STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075280	A. BUILDING _____ B. WING _____	**05/07/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WESTPORT REHABILITATION COMPLEX	**1 BURR ROAD WESTPORT, CT 06880**

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 a clinical record review, staff interviews, and a review of the facility policy for one sampled resident admitted to the hospital with [REDACTED].#1), the facility failed to notify the physician and responsible party timely, when the resident had symptoms of COVID-19 in accordance with the plan of care. The findings included: Resident #1's [DIAGNOSES REDACTED]. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified moderate cognitive impairment and required extensive assistance with activities of daily living. The care plan dated 3/11/20 identified the resident at risk for COVID-19 related to a widespread pandemic. Interventions directed to monitor the resident's temperate and oxygen saturation level. If the resident's temperature was over 100.4 degrees Fahrenheit and, and an oxygen saturation level was below 90%, to notify the physician. Interventions also directed to monitor for a cough, shortness of breath, headache, lack of appetite, throat and chest discomfort. Physician's orders dated 4/6/20 directed to administer [MEDICATION NAME] 1000 milligrams (mg) by mouth two times daily as needed for pain. Review of the nursing notes dated 4/21/20 identified Resident #1 was alert and responsive. A cough was noted, therefore, the resident was evaluated by an Advanced Practice Registered Nurse (APRN) and and order was obtained for [MEDICATION NAME] 10 milliliters (ml) as needed and a COVID-19 swab if the temperature went above 100.5 Fahrenheit (F). Review of 24-hour Change of Status Report dated 4/22/20 identified Resident #1 had a nonproductive cough, and [MEDICATION NAME] was given with relief. Review of the Nurse's Medication Notes dated 4/24/20 at 12:00 AM identified Resident #1 had temperature of 101.5 F and received Tylenol 650 mg. Further record review identified on 4/25/20 at 12:00 AM, the resident received Tylenol 1000 mg by mouth for an increased temperature. The resident received [MEDICATION NAME] 10 ml by mouth for a cough, however the time the [MEDICATION NAME] was administered was not documented. Review of 24-hour Change of Status Report dated 4/25/20 identified Resident #1 with 100.5 F temperature, lungs were clear, no shortness of breath was noted. Tylenol was administered for an elevated temperature. A repeat temperature was documented as 96.7 Fahrenheit. Review of the nursing notes dated 4/25/20 at 7:32 AM identified Resident #1 was alert and oriented. Lungs without wheezing or congestion, his/her skin was warm and dry. The resident's temperature was 100.5 F and Tylenol was administered for complaints of generalized discomfort. [MEDICATION NAME] was administered for a cough. A repeat temperature of 96.9 degrees F, pulse 88 beats/minute, a respiratory rate of 20 breaths/minute, a blood pressure of 146/88 and an oxygen saturation level of 95.5% on room air was noted. Review of the Medication Record identified initials of three nurses that identified Tylenol was administered on 4/24/20, 4/26/20. The resident was discharged to the hospital on [DATE]. Review of clinical record dated 4/26/20 identified Resident #1 became unresponsive, cardiopulmonary resuscitation was initiated, the resident was transferred to the hospital and admitted with a COVID-19 diagnosis. Interview with Person #1 (responsible party) on 5/7/20 at 9:20 AM identified he/she was not notified that Resident #1 was evaluated by APRN on 4/21/20 and new orders were implemented. Further interview identified the facility failed to notify Person #1 of the residents increased temperature and cough until 4/26/20 when the resident was transferred to the hospital. Interview with the Administrator on 5/7/20 at 4:00 PM identified the facility policy was to notify the physician and responsible party of any change in condition, or if the resident was suspected or diagnosed with [REDACTED].