STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075390	A. BUILDING _____ B. WING _____	**06/09/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BEACON BROOK HEALTH CENTER	**89 WIED DRIVE NAUGATUCK, CT 06770**

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 clinical record review, review of facility documentation, review of facility policy, and interviews for one of two sampled residents (Resident # 1) reviewed for change in condition, the facility failed to act timely with implementing a swab test for COVID -19 as directed by the physician to ensure proper medical treatment after a change in condition. The findings include: Resident # 1's [DIAGNOSES REDACTED]. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident # 1 was without cognitive impairment and required extensive assistance with bed mobility, personal hygiene, and dressing. The physician order's dated [DATE] directed to administer 10 milliliters (mls) of [MEDICATION NAME] DM sugar- free ,[DATE] milligrams (mg) as needed every 6 hours for cough, to administer one tablet of [MEDICATION NAME]-[MEDICATION NAME] 37XXX,[DATE] milligrams every 6 hours as needed for pain, and administer two tablets every 6 hours as needed for temperature 101.0 degrees Fahrenheit (F) or above. The Resident Care Plan (RCP) dated [DATE] identified Resident #1 has a [DIAGNOSES REDACTED]. The nurse's note dated [DATE] at 3:25 A.M. identified Resident #1's temperature was 101.4 (Normal range 98.6) Fahrenheit (F) degrees, no cough at this time, and lung sounds clear. The Advanced Practice Registered Nurse (APRN #2) was notified and directed to administer Tylenol while awake and if Resident #1 persists with further symptomatology swab for COVID-19. A review of Resident #1's vital sign flowsheet dated [DATE] at 6:54 A.M. identified his/her temperature was recorded as 99.5 degrees F. A review of the Medication Administration Record [REDACTED].M. identified Resident #1 was administered one table of [MEDICATION NAME]- [MEDICATION NAME] 37XXX,[DATE]mg for pain with good effect. The nurse's note dated [DATE] at 5:21 P.M. identified Resident #1 complains of pain and noted the resident's temperature at 98.5 degrees F. Resident #1 was also noted with an occasional cough. A review of the Medication Administration Record [REDACTED].M. identified Resident #1 was administered two tablets of [MEDICATION NAME] (Tylenol) 325 Milligrams (MG for complaints of general discomfort with good effect . The nurse note dated [DATE] at 10:46 P.M. identified Resident #1 was medicated for complaints of general discomfort with good effect. Resident #1's COVID-19 test results pending. A review of the state agency COVID-19 outbreak submission report for Reportable Events identified the facility reported that Resident #1 was swabbed for COVID-19 on [DATE]. The nurse note dated [DATE] at 2:40 A.M. identified Resident #1's COVID-19 results pending. Droplet precautions maintained. A review of the MAR indicated [REDACTED].M. identified Resident #1 was administered one tablet of [MEDICATION NAME]-[MEDICATION NAME] 37XXX,[DATE]mg for a pain of 8 out 10 on a (scale of ,[DATE]). The APRN note dated [DATE] at 3:59 P.M. identified a visit was conducted to evaluate Resident #1 for a fever this week and indicated Resident # 1 was swabbed for COVID-19. Resident #1 complained of an occasional non-productive cough. A review of systems identified Resident #1 had a cough. The assessment and [DIAGNOSES REDACTED]. A review of the MAR indicated [REDACTED].M. identified Resident #1 was administered one tablet of [MEDICATION NAME]-[MEDICATION NAME] 37XXX,[DATE]mg without a rationale for why Resident #1 needed the [MEDICATION NAME]- [MEDICATION NAME]. A review of Resident #1's vital sign flowsheet dated [DATE] at 10:36 P.M. identified the temperature recorded as 100.6 degrees F. A review of the MAR indicated [REDACTED].M. identified Resident #1 was administered 10ml ' s of [MEDICATION NAME] DM sugar-free. The nurse's note dated [DATE] at 2:25 P.M. identified Resident #1's COVID-19 test results are pending. Resident #1 complains of pain all over and indicated the resident was medicated as ordered with positive effect. [MEDICATION NAME] in use as ordered with positive effect. A review of the MAR indicated [REDACTED].M. identified Resident #1 was administered two tablets of [MEDICATION NAME] 325mg for fever. The nurse's note dated [DATE] at 9:00 P.M. identified Resident #1 noted with increased fatigue this shift with temperature of 102.3 degrees F. Resident #1 medicated with [MEDICATION NAME] 650 mg with positive effect. Resident #1 denies shortness of breath no cough or congestion noted. The nurse's notes failed to reflect the physician had been notified of the elevated temperature of 102.3. A review of Resident #1's vital sign flowsheet identified on [DATE] at 2:51 A.M. temperature recorded as 98.5 degrees F and at 12:46 P.M. temperature recorded as 99.6 degrees F. A review of the MAR indicated [REDACTED].M. identified Resident #1 was administered one tablet of [MEDICATION NAME]-[MEDICATION NAME] 325mg. The nurse's note dated [DATE] at 2:12 P.M. identified Resident #1 has an occasional dry cough, lung sounds noted to be diminished, and had loose stools this shift. A review of Resident #1's vital sign flow sheet identified on [DATE] at 10:08 P.M. temperature recorded as 98.9 degrees F. The nurse's note dated [DATE] at 10:17 P.M. identified Resident #1 noted to have a large reddened area that is raised and warm to touch to his/her right outer thigh. Resident #1's oxygen saturation level is 93% on room air Resident he/she denies shortness of breath. The supervisor was made aware and assessed #1 and indicated he/she will notify APRN on-call. A review of Resident #1's vital sign flowsheet identified on [DATE] at 2:32 P.M. temperature recorded as 99.2 degrees F. The nurse's note dated [DATE] at 4:18 P.M. identified Resident #1 has new order to administer Keflex (antibiotic) 500 Milligrams (MG) every six hours for seven days and Acidophilus one capsule twice per day for ten days for right thigh [MEDICAL CONDITION]. The APRN note dated [DATE] at 4:24 P.M. identified reason for visit was secondary to staff request for evaluating Resident #1's right thigh for redness and warmth and follow up on fever. Resident #1 [DIAGNOSES REDACTED]. Assessment and [DIAGNOSES REDACTED]. The plan was to start Keflex 500 milligrams by mouth every six hours for seven days and Acidophilus one capsule by mouth twice per day for ten days. Continue to monitor for signs and symptoms and await COVID-19 swab results. The nurse's note dated [DATE] at 9:34 P.M. identified Resident #1 slept most of this shift his/her lung sounds are diminished with occasional wheeze. Nebulizer treatment administered with good effect. SPO2 saturation 88% on room air placed on oxygen at 2 liters per minute saturation level now at 94%. No shortness of breath is noted. Resident #1 states he/she is shaky and unable to fed self this writer fed the resident. Resident # 1 consumed 25% fluids with encouragement. The nurse's note dated [DATE] at 2:13 A.M. identified Resident #1 with an increased temperature 102.7 degrees, respiratory rate 42 per minute, and blood pressure of ,[DATE]. Resident #1 was noted with rhonchi and wheezing throughout lung fields, speech is unclear, and increased lethargy. Supervisor notified. The nurse note dated [DATE] at 2:21 A.M. identified Resident #1 was in respiratory distress lungs have rhonchi throughout using accessory muscles to breath, increased lethargy, and tremulous. APRN notified directed to transfer resident to hospital. Resident transferred to hospital via EMS. A review of Resident #1's emergency room and hospitalization records dated [DATE] through [DATE] identified on [DATE] at 3:53 A.M. identified Resident # 1 presented in emergency room from the Extended Care Facility with respiratory distress. Per EMS the staff at the facility report Resident #1 has increased weakness with altered mental status and at 1:00 A.M. the staff at the facility had difficulty waking the resident up. Resident #1's vital signs in the emergency room were: temperature 102.4 degrees F (97XXX,[DATE].0 F), pulse between ,[DATE] beats per minute (,[DATE] beats per minute), respiratory rate 30 respirations per minute (,[DATE] breaths per minute), and SPO2 on 6 liters of oxygen is 94%. Resident #1's assessment in the emergency room identified he/she presented with tachypneic respiratory rate, diaphoretic, with rhonchus lung fields and is in moderate respiratory distress. The emergency room laboratory results for the Urine culture are positive for Escherichia coli bacteria, white

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 0580 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) blood cell count is high, and his/her Troponin level is elevated. COVID-19 swab obtained in emergency room is positive. Resident # 1 will be admitted to the hospital. Resident #1's [DIAGNOSES REDACTED]. Resident #1 clinical condition deteriorated quickly requiring increased oxygen requirements he/she was transferred to the intensive care unit due and intubated subsequently he/she expired on [DATE] with the cause of death being complications related to COVID-19 infection. Although, the facility submitted to the state agency COVID-19 outbreak submission report that Resident #1 was swabbed for COVID-19 on [DATE]. The clinical record on [DATE] failed to reflect any documentation and evidence of Resident # 1's COVID 19 swab was completed for [DATE]. Interview and clinical record review with the Director of Nursing Services (DNS) on [DATE] at 8:00 A.M. failed to provide documentation that Resident #1 nasopharyngeal swab for COVID-19 was obtained from [DATE] through [DATE]. The DNS could not explain why it was not done. Review of the nurse progress notes indicated from [DATE] through [DATE] Resident #1's COVID-19 swab results were pending the DNS indicated it must have been a mistake in the documentation. In addition; the DNS indicated if any physician order [REDACTED]. Interview with APRN #1 on [DATE] at 1:55 P.M. APRN #1 identified he/she did see Resident #1 on [DATE] to evaluate his/her fever. APRN #1 indicated on [DATE] he/she was told by nursing staff Resident #1 was in fact swabbed for COVID-19 and laboratory results were pending. APRN also indicated he/she saw Resident #1 again on [DATE] due to a new onset of redness and warmth to right thigh and follow up for fever. APRN #1 indicated he/she diagnosed Resident #1 with right thigh [MEDICAL CONDITION] and his/her plan was to await results of COVID-19 swab test. APRN #1 further indicated it was not unusual for COVID-19 swab results to still be pending; however, he/she would expect laboratory results for COVID-19 testing to be available in 7 days. Interview with LPN #3 on [DATE] at 3:45 P.M. identified Resident #1 was placed on transmission- based precautions related to COVID-19 swab results pending. LPN #3 indicated on [DATE] Resident #1 started to decline he/she was weaker and more fatigued than usual. LPN #3 identified on [DATE] Resident #1 complained of feeling shaky and was unable to feed self. LPN #3 identified he/she fed Resident #1 and noted a decline in his/her appetite. LPN #3 further indicated he/she felt Resident #1's illness came on slowly and worsened over time. A second interview with RN #3 on [DATE] at 10:45 A.M. RN #3 identified he/she is responsible for obtaining nasopharyngeal swabs on the residents to test for COVID-19. RN #3 identified from [DATE] through [DATE] he/she had obtained other residents residing in the facility COVID-19 tests via nasopharyngeal swabs. RN #3 identified the facility had a supply of swabs during [DATE] through [DATE]. RN #3 indicated he/she did not obtain a COVID-19 swab from Resident #1 and could not explain why. Interview with MD #2 on [DATE] at 12:15 P.M. MD #2 identified he/she was Resident #1's primary care physician. MD #2 indicated he/she was unaware of Resident #1's changes in conditions since [DATE] through [DATE]. MD #2 indicated when Resident #1 exhibited signs or symptoms of COVID-19 he/she would have expected the facility to swab Resident #1 for COVID-19. MD #1 further indicated he/she would expect laboratory results within 3 days. Interview with LPN #5 on [DATE] at 12:30 P.M. LPN #1 identified on [DATE] Resident #1 was fatigued not acting like himself/herself and had a temperature of 102.3 degrees Fahrenheit. LPN #1 indicated he/she administered Resident #1 two 325 mg tablets of [MEDICATION NAME] per physician order [REDACTED]. LPN #1 identified he/she thought Resident #1 was pending results of his/her swab for COVID-19 as reported to her/him in report. Interview with RN #2 on [DATE] at 5:40 A.M. RN #2 indicated he/she did in fact on [DATE] at 3:25 A.M. obtained a verbal order to obtain a swab to test Resident #1 for COVID-19 if he/she had any further symptoms of COVID-19. RN #2 identified as soon as he/she obtains any verbal orders he/she enters the orders into the specific resident's electronic health record. RN #2 again indicated physician orders [REDACTED].