STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075324	A. BUILDING _____ B. WING _____	09/14/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BAYVIEW HEALTH CARE	301 ROPE FERRY RD WATERFORD, CT 06385

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 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation, facility policies and staff interviews for two of four sampled residents (Residents #2 and #4) reviewed for allegations of abuse, the facility failed to ensure the residents were free from verbal abuse. The findings include: a. Clinical record review on 8/10/20 identified Resident #2 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 was cognitively intact and required extensive assistance with activities of daily living (ADL). A Nursing Post Event Progress Note dated 6/2/20 at 4:28 PM identified that at approximately 2:00 PM on 6/2/20 Social Worker (SW) #1 was informed about an incident that occurred the previous night. The nursing note indicated Resident #2 had reported that on 6/1/20 during the 3:00 PM to 11:00 PM shift Nurse Aide #1 told the resident that if Resident #2 and Resident #4 continued to ring for assistance, the call bell would be pulled out of the wall. The note identified that although Nurse Aide #1 fooled around a lot, Resident #2 did not think the nurse aide was kidding around when the statement was made. Resident #2 further indicated that s/he was fearful of ringing the call bell again. The nursing note identified that key facility personnel had been notified of the allegation, and Nurse Aide #1 was removed from the schedule pending review of the incident. A Social Work Progress Note dated 6/2/20 at 5:01 PM further identified that Resident #2 and Resident #4 had reported an interaction with a nurse aide on the evening of 6/1/20 which caused the residents concern. The note further identified that the social worker (SW #1) and the Director of Nursing Services (DNS) subsequently met with Resident #2 and Resident #4 who presented at baseline mood without symptoms of acute distress or negative effects resulting from the incident. Review of a Resident Care Plan (RCP) dated 6/3/20 identified Resident #2 had reported an upsetting interchange with a nurse aide and indicated that an investigation regarding the incident had been initiated. The care plan further included an intervention for the social worker to follow up with the resident to provide post event support and an opportunity for discussion. b. Review of Resident #4's clinical record identified the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A quarterly Minimum Data Set assessment dated [DATE] identified that Resident #4 had intact cognition and required extensive assistance of two staff with activities of daily living. A Nursing Post Event Progress Note dated 6/2/20 at 4:37 PM identified that at approximately 2:00 PM on 6/2/20 the facility's Social Worker was made aware of an incident which occurred the previous evening. The note identified that Resident #4 described NA #1 as an individual who frequently fooled around and was frustrated by the residents' use of call bells on 6/1/20 during the 3:00 PM to 11:00 PM shift. The nursing note indicated Resident #4 reported that NA #1 had stated s/he would pull the call bell from the wall if the resident kept ringing the bell, and Resident #4 did not perceive the response as kidding around. The note further identified that Resident #4 had stated h/she was fearful of ringing the call bell again. A Social Work Progress Note dated 6/2/20 at 5:01 PM also identified Resident #2 and Resident #4 had reported an interaction with a nurse aide on the evening of 6/1/20 that caused the residents concern. Review of Resident #4's Care Plan dated 6/3/20 identified the resident had reported an interchange with a nurse aide that was upsetting. The care plan indicated that an investigation regarding the incident had been initiated, and the social worker would follow up to provide the resident an opportunity for discussion and provide post event support. Facility documentation dated 6/2/20 identified the Director of Nursing and Social Worker #1 conducted an interview with Resident #2 and Resident #4. The documentation identified Resident #4 reported that when NA #1 stated, If you ring again, I'm going to bust that thing out of the wall, h/she felt threatened and was shaking because the nurse aide made him/her nervous. c. Review of employee files identified a job training document dated 2/14/20 which indicated Nurse Aide #1 was provided in-service education on customer service approaches for responding to resident needs with dignity and respect. A subsequent employee warning notice dated 2/19/20 identified NA #1 was provided a verbal warning for a disrespectful attitude. On 3/13/20 a suspension notice identified NA #1 had been suspended in response to an intimidating conversation directed towards co-workers due to NA #1's refusal