STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075017	A. BUILDING _____ B. WING _____	06/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MONTOWESE HEALTH & REHABILITATION CENTER	**163 QUINNIPIAC AVENUE NORTH HAVEN, CT 06473**

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 review of facility documentation, review of facility policy, and interviews, for one of three Residents reviewed, (Resident #2), the facility failed to notify the Resident Representative and the Advanced Practice Registered Nurse (APRN) for a change in condition during the COVID-19 pandemic. The findings include: Resident #2's [DIAGNOSES REDACTED]. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 was moderately cognitively impaired and required extensive assistance with bed mobility, transfers, dressing, and personal hygiene. An APRN note dated 4/11/2020 directed a COVID-19 swab. Review of the laboratory results dated [DATE] identified Resident #2 was COVID-19 positive. The Resident Care Plan (RCP) dated 4/13/2020 identified Resident #2 had an actual COVID-19 infection. Interventions directed to place Resident #2 on transmission-based precautions as ordered, conduct vital signs as indicated, follow up with the physician/APRN if indicated. 1. The nurse's note dated 5/16/2020 at 11:28 PM identified that at approximately 11:00 PM, Resident #2 was observed laying supine on the floor near the foot of the bed. Resident was hallucinating saying, I am looking for the six cats. The physician's orders [REDACTED]. Interview and review of facility documentation, APRN notes, nurse's notes and physician order's with APRN #1 on 6/4/2020 at 3:15 PM, identified that although he/she had been notified Resident #2 had fallen, she not been notified that Resident #2 had been searching for six cats when he/she fell . Additionally, if he/she had been made aware of the hallucination, APRN #1 may have started an antibiotic sooner, however, the antibiotic was started approximately twelve hours later. APRN #1 identified that Resident #2 was diagnosed with [REDACTED]. 2. The nurse's progress note dated 5/17/2020 at 2:34 PM identified that Resident #2 was positive for a right upper lobe pneumonia with an intermittent non-productive cough. APRN #1 was made aware and ordered an antibiotic for 10 days. Interview and review of facility documentation, nurse's notes, and APRN notes with the Director of Nursing (DNS) on 6/4/2020 at 2:38 PM identified that although the wing nurse was made aware of the new physician's orders [REDACTED]. Additionally, although APRN #1 spoke with the resident representative frequently, the DNS could not find any documentation that he/she had done so. The DNS identified that the facility is supposed to document when notifications are completed. Interview and review of facility documentation, nurse's notes, and APRN notes, with APRN #1 on 6/4/2020 at 3:15 PM identified that Resident #2 had become ill over the weekend when he/she was not at the facility and that he/she had directed the nurse on the unit to call the Resident Representative. APRN #1 was unable to find any documentation that the Resident Representative was notified.
F 0583 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Keep residents' personal and medical records private and confidential.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility documentation, review of facility policy, and interviews, for the only Resident reviewed for privacy, (Resident #6), the facility failed to ensure a medical discussion was conducted to ensure privacy. The findings include: Resident #6 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Interview with Resident #6 on 6/4/2020 at 11:20 AM identified that his/her privacy was violated when Advanced Practice Registered Nurse (APRN) #2, in front of Resident #6's roommate, identified personal information about Resident #6, prior to coming to the facility. Resident #6 identified that his/her privacy was violated and that he/she was upset due to his/her roommate overhearing the conversation which he/she felt should have been discussed privately. Interview with APRN #2 on 6/4/2020 at 2:25 PM identified that Resident #6 was requesting pain medication. APRN #2 identified that he/she was trying to educate Resident #6 on the use of opioids being contraindicated due to another medication that Resident #6 was receiving. APRN #2 identified that he/she had talked to Resident #6 in his/her room due to the COVID-19 pandemic and that he/she had no other options to speak privately with Resident #6 as Resident #6 was quarantined to his/her room due to his/her new admission status. APRN #2 identified that Resident #6 had been upset that his/her roommate had overheard the conversation. The facility failed to ensure interventions were in place to ensure a discussion regarding personal medical information could be conducted to ensure privacy.
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 observations, review of facility documentation, review of facility policy, and interviews, for one of three Residents reviewed, (Resident #2), the facility failed to monitor vital signs according to Advanced Practice Registered Nurse (APRN) orders during the COVID-19 pandemic. The findings include: Resident #2's [DIAGNOSES REDACTED]. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 was moderately cognitively impaired and required extensive assistance with bed mobility, transfers, dressing and personal hygiene. An APRN note dated 4/11/2020 directed a COVID-19 swab. Review of the laboratory results dated [DATE] identified Resident #2 was COVID-19 positive. The Resident Care Plan (RCP) dated 4/13/2020 identified Resident #2 had an actual COVID-19 infection. Interventions directed to place on transmission-based precautions as ordered, conduct vital signs as indicated, follow up with the physician/APRN. A physician's orders [REDACTED]. APRN notes dated 4/21/2020, 4/22/2020, 4/23/2020, 4/24/2020, 4/25/2020, 4/26/2020, 4/27/2020 (monitor closely), 4/28/2020, 4/29/2020, 5/5/2020, 5/7/2020, 5/19/2020, and 5/20/2020 identified Resident #2 was COVID-19 positive and that temperature and respiratory status should be monitored closely. Interview and review of facility documentation, vital signs, nurse's notes and treatment administration records with the Director of Nurses (DNS) on 6/4/2020 at 2:38 PM identified that the facility every four-hour monitoring and vital sign documentation was incomplete for Resident #2. It was noted that from 4/21/2020 through 5/21/2020 on the 11:00PM to 7:00AM shift all or part of the facility monitoring documentation was lacking for 8 out of 32 opportunities; on the 7:00AM to 3:00PM shift all or part of the facility monitoring documentation was lacking 13 out of 34 opportunities; and on the 3:00PM-11:00PM shift, all or part of the facility monitoring documentation was lacking for 19 out of 33 opportunities. The DNS identified that he/she would expect the facility staff to follow the physician's orders [REDACTED].
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, review of facility documentation, review of facility policy, and interviews, the facility failed to ensure appropriate use of Personal Protective Equipment (PPE) during the COVID-19 pandemic. The findings include: 1. Resident #4 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The Resident Care Plan (RCP) dated 6/4/2020 identified Resident #4 was on COVID-19 precautions due to new admission status. Interventions directed to maintain

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 -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) transmission-based precautions as ordered or indicated. 2. Resident #5 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #5 was without cognitive impairment and required extensive assistance with bed mobility, transfers, dressing, toilet use, and personal hygiene. A Point Prevalence test dated 5/27/2020 identified Resident #5 was negative for COVID-19. During a tour of the facility with Registered Nurse (RN) #1, an observation on 6/4/2020 at 11:30 AM of Housekeeper #1 identified he/she went into Resident #4's room wearing gloves, mask, gown, and face shield. A PPE cart was noted outside of Resident #4's door as well as a sign indicating transmission-based precautions. Housekeeper #1 then exited Resident #4's room wearing the same PPE and entered Resident #5's room. There was no signage or PPE cart noted outside of Resident #5's room. Housekeeper #1 was about to re-enter Resident #4's room and was stopped by the surveyor. Interview with Housekeeper #1 on 6/4/2020 at 11:30 AM identified that Resident #4 was on droplet precautions and that he/she should have removed her PPE prior to going into Resident #5's room. Housekeeper #1 identified that he/she had gone into Resident #4's room to clean the bathroom and when he/she realized he/she did not have his/her cleaning equipment, he/she went across the hall into Resident #5's room to retrieve the items he/she had left there. Interview with RN #1, the Infection Preventionist, on 6/4/2020 at 11:32 AM identified that Resident #4 was on a 14-day quarantine (suspected COVID-19) due to his/her new admission status as are all new admissions. RN #1 identified that Housekeeper #1 should have removed his/her PPE prior to going into Resident #5's room. RN #1 identified that Housekeeper was a new employee and that he/she was last in-serviced on PPE use during an orientation that occurred on 4/22/2020.