STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075417	A. BUILDING _____ B. WING _____	08/19/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
THREE RIVERS	60 CROUCH AVENUE NORWICH, CT 06360

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 -** Immediate jeopardy **Residents Affected -** Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of facility documentation, facility policies and staff interviews for 20 of 20 residents (Resident #'s #2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15. 16, 17, 18, 19, 20, and 21) located on the A and B units, the facility failed to ensure appropriate cohorting of residents to prevent the transmission of COVID-19, failed to utilize Personal Protective Equipment (PPE) in accordance with Centers for Disease Prevention and Control (CDC) standards, failed to ensure appropriate designation of staff, and failed to maintain an updated, accurate or accessible outbreak listing of the COVID-19 status of the residents. The facility further failed to ensure that a required fourteen-day quarantine was maintained for the only resident reviewed for the implementation of the facility's COVID-19 protocols for residents with possible exposure or whose COVID-19 status was under investigation (Resident #1) and failed to ensure that an aerosolized medication was administered to Resident #1 in a manner consistent with current infection control standards. The facility also failed to ensure that visitor screening regarding a person's recent travel history was conducted in accordance with an Executive Order dated 6/25/20 that was issued by the Governor of the State of Connecticut. Additionally, the facility failed to ensure appropriate storage of reusable isolation gowns to maintain infection control standards. The failure of the facility to implement the necessary measures to prevent the transmission of infection was determined to constitute a finding of Immediate Jeopardy. The findings include: 1. On entrance to the facility on [DATE], documentation was requested to identify and locate residents according to their cohorted status. Interview with the Director of Nursing Services (DNS) and RN #1 on 8/17/20 at 10:45 AM and review of documentation of the COVID-19 status of the residents identified that the facility failed to maintain an accurate or current listing. The DNS stated that although the list indicated Resident #1 was under investigation for COVID-19, the precautions had been discontinued. Although the DNS stated that the list would be revised, subsequent review of Resident #1's record on 8/18/20 and interview with the Infection Preventionist identified that the precautions had been removed prior to the required 14-day recommendation. RN #3 subsequently placed Resident #1 back on transmission-based precautions for the remaining time period. Further interview and review of the facility cohorting strategy with the DNS on 8/17/20 at 11:30 AM identified that the first resident tested positive for COVID-19 on 8/2/20 at the hospital. The A Unit, as planned, was designated as the COVID-19 positive unit. The DNS stated that as more testing results became available, the unit could not accommodate all the residents who were under investigation or who had tested positive for COVID-19. The DNS identified that she had not instituted a plan for three distinct units and residents who were positive, negative and under investigation for COVID-19 were interspersed on the A and B Units. Continued interview with the DNS and RN#1 on 8/17/20 at 11:45 AM and review of the facility's bed board which identified the location and COVID-19 status of the residents, identified that both COVID-19 positive and negative residents were located on the B Unit and that residents COVID-19 positive and/or under investigation were located on the A Unit. Subsequent to surveyor inquiry, the facility adapted a new cohorting strategy that included three distinct areas, COVID-19 positive, negative and residents under investigation. The DNS and RN #1 identified a plan in which the B Unit would now be used to house Residents with a status of COVID-19 positive, Resident #'s 2, 3, 4, 5, 6, 8, 15, 16 and 17 in the rooms furthest from the nursing station and residents under investigation, Resident #'s 18, 19, 20 and 21 in the rooms closest to the nursing station. Additionally, A Unit would house those residents who had previously tested negative for COVID-19, Resident #'s 7, 9, 10, 11, 12, 13 and 14. The DNS and facility Administrator identified that room changes would occur immediately ensuring terminal cleaning of rooms and appropriate use of PPE use. Interview and review of the facility cohorting strategy roster on 8/18/20 at 10:44 AM with the DNS identified two previously negative residents, Resident #12 and #13, had developed symptoms of COVID-19 and were moved to the B Unit with residents under investigation. Resident #13, on 8/18/20, subsequently