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 _____	10/17/2020

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 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** 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. Interview with Licensed Practical Nurse (LPN) #1 on 10/17/20 at 9:45 AM identified that he/she had to excuse him/herself from the interview because he/she had to obtain a surgical mask for Nurse Aide (NA) #1. Observation identified LPN #1 go and retrieve a surgical mask for NA #1, and when LPN #1 approached NA#1, NA #1 already had a surgical mask on over a cloth mask. Further interview with LPN #1 identified that he/she had observed the NA at the beginning of the shift (7:00 AM) with a cloth mask, and had seen NA #1 subsequently in the hallway several times with only the cloth mask. LPN #1 stated that upon surveyor entry onto the nursing unit NA#1 asked for a surgical mask to place over the cloth mask. LPN #1 stated that he/she did not instruct the NA to don a surgical mask at the beginning of the shift because nothing came to mind when she saw her, and furthermore that when he/she approached NA#1 to give him/her the surgical mask to cover the cloth mask NA#1 had already obtained a surgical mask elsewhere and had applied it over the cloth mask. Interview and observation of NA #1 at 9:47 AM on 10/17/20 identified that he/she was wearing a surgical mask over the cloth mask. NA #1 stated that he/she likes to wear the cloth mask, but wears a surgical mask over the cloth mask. NA #1 further identified that he/she had been wearing the surgical mask over the cloth since the beginning of the shift while caring for residents. Clarification was made with LPN #1 on 10/17/20 at 9:50 AM that NA#1 was wearing only a cloth mask from the beginning of the shift until surveyor entry onto the unit at 9:45 AM when NA #1 asked LPN #1 for a surgical mask, and that NA #1 must have found a mask elsewhere to apply prior to LPN #1 finding one. Review of the mask use guidance for the facility identified that a facemask should be used instead of a cloth face covering and is recommended for health care providers because a facemask offers both source control and protection from exposure to splashes and sprays of infectious material from others. Interview with the Director of Nurses (DNS) on 10/17/20 at 1:45 PM identified that all staff in the facility should be wearing surgical masks. b. Observation on 10/17/20 at 9:50 AM on the D unit identified that Resident #1 and Resident #2 (both Covid 19 negative residents) were sitting in close proximity to each other, at a small table, both unmasked. Resident #1 had just finished breakfast and Resident #2 was continuing to eat his/her breakfast. Observation and interview at 9:51 AM with the 7:00 AM to 3:00 PM Supervisor (RN #1) identified that the residents were unable to self-propel in their wheelchairs, so they had to be placed at the table by staff. RN #1 further identified that the residents were sitting approximately 2 feet apart at the table without masks and should have been at least six feet apart while eating because they were not wearing masks. Interview with NA #2 on 10/17/20 at 9:52 AM identified that when he/she brought Resident #1 to the table there was no other residents seated at that table and he/she did not place Resident #2 at the table. Interview with NA #3 and #4 on 10/17/20 at 10:00 AM who were the only other NA's on the D unit identified they did not seat Resident #2 in close proximity to Resident #1 at the table. Further interview with RN #1 on 10/17/20 at 10:30 AM identified that he/she was under the impression that it was NA #4 who placed Resident #2 at the table with Resident #1. Review of the Covid 19 dining activity policy identified that residents will be allowed to dine in a common area six (6) feet apart. c. Interview on the Covid-19 observation unit 10/17/20 at 11:25 AM with NA #5 identified that he/she wears his/her face shield when he/she goes into and out of the droplet precaution rooms and cleans the face shield at the end of his/her shift with soap and water and stores it in a bag until his/her next scheduled day to work. Interview on the Covid-19 observation unit on 10/17/20 at 11:30 AM with NA #6 identified that he/she wears his/her face shield when he/she enters the droplet precaution rooms and at the end of the shift he/she washes the face shield with soap and water and places it in a bag to store until his/her next scheduled day to work. Interview with the Administrator on 10/17/20 at 2:00 PM identified that the NA's should be cleaning their face shields with an alcohol wipe or an EPA approved disinfectant when they are finished working for the day, and store it appropriately until their next scheduled day to work. Review of the face shield use policy identified that the same face shields may be worn on a designated unit, but the face shield needs to be cleaned and disinfected with a neutral detergent and warm water and then rinsed with water. This should be completed when leaving the unit and then store the face shield in a clean area away from other personal protective equipment. d. Observation on 10/17/20 at 9:00 AM identified that upon entry into the building, the receptionist scanned the surveyor for a temperature reading, but the low battery signal was indicated. The receptionist informed the supervisor and the supervisor left the lobby area to obtain another thermometer. At 9:03 AM Physical Therapy Assistant (PTA) entered the building and was told by the receptionist that they were waiting for a replacement thermometer. The PTA stated that he/she was going into the physical therapy room and would be back to do his/her screening and have his/her temperature taken. At 9:19 AM (16 minutes after he/she initially entered the building) the PTA entered the lobby area, had his/her temperature taken, and completed the screening questions. Interview with the PTA on 10/17/20 at 9:20 AM identified that he/she went into the therapy room and set up for the day prior to being screened, but there were no residents or staff in the therapy room. Interview with the receptionist on 10/17/20 at 2:39 PM identified that he/she did not screen the PTA upon entry into the facility because the PTA stated that he/she would be back to be screened and that there was no one in the therapy gym at the time. He/She further identified that he/she is aware that screening should be done when the staff member initially enters the facility. Interview with the Administrator on 10/17/20 at 2:19 PM identified that although no other staff or residents were in the therapy gym with the PTA, staff should be screened as soon as they enter the facility, and the receptionist should have asked the PTA to wait to be screened before entering the therapy gym. Review of the facility screening policy identified that a temperature screening and surveillance questionnaire will be completed upon the arrival to the facility.
F 0886 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	Based on interviews from facility staff, the facility failed to have information on Covid 19 testing and screening practices of medical staff and contractors that entered the building that had contact with residents. The findings include: Interview with the Administrator on 10/17/20 at 2:13 PM identified that the facility was currently in their first round of staff testing, and that 25% or more of the staff were being tested every week. He/She stated that the Optometrist was in the building on 10/6/20, and although the Optometrist was screened upon entry into the facility, the facility did not have evidence of the Optometrist's Covid-19 testing result and/or if he/she was tested . The Administrator further identified that the Wound Care Physician (WCP) was in the building on 10/16/20 and although screened upon entry the facility did not have evidence of the WCP testing results and/or if the WCP was tested . The Administrator identified that he/she also did not have any evidence of the laboratory staff that enter the building regularly, and assumed that the WCP, the optometrist, and the laboratory staff had an employee screening policy in place, although he/she had not inquired and was unaware of the policies that were in place for screening of these providers, The Administrator further identified that resident transportation companies that arrive to pick the residents up for appointments are not screened because they do not enter the building (although they have contact with the facility residents when they leave the building for appointments). He/She further identified that he/she was unaware of the transportation companies screening policies. The Administrator stated