to answer call bells and yelling at the nurse's station with residents nearby. A subsequent suspension notice dated 6/3/20 identified NA #1 was suspended pending an investigation regarding an allegation of resident abuse. Documentation dated 6/9/20 indicated that Nurse Aide #1's employment was in the process of termination. Interview with LPN #5 on 8/10/20 at 2:49 PM identified Resident #4 did not typically use the call bell and usually went to the nurse's station if h/she had a concern or needed something. LPN #5 stated that on the evening of 6/1/20, Resident #4 complained of not feeling well without any other issues expressed, and s/he was unaware of any concerns about an incident with Nurse Aide #1. Interview with Nurse Aide #1 on 8/12/20 at 9:58 AM identified s/he frequently joked around with Resident #4. Nurse Aide #1 indicated that on the evening of 6/1/20 the resident complained of not feeling well and may not have been in a mood for jokes. Nurse Aide #1 further stated on 6/2/20 s/he was notified of a suspension pending an investigation and was told that the four-day suspension was related to an interaction which occurred on 6/1/20 pertaining to the call bell. Nurse Aide #1 further identified that two weeks later the facility provided notification of the termination of NA #1's employment. Interview and review of the clinical record with Social Worker #1 on 8/12/20 at 3:30 PM identified she saw Resident #2 on 6/2/20 around 2:00 PM for a routine visit when the resident mentioned the call bell response. Social Worker #1 indicated that during the conversation Resident #4 provided input about what happened during the 3:00 PM to 11:00 PM shift on 6/1/20. Social Worker #1 stated that both Resident #2 and Resident #4 were reliable historians. S/he further identified that sometimes the residents would leave voice mail messages to ensure their concerns were heard. Social Worker #1 indicated s/he had told the residents that a comment about ripping out the call bell was not a very dignified way to respond. She stated that follow up interventions post event included assurance the residents would be treated with respect and that their needs would be met. Social Worker #1 further identified the residents expressed resolution and did not mention the incident again during subsequent visits. Interview with the Administrator and Director of Nursing on 9/14/20 indicated that although the nurse aide's behavior was inappropriate, the facility had not substantiated abuse. The facility's Abuse Prohibition Policy defined verbal abuse as the willful use of oral or gestured language to inflict intimidation or punishment with resulting mental anguish. The facility's investigation identified the residents felt threatened by Nurse Aide #1's words regarding the removal of the call bell that resulted in their report of fear. The facility failed to ensure Resident #2 and Resident #4 were free from verbal abuse.
F 0730 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	**Observe each nurse aide's job performance and give regular training.** Based on review of facility documentation, facility policies and staff interviews for two of three sampled nurse aides (Nurse Aide #2 and #3) reviewed for job performance evaluations, the facility failed to provide the necessary performance reviews in accordance with facility policy. The findings include: Review of employee files on 8/11/20 identified Nurse Aide

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

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F 0730 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	(continued... from page 1) (NA) #2's date of employment was 10/6/2015. The file included only two documented Employee Performance Evaluations for NA #2 which were dated 2/3/17 and 12/6/19. Review of NA #3's file identified an employment date of 6/5/18 with only one documented Performance Evaluation dated 10/17/19. Interview with the Administrator on 8/11/20 at 1:55 PM and review of the employee files and the facility's Performance Review Policy identified the purpose of a performance review was to assure the employee's efforts were recognized, assure the employee was properly placed in his/her current position, and performance was based on standards in the job description. The policy identified that a review of every staff member's performance was required at the end of the introductory period and at least once a year. The administrator defined the introductory period as a six-month probationary period following employment. Further review of the files of Nurse Aide #2 and Nurse Aide #3 failed to identify that performance evaluations had been conducted in accordance with facility policy or at a minimum of every twelve months in order for the facility to ensure the employee was meeting required performance standards and/or for the necessary in-service education to be provided based on the outcome of the reviews.