experienced a decline in condition and was sent emergently to the hospital. Interview with the Administrator on 8/19/20 at 3:15 PM identified that Resident #13 had tested positive in the hospital, for COVID-19. Review of the facility policy on Cohorting of Residents during the Pandemic of COVID-19 in 2020 identified, in part, that careful consideration of room assignment is important for residents who have COVID-19 or who are suspected of having COVID-19. Rooms with residents who are on precautions secondary to suspected or confirmed COVID-19 will be grouped on a specific unit, wing or section of the unit. This will allow staff to care for groups of residents who are positive for [MEDICAL CONDITION] without passing areas or rooms where residents are negative for [MEDICAL CONDITION]. Further, daily review of room assignment and resident status will take place as part of the facility clinical rounds and start up meeting. Changes will be made on a daily basis (or more if necessary) to ensure that resident placement is appropriate. A room or rooms will be designated for use on off shifts when a resident becomes symptomatic. (not when the test results return). The resident is to be moved to the designated precaution room at the time the resident becomes symptomatic or has reason to be investigated for COVID-19. 2. Interview and review of facility staffing with the DNS on 8/17/20 at 11:30 AM identified that the facility staffing dated 8/17/20 for the A and B Units had one nurse and two NA to care for the twenty residents on the first floor. The DNS identified that she was unable to implement a plan for designated staff to care exclusively for COVID-19 positive residents, residents under investigation, or for negative residents due to a lack of available staff. The DNS identified that although she had requested staff for several weeks from the only staffing agency with which the facility had a contract, the agency was not able to provide additional staff. The DNS identified that she has utilized licensed nurses to perform NA duties in order to ensure timely care for residents. Although the DNS identified they had reached out to the corporate office, they were unable to provide any additional staffing relief. The DNS indicated that she also has been working to cover shifts as a Nursing Supervisor. 3. During a tour of the facility on the A and B Units with the DNS on 8/17/20 at 3:37 PM Housekeeper #1 was observed wearing an N-95 mask with a valve. Housekeeper #1 identified that the facility had provided her with the mask at the beginning of the shift. The DNS stated that she should not have been given a mask with a valve. Interview and review of facility documentation with the DNS on 8/17/20 at 3:32 PM identified that RN #2 worked as an RN Supervisor every Friday on the 11:00 PM to 7:00 AM shift. The DNS identified that RN #2 was the resident representative of Resident #22 and had visited with him/her prior to working 7/24/20. The DNS stated that when s/he supervised the visit it was necessary to repeatedly ask RN #2 to replace his/her mask and step back to maintain the required social distancing from Resident #22. The DNS identified that on 7/24/20, RN #2 worked on the 3:00 PM to 11:00 PM shift and 11:00 PM to 7:00 AM shift on 7/24/20. The DNS stated that RN #2 had been tested for COVID-19 during facility wide, routine, staff COVID-19 testing prior to beginning the two shifts on 7/24/20. The DNS identified that RN #2's positive COVID-19 test results were obtained on 7/27/20 and RN #2 had not worked in the facility since completing the two shifts. The DNS further identified that RN #2 had worked with LPN #1 on the 11:00 PM to 7:00 AM shift on 7/24/20 and LPN #1 subsequently tested positive for COVID-19. The DNS identified that RN #2 had vacationed out of state prior to 7/24/20. The DNS stated that she was unaware of the nurse's possible exposure to COVID-19 until after RN #2 received the positive test results on 7/27/20. Interview with LPN #1 on 8/19/20 at 10:47 AM indicated that she had tested positive for COVID-19. LPN #1 stated that when she reported to work on 7/24/20 for the 11 PM to 7 AM shift, RN #2 indicated that she was

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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F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 1) not feeling well. During the shift on 7/24/20 LPN #1 further stated RN #2 had indicated that family members visiting from another state were awaiting pending COVID-19 test results. When RN #2 indicated she was experiencing sinus issues, LPN #1 asked her to move away. LPN #1 identified that when RN #2 tested positive for COVID-19, the facility moved Resident #22 to the A Unit where residents were quarantined and under investigation. LPN #1 identified that there were only two staff on the night shift for the A and B units and that residents who were under quarantine received care from the same staff who worked on the negative unit. Interview with LPN #2 on 8/19/20 at 11:17 AM identified she worked on 7/24/20 on the 3:00 PM to 11:00 PM shift when RN #2 was the Supervisor. LPN #2 identified that she had a conversation with RN #2, who indicated she had gone on an out of state vacation with family members, noting that one family member had been exposed to COVID-19. LPN #2 stated that during the conversation on the unit, RN #2 was not wearing a mask. LPN #2 indicated she did not address RN#2's failure to use a mask. LPN #2 also stated that RN #2 had stated she was not feeling well. LPN #2 stated that she was responsible to care for residents who had tested positive as well as residents who were under investigation for COVID-19 when she was assigned on the A and B Units. Interview with RN #2 on 8/19/20 at 11:56 AM identified that she was tested for COVID-19 on 7/24/20 and received the positive results on 7/27/20. RN #2 identified the testing occurred during routine staff screening. RN #2 identified that two family members were tested and confirmed positive for COVID-19 on 7/26/20. RN #2 identified that she had been exposed to both family members and she knew there was a possibility that she would test positive. RN #2 stated that she had been with several family members the previous weekend, two of which were the family members who had tested positive on 7/26/20. A written interview with the DNS on 8/19/20 received at 2:48 PM identified that on 8/15/20 ten new positive COVID-19 cases were identified, and that A-Unit could not house all the residents who had changes to their COVID-19 status. The DNS identified that the Infection Preventionist was responsible to implement cohorting plans. Interview with LPN #4 on 8/19/20 at 3:20 PM identified that around the middle of July RN #2 had stated that two family members had contracted COVID-19. LPN #4 identified that RN #2 would lower her face mask down to talk to staff. LPN #4 identified that although she did not request RN #2 to properly wear her mask when she spoke, she and other staff kept their distance and kept their masks in place. LPN #4 identified that prior to the last time she worked, approximately 10 days ago, staff asked both licensed nurses and the DNS why they were working with negative, positive, and persons under investigation for COVID-19 on the same shift. Interview with NA #2 on 8/19/20 at 3:30 PM identified that she had worked on both the A and B Units and had taken care of all the residents on both units on the same shift regardless of their COVID-19 status. Interview with NA #3 on 8/19/20 at 3:35 PM identified that she had worked on 7/24/20 with RN #2 and had observed RN #2 speaking with other nurse's without the benefit of a mask. Interview with NA #4 on 8/19/20 at 3:45 PM stated that although s/he had observed LPN #1 without a mask in place, s/he had never observed RN #2 without a mask. NA #4 identified that s/he had been responsible to take care of all residents on the first floor on both the A and B Units regardless of their COVID-19 status. Interview with NA #5 on 8/19/20 at 3:58 PM identified that s/he had taken care of residents, during the same shift, who were negative, positive and under investigation for COVID-19. NA #5 indicated that s/he had observed RN #2 without the benefit of a mask mostly at the nurse's station. NA #5 identified that LPN #1 would go to the nurse's station, remove his/her mask and turn on the fans. Review of the facility infection control Guidelines for patients with confirmed COVID-19 policy identified, in part that CDC recommended guidelines for infection control practices related to newly identified COVID-19 virus will be followed and updated as new information is released by the CDC as well as state and local guidelines. Additionally, managing ill and exposed health care personnel identified that employees that fall within the CDC guidelines or persons being potentially exposed/infected with be handled according to CDC guidelines that are in place at the time the employee is exposed. Review of the facility masking policy identified, in part, that masks will be worn at all times during the shift, masks will be in proper position at all times and should not be pulled below the nose or mouth. According to CDC guidance for Health Care Personnel (HCP) updated 6/25/20: The facility should educate and train HCP including facility based and consultant personnel who provide care or services in the facility. The facility should reinforce sick leave policies and remind HCP not to report to work when ill. Healthcare personnel should wear a facemask at all times while in the facility. The facility should also reinforce adherence to standard infection prevention and control measures including hand hygiene and selection and correct use of personal protective equipment. 