STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075377	A. BUILDING _____ B. WING _____	**07/07/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WEST RIVER REHAB CENTER	**245 ORANGE AVENUE MILFORD, CT 06460**

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, review of facility documentation, review of facility policy, and interviews, for one of seven residents reviewed, (Resident #1), the facility failed to appropriately monitor vital signs and failed to ensure appropriate use of Personal Protective Equipment (PPE) during the COVID-19 pandemic. The findings include: 1. Resident #1 ' s [DIAGNOSES REDACTED]. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 was without cognitive impairment, required extensive assistance with bed mobility and dressing, and required limited assistance with transfers and toilet use. The Resident Care Plan (RCP) dated 5/19/2020 identified a risk for alteration in mood state and psychosocial well being secondary to potential/actual room change secondary to COVID-19. Interventions directed to educate resident and family regarding COVID-19 cohorting guidelines. The nurse ' s note dated 5/21/20 at 4:22 PM identified that Resident #1 complained of not feeling well and not having an appetite. Resident #1 was noted to have a new order for lab work in the morning and Resident #1 had a temperature of 97.5. An Advanced Practice Registered Nurses (APRN) note dated 5/21/2020 identified that Resident #1 was seen for a poor intake, reported feeling fatigued and had body aches and muscle weakness was identified. The assessment identified malaise and fatigue. Impression identified blood work was ordered, fluids were to be encouraged, a recent COVID test was negative and notify the physician/APRN if fever or respiratory distress occurred. An APRN note dated 5/22/2020 identified that Resident #1 was seen for poor intake, feeling fatigued, and body aches and muscle weakness was identified. A temperature of 98.1 was identified. The assessment identified malaise and fatigue, labs within normal limits, will order STAT urinalysis, culture and sensitivity (UA C&S), STAT Kidney, ureter and bladder x-ray, and staff should monitor for fever. An APRN note dated 5/26/2020 identified that Resident #1 was seen for poor intake, reported feeling fatigue and body aches which had continued since last week. The UA C&S was noted to be negative; muscle and generalized weakness were noted. Resident #1 had a temperature of 98.8. The assessment identified malaise and fatigue. The impression identified a house supplement shake was ordered twice daily, COVID-19 swab ordered, results were pending and to monitor for fever. The Nurse ' s Note dated 5/27/20 at 10:49 PM identified that at approximately 6:15 PM he/she was called to the floor due to Resident #1 having a temperature of 103 and an oxygen level of 80% on room air. Resident #1 had oxygen placed and complained of nausea, the physician was notified, and the resident was sent to the Emergency Department of treatment and evaluation. Interview and review of facility documentation with the Director of Nurses (DNS) on 7/7/2020 at 4:40 PM identified that although the facility policy was to monitor every resident every shift for temperature changes since the onset of COVID-19, the DNS was unable to provide evidence that temperatures were being monitored for Resident #1. According to the clinical record from 5/1/2020 through 5/27/2020 Resident #1 ' s temperature had been taken six times on 5/21/20, 5/22/20, 5/26/20 and twice on 5/27/20, or a total of 6 out of 79 opportunities. Although the DNS identified that staff were using a paper to track the temperatures, he/she was unable to find the paper. Additionally, the DNS identified that the temperatures that had been taken should have been entered into Resident #1 ' s clinical record per the facility policy. The DNS identified that he/she had contacted Information Technology to locate Resident #1 ' s missing temperatures and was unable to explain why the remaining vital signs (blood pressure, pulse respirations and oxygen saturations) were all present in the vital sign results, and the temperatures were not. 2. A. Resident #6 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. B. Resident #7 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. During a tour of the facility observational unit on 7/6/2020 at 1:10 PM with the Administrator and DNS, it was identified that Nurse Aide (NA) #2 walked away from the dining delivery cart, entered Resident #6 ' s room wearing a short-sleeved hospital gown, with no gloves or face shield. Outside of Resident #6 ' s room were signs indicating that Resident #6 was on precautions. NA #2 then returned to the dining cart, placed Resident #6 ' s tray onto the cart, pushed the cart forward and walked into Resident #7 ' s room. Resident #7 also had signs indicating that he/she was on precautions. NA #2 was wearing the same PPE equipment and had not washed or sanitized his/her hands. NA #2 was stopped from coming out of Resident #7 ' s room by the Administrator and was told to remove his/her gown between rooms and was told by the DNS to wash his/her hands. Interview and review of facility policy with NA #2 identified that although he/she had recently been educated on PPE, NA #2 identified that sometimes it was just overwhelming. NA #2 identified that he/she had forgotten to remove her gown and discard it and reapply a new gown prior to entering the next room. NA #2 identified that he/she had also forgotten to wash her hands between rooms. Review of the facility policy with the DNS and Administrator on 7/6/2020 at 3:15 PM identified PPE needed to be changed and hands washed or sanitized when going between rooms.

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