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 review of clinical records, facility documentation, observations and staff interviews for two of three sampled residents (Resident #1 and Resident #9) reviewed for infection control, the facility failed to ensure staff stored personal care items in a sanitary manner in accordance with facility policies. The findings include: 1. Clinical record review on 8/10/20 identified Resident #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The record identified that the resident had intact cognition (BIMS 15) and required required extensive assistance with activities of daily Living (ADL). A Resident Care Plan (RCP) dated 2/27/19 identified that Resident #1 had an indwelling suprapubic catheter due to a [DIAGNOSES REDACTED]. On 3/6/20 the care plan was revised to identify a history of urinary tract infections with interventions to observe standard precautions for infection control. On 8/10/20 at 9:25 AM a tour of the facility which was conducted in the presence of the Director of Nursing identified Resident #1 sitting at the edge of the bed, dressed in a shirt and trousers with feet on the floor. Observation identified that an indwelling catheter was in use with the tubing unsecured and the collection bag lying on the floor. Further observation identified two wash basins in Resident #1's bathroom that were stored on the floor under the sink. A third wash basin was stored in the bathroom behind the toilet between the top of the surface of a grab bar and a sharps container that was mounted on the wall. A bedpan without any protective covering was also stored in Resident #1's bathroom between the wall and a grab bar next to the toilet. Interview with Nurse Aide (NA #3) on 8/10/20 at 9:45 AM identified personal care items such as wash basins should be stored in the resident's bedside stand. S/he stated the bedpan should be stored in a plastic bag and placed in the lowest drawer of the resident's bedside stand. S/he further indicated that after Resident #1 received morning care on 8/10/20, the drainage bag should have been secured to the bed frame to keep the tubing and the bag off the floor. Interview and review of the General Infection Control Nursing Policies with the Director of Nursing on 8/10/20 at 2:30 PM identified all personal care items should be cleaned and disinfected and stored in the resident's bedside stand in accordance with infection control practices. Review of the facility's Safety Standards Policy identified care must be taken with a resident with urinary catheters to ensure the tubing was not on the floor, kinked or pulled tight. The facility failed to ensure Resident #1 received catheter care in accordance with infection control standards and the resident care plan 2. Clinical record review identified that Resident #9 was readmitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A readmission 5-day Minimum Data Set assessment dated [DATE] identified that Resident #9 had moderate cognitive impairment (BIMS 11) and required extensive assistance of two staff with activities of daily living. A tour of the facility on 8/11/20 at 7:30 AM identified Resident #9 resided in a semi-private room with a bathroom that was shared with a roommate. A bedpan which was labeled with Resident #9's name was stored on the floor of the shared bathroom between the base of the toilet and the wall. Interview and observation of personal care items in Resident #9's bathroom with the Assistant Director of Nursing (ADNS) on 8/11/20 at 7:35 AM further identified the storage of a wash basin under the sharps container mounted on the bathroom wall. The wash basin further failed to include the name of a resident. Further review of the General Infection Control Nursing Policies identified all nursing activities would be performed to minimize the potential for infection. The policy specific guidelines for personal care items identified the items would be appropriately labeled with the resident's name, cleaned and disinfected in accordance with infection control practices and stored in the bedside stand as indicated. The facility failed to ensure the proper storage of personal care items in accordance with facility policies.
F 0921 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of facility documentation and staff interviews the facility failed to ensure a safe and comfortable environment. The findings include: Tours of the facility on 8/10/20 and 8/11/20 identified hot water plumbing fixtures for resident use carried water temperatures that exceeded one hundred twenty degrees (120) Fahrenheit (F). Observations on 8/10/20 at 9:00 AM identified that two residents were receiving showers in a second-floor bathroom. The hot water temperature at one of two sinks located in the second-floor bathroom was recorded at 122.9 degrees F. On 8/10/20 at 9:05 AM the water temperature in room [ROOM NUMBER] was identified to be 121.4 degrees Fahrenheit. Interview and further testing of the water temperature with the Director of Physical Plant using the facility's thermometer and the surveyor's thermometer was conducted on 8/10/20 at 9:50 AM. The testing of the water at the sink faucet located in the second-floor bathroom identified the facility's thermometer was one (1) degree lower than the surveyor's reading of 122.9 degrees Fahrenheit although both were above the required 120 degrees Fahrenheit. Subsequently, on 8/11/20 at 7:20 AM the water temperature at the same second-floor bathroom sink faucet was identified to be 124.3 degrees Fahrenheit. The temperature of the water at the faucet in the bathroom sink in room [ROOM NUMBER] was identified to be 123.3 degrees Fahrenheit on 8/11/20 at 7:30 AM. Review of the facility's Physical Plant Daily Worksheets dated 7/29/20 through 8/4/20 and interview with the Director of Physical Plant on 8/11/20 at 9:45 AM indicated the facility tested the water temperatures in three locations daily. The worksheets identified the water temperatures had been obtained on the East nursing unit, the West nursing unit and on the second floor without identification of the specific location of the water faucet or the time of day that the water testing was conducted. Further review of facility documentation including the Water Management Safety Plan failed to identify a policy or procedure for water temperature monitoring.