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.

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 _____	**10/17/2020**

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 0886 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) that he/she would be calling the Optometrist, WCP, laboratory, and the transportation company to inquire about screening/testing practices. A state agency blast fax 2020-90 dated September 23, 2020 directed nursing homes to test staff on a monthly basis (the executive order defines staff as all personnel working in a nursing home staff and includes but is not limited to medical staff, and contractors with a regular presence in the facility). Nursing homes with greater than 100 staff members will test 25% of their staff weekly, which will enable the facility to ensure that 100% of their staff tested monthly.
F 0908 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Keep all essential equipment working safely.** Based on observation and interviews for one resident (Resident #3) who had an electrical device in the room, the facility failed to ensure the electrical device was not a safety hazard. The findings include: Observation on 10/17/20 at 1:30 PM identified a loud buzzing sound upon entering Resident #3's room. Resident #3 stated that the buzzing noise was coming from his/her surge protector. Observation of the surge protector identified that it was making a loud buzzing sound and had one plug from the resident's television inserted into one of the eight plugs available and the surge protector itself was plugged into the facility electrical outlet in the wall. Resident #3 stated that he/she had been using the surge protector for as long as he can remember. Further observation failed to identify any evidence that the appliance had been inspected for safety by facility staff. Interview with the Administrator on 10/17/20 at 1:45 PM identified that he/she had contacted the Maintenance Director who was aware that the surge protector was being used by Resident #3, and thought the electrical device was appropriate for use in the facility. The Administrator further identified that all electrical equipment in the facility should be checked by the facility prior to use. The Administrator identified that the device would be removed and the television that the resident had plugged into the surge protector could be plugged into the wall outlet in the resident's room.