4. Interview with the Infection Preventionist, RN #3, on 8/17/20 at 11:00 AM identified that s/he was currently working to update the COVID-19 outbreak line listing of resident infection test results that were received on the weekend of 8/15/20. RN #3 identified that s/he had not left a line list for the A or B Unit staff to utilize or update over the weekend. 5. Observation in the kitchen hallway with the DNS on 8/17/20 at 10 AM identified three blue gowns utilized by dietary staff, one hanging on a hook on the wall touching a meal delivery cart, another gown touching the portable ice chest as well as the mop bucket and handle, and a third gown hanging on an empty hand sanitizer container and touching a second ice chest with clothes in a plastic bag and other items on the portable ice chest cart. Interview with RN #1 on 8/17/20 at 10:18 AM identified that s/he had placed hooks in the hall to store the reusable gowns for kitchen staff to deliver the meals to the area outside the closed doors on the A and B COVID positive Units. RN #1 identified that the reusable gowns should not have been touching any items and that s/he had previously cleared the area of all items to ensure that nothing was near the gowns. 6. Interview and observation during a facility tour with the DNS on 8/17/20 at 4:00 PM identified Resident #1 in his/her room in bed receiving a nebulizer treatment with the door to the room open. During the initial interview on entry on 8/17/20, the DNS indicated that Resident #1 had been removed as a resident under investigation. Resident #1 was noted not to have any transmission-based precaution signs or PPE bins outside of his/her room. Interview with LPN #2 on 8/17/20 at 4:11 PM identified that she knew that the door to the room should be closed when administering nebulizer treatments during the COVID-19 pandemic, but that Resident #1 was known to pull off the nebulizer mask. LPN #2 identified that she had to keep checking on Resident #1 every few minutes to ensure placement. LPN #2 identified that Resident #1 was not oriented and was not capable of self-administering his/her nebulizer treatment. Resident #1's [DIAGNOSES REDACTED]. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had both long- and short-term memory deficits and required was totally dependent on staff for activities of daily living. A review of Resident #1's clinical record identified a physician's order dated 8/7/20 that directed Resident #1 be placed on droplet precautions for 14 days. Further, a physician's order dated 8/17/20 directed to discontinue Resident #1's droplet precautions (12 days after test results were received and 10 days after the physician's order directed droplet precautions). Review of the self-administration of medication assessment dated [DATE] identified that Resident #1 was unable to safely self-administer medications. Interview and review of Resident #1's COVID-19 status with RN #3, the Infection Preventionist on 8/18/20 at 5:15 PM identified that Resident #1's roommate, Resident #21 was tested on [DATE] and determined to be COVID-19 positive on 8/5/20 transmission based precautions were implemented for a resident under investigation/exposed and Resident #21 was moved out of the room. RN #3 identified that Resident #1 should not have had precautions discontinued until 8/19/20 and that the door should have been closed for the aerosolized nebulizer treatment. Subsequent to surveyor inquiry, Resident #1 was placed back on transmission-based precautions. Interview with the Administrator on 8/18/20 at 5:39 PM identified that RN #3 was responsible to ensure that residents under investigation for COVID-19 received a full 14-day quarantine and that RN #3 was the staff member responsible to remove Resident #1 from transmission-based precautions. Interview with RN #4, the Corporate Nurse on 8/19/20 at 9:56 AM identified that the facility protocol was to inform the Corporate Infection Preventionist of any aerosolized nebulizer treatments that could not be replaced with other medications or eliminated. Although requested, the facility failed to provide documentation that the physician had assessed the Resident #1 for the use of alternative inhalation therapy and failed to provide a respiratory resident care plan. 7. Interview and review of facility visitor sign in documentation dated 7/9/20 and 7/23/20 with the Administrator on 8/19/20 at 2:17 PM identified that the facility screening document did not include an out of state travel question following the implementation of the Governor's Executive order that went into effect 6/25/20. The Administrator identified that the facility received visitation and staff screening forms from their corporate office and that the last update to the form that she had received was dated 6/17/20. According to CDC guidance updated 6/25/20 the facility should establish polices and procedures for managing, screening, educating and training all visitors.