#1 were notified timely of the residents change in condition. The DNS stated the nursing staff was responsible to conduct an assessment of the resident, notify the physician, Person #1, and document both the assessment and notification to the physician and responsible party in the nursing notes and did not. Interview with MD #1 on 5/8/20 at 2:50 PM identified the nursing staff should have followed the physician's order and administered Tylenol 1000 mg for pain and not for elevated temperature. MD #1 further identified the facility should have assessed the resident and notified the physician on 4/24/20. MD #1 indicated if he/she was notified, dependent on the assessment and resident's condition, the on-call doctor most likely would have ordered Tylenol for the temperature and COVID-19 testing. Interview and record review with RN #4 on 5/13/20 at 6:00 AM identified on 4/24/20 at 12:00 AM she/he administered Tylenol 650 mg for temperature of 101.5 F because usually residents have physician's orders to administer Tylenol for a fever. RN #4 further identified she/he did not assess the resident and did not notify the physician or responsible party because the temperature went down to 96.6 F. Interview and record review with RN #1 on 5/11/20 at 9:20 PM identified that although on 4/25/20 she/he called the on call practitioner and Responsible Party (Person #1) to notify them about the temperature elevation and cough, she/he failed to document the notification in the residents clinical record and/or 24-hour Change of Status Report. RN #1 was unable to recall if she/he spoke to the on call APRN. RN #1 stated that she/he also called Person #1 to notify of change in condition but was not sure if she/he called the correct telephone number and possibly left a message for somebody else by mistake. Review of the facility Novel Coronavirus Prevention and Response identified the facility would monitor all residents daily for signs and symptoms of COVID-19. Staff would be alert to signs of COVID-19 and notify the resident's physician if a fever, cough, shortness of breath and a decreased in oxygen saturation levels occurred.
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 a clinical record review, staff interviews and a review of the facility documentation for one sampled resident admitted to the hospital with [REDACTED].#1), the facility failed to ensure an assessment and a diagnostic test was conducted with a change in condition and/or failed to administer medications in accordance with the physician's orders. The findings included: Resident #1's [DIAGNOSES REDACTED]. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified moderate cognitive impairment and extensive assistance with activities of daily living. The care plan dated 3/11/20 identified the resident was at risk for COVID-19 related to a widespread pandemic. Interventions directed to monitor the resident's temperate and oxygen saturation level. If the resident's temperature was over 100.4 degrees Fahrenheit and, an oxygen saturation level was below 90%, to notify the physician. Interventions also directed to monitor for a cough, shortness of breath, headache, lack of appetite, throat and chest discomfort. Physician's orders dated 4/6/20 directed to administer [MEDICATION NAME] 1000 milligrams (mg) by mouth two times daily as needed for pain. Review of the nursing notes dated 4/21/20 identified Resident #1 was alert and responsive. A cough was noted, therefore, the resident was evaluated by an Advanced Practice Registered Nurse (APRN) and and order was obtained for [MEDICATION NAME] 10 milliliters (ml) as needed and a COVID 19 swab for a temperature above 100.5 Fahrenheit (F). Review of 24-hour Change of Status Report dated 4/22/20 identified Resident #1 had a nonproductive cough, and [MEDICATION NAME] was administered with relief. Review of the Nurse's Medication Notes dated 4/24/20 at 12:00 AM identified Resident #1 had temperature of 101.5 F and received

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 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) Tylenol 650 mg. Further review identified on 4/25/20 at 12:00 AM, the resident received Tylenol 1000 mg by mouth for an increased temperature. The resident was also administered [MEDICATION NAME] 10 ml by mouth for cough, however the time the [MEDICATION NAME] was administered was not documented. Review of 24-hour Change of Status Report dated 4/25/20 identified Resident #1 with 100.5 F temperature, lungs were clear, shortness of breath was not noted. Tylenol was administered for an elevated temperature with effectiveness. Review of the nursing notes dated 4/25/20 at 7:32 AM identified Resident #1 was alert and oriented. Lungs were without wheezing or congestion, the resident's skin was warm and dry. Resident #1's temperature was 100.5 F. Tylenol was administered for complaints of generalized discomfort and [MEDICATION NAME] for a cough. A repeat temperature of 96.9 degrees Fahrenheit, a pulse of 88 beats/minute, a respiratory rate of 20 breaths/minute, a blood pressure of 146/88 and an oxygen saturation level of 95.5% on room air was noted. Review of the Medication Record identified initials of three nurses that indicated Tylenol was administered on 4/24/20, 4/25/20 and 4/26/20. The resident was discharged to the hospital on [DATE]. Review of clinical record dated 4/26/20 identified Resident #1 became unresponsive, cardiopulmonary resuscitation was initiated, the resident was transferred to the hospital and admitted with a COVID-19 diagnosis. 1.Interview and record review with RN #4 on 5/13/20 at 6:00 AM identified on 4/24/20 at 12:00 AM she/he administered Tylenol 650 mg to Resident #1 for a temperature of 101.5 F because usually residents have physician's orders to administer Tylenol for a fever. RN #4 further identified that although she/he administered Tylenol for the resident's elevated temperature, she/he questioned the accuracy of the temperature because the resident was not hot to touch. Further interview identified RN #4 did not conduct a comprehensive assessment of Resident #1 on 4/24/20 and did not notify the physician, conservator, and swab the resident in accordance with the physician's orders, because the temperature went down to 96.9 F, and the resident was alert. Interview with the Director of Nursing (DNS) on 5/7/20 at 4:05 PM and 5/8/20 at 2:22 PM indicated the nursing staff was responsible to conduct an assessment of Resident #1's temperature, lung sounds, cough, oxygen saturation and fluid intake every shift when respiratory symptoms were identified on 4/21/20. Review of the clinical record and facility documentation failed to provide evidence that consitent nursing assessments were conducted commencing 4/21/20 and when the resident had a change in condition (elevated temperature and persistent cough) on 4/24/20. Interview with MD #1 on 5/8/20 at 2:50 PM indicated the facility should have assessed Resident #1 on 4/24/20 when the cough persisted and a temperature elevation was identified. MD #1 indicated he should have been notified at that time. MD #1 identified if the practitioner was notified, a COVID-19 test would have been obtained and Tylenol would have been prescribed for an elevated temperature. Review of the facility Novel Coronavirus Prevention and Response identified the facility would monitor all residents daily for signs and symptoms of COVID-19. Staff would be alert to signs of COVID-19 and notify the resident's physician when a fever, cough, shortness of breath and a decrease in oxygen saturation levels occured. 2. Interview and record review with RN #4 on 5/13/20 at 6:00 AM identified she/he was not aware that Resident #1 had physicians order to administer Tylenol 1000 mg for pain. RN #4 indicated on 4/24/20 at 12:00 AM she/he administered Tylenol 650 mg for temperature of 101.5 F because usually residents have physician's orders to administer Tylenol for a fever. RN #4 identified that although she/he administered Tylenol for an elevated temperature, she/he questioned the accuracy of temperature of 101.5 F because the resident was not hot to touch. Interview and record review with RN #1 on 5/11/20 at 9:20 PM identified Tylenol 1000 mg by mouth was ordered for pain. RN #1 indicated on 4/25/20 the resident had a temperature of 100.5 and was coughing, she/he made a mistake and documented in Nurse's Medication Notes and 24-hour shift report that the resident received Tylenol for an elevated temperature when the Tylenol was administered for general discomfort. Interview with the DNS on on 5/7/20 at 4:10 PM identified he/she was not aware that a medication was administered in the absence of a physician's order, and that was a medication error. The DNS also indicated Tylenol should have been administered for the correct indication. Interview with MD #1 on 5/8/20 at 2:55 PM identified he/she should have been notified when Resident #1's temperature was elevated and an order for [REDACTED]. The individual administering the medication must check the label to verify the right resident, right medication, right dose, right time and right method of administration before giving the medication. The policy further directed that the individual administrating the medication would initial the resident's Medication Administration Record [REDACTED].