicated therapy staff should have waited until Resident #4 left the gym, sanitized the equipment used by the prior resident before bringing the other 2 residents from the observation unit into the gym. The facility failed to isolate and treat residents on COVID-19 negative unit first followed by COVID-19 quarantined residents for the last rehabilitation sessions of the day in accordance with the facility protocol. Interview with OTA #1 on 8/26/20 at 10:55 AM identified he was using a gait belt for walking and he was supporting Resident #2's left upper extremity due to a non-weight bearing status. OTA #1 indicated that wearing N95 mask and goggles was sufficient during the treatment of [REDACTED]. Interview with DON and RN #1 on 8/26/20 at 11:09 AM identified if a therapist was providing direct care and OTA #1 should have worn an isolation gown in addition to N95 mask and goggles. The COVID-19 infection control guidance for nursing homes dated 6/22/20 directed in part that short term rehabilitation (STR) patients that required the use of the rehabilitation gym should meet criteria for transmission-based precautions. The Department of Public Health offered the following infection control considerations: schedule quarantine residents for the last rehabilitation session(s) of the day, full transmission-based PPE should be worn by the therapist(s), if multiple residents were allowed in the gym at the same time, they should be appropriately physically distanced and any equipment used should be adequately disinfected between uses.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE