STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075183	A. BUILDING _____ B. WING _____	**09/24/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FOX HILL CENTER	**1253 HARTFORD TNPK ROCKVILLE, CT 06066**

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 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, review of facility documentation, and interviews, for two of three residents reviewed for Activities of Daily Living (ADL's), (Resident #1 and Resident #4), the facility failed to ensure care was provided in a timely manner to a resident who required extensive assistance and total care with ADL's. The findings include: a. Resident #1 had [DIAGNOSES REDACTED]. A quarterly Minimum Data Set ((MDS) dated [DATE] identified that Resident #1 had moderate cognitive impairment, required extensive assistance with activities of daily living, was dependent for bathing activity, was frequently incontinent of bowel and bladder, and was at risk for pressure ulcers. A care plan dated 7/26/20 identified that Resident #1 was dependent for ADL's, with interventions that included to provide assistance of one staff member for dressing, washing, and bathing and to assist the resident with repositioning four times a shift. b. Resident #4 had [DIAGNOSES REDACTED]. A quarterly MDS dated [DATE] identified that the resident had sever cognitive impairment, was dependent for all ADL's, was always incontinent of bowel and bladder, and was at risk for pressure ulcers. A care plan dated 6/30/20 identified that the resident was dependent with ADL's and to provide assistance with all ADL's, assistance of two (2) people every two (2) hours for repositioning, and to assist with perineal care as needed. Review of the Nurse Aide (NA) assignment for 9/24/20 for the 7:00 AM to 3:00 PM shift at 2:30 PM identified that there were 6 assignments for the unit, each assignment had room numbers assigned. There were six assignments on the assignment sheet, but only 5 NA on the floor. Review of the 6th assignment (the NA assigned to this assignment had called out) identified handwritten NA names next to the room numbers on the 6th assignment. The assignment identified that there were no NA names for Resident #1 and Resident #4. Interview with NA #2, #3, #4, #5, #6, and with Registered Nurse (RN) #1, RN #2, and Licensed Practical Nurse (LPN) #1 (the entire staff on Resident #1 and #4's unit) on 9/24/20 at 2:35 PM identified that none of the staff had cared for Resident #1 and Resident #4 on the 7:00 AM to 3:00 PM shift. At 2:45 PM when it was determined that Resident #1 and Resident #4 had not received care, the NA's worked together to provide care for Resident #1 and Resident #4 before their shift was over. Interview with NA #4 on 9/25/30 at 3:05 pm identified that Resident #4 was incontinent of urine and Resident #1 was dry because he/she used the urinal. Interview with RN #1 and RN #2 on 9/25/20 at 3:00 PM identified that they had performed a skin assessment on Resident #1 and Resident #4 and their skin was intact and free from redness. Interview with RN #1 on 9/24/20 at 2:50 identified that he/she was the supervisor for Resident #1 and Resident #4's nursing unit and there was a call out for the 7:00 AM to 3:00 PM shift leaving five (5) NAs and the patient assignments were split up between six (6) NAs. He/She further identified that he/she had left it up to the NAs to split the sixth assignment, but did not check to ensure that all residents had an assigned NA. Interview with the Director of Nurses (DNS) on 9/24/20 at 3:15 PM identified that Resident #1 required assistance with ADL's and repositioning, but did not require incontinent care. Resident #4 was dependent with ADL's required turning and repositioning and incontinent care every two (2) hours. The DNS identified that it would be the responsibility of the supervisor or the charge nurse to split up a NA assignment when there is a call out to ensure all residents have an assigned NA. The DNS identified that an investigation would be started, and staff education would be provided.
F 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, review of facility documentation, and interviews, for three of four residents reviewed for Activities of Daily Living (ADL's), (Residents #1, #2, and #3) the facility failed to provide adequate staffing to provide residents with weekly showers. The findings include: a. Resident #1 had [DIAGNOSES REDACTED]. A quarterly Minimum Data Set ((MDS) dated [DATE] identified that Resident #1 had moderate cognitive impairment, required extensive assistance with activities of daily living, was dependent for bathing activity, and was frequently incontinent of bowel and bladder. Review of a resident care card as of 9/24/20 identified that it was important for Resident #1 to be able to choose between a bed bath or a shower. Review of ADL record for Resident #1 for August and September 2020 failed to identify that Resident #1 had received a shower. Review of the unit shower sheet identified that Resident #1's shower day was Tuesday on the 3:00 PM to the 11:00 PM shift. Interview with Resident #1 on 9/24/20 at 10:15 AM identified that although he/she would like to have a shower, which would usually be given on Tuesday night, he/she has not had a shower in at least 4 weeks. Resident #1 stated when he/she asks about the showers is told that there are call outs and they do not have enough staff to give showers. Interview with Nurse Aide (NA) #1 on 9/25/20 at 12:30 PM identified that he/she had Resident #1 on Tuesday 9/22/20 on the 3:00 PM to 11:00 PM shift, and although it was Resident #1's scheduled shower day, he/she did not have a time to give the resident a shower because they were short staffed and he/she just didn't have time to do it. b. Resident #2 had a [DIAGNOSES REDACTED].#2 had moderately impaired cognition and was independent with ADL's, but required extensive assistance with bathing. Review of the ADL record for Resident #2 for August and September 2020 failed to identify that Resident #2 had received a shower. Review of a unit shower sheet identified that Resident #2's shower day was Friday on the 7:00 AM to 3:00 PM shift. Interview with Resident #2 on 9/25/20 at 10:00 AM identified that he/she had not had a shower in a long time, maybe a few months. Resident #2 stated that although he/she would like a shower, she had not mentioned it to the staff. Interview with NA #2 on 9/25/20 at 1:30 PM identified that he/she had worked on Friday 9/18/20 on the 7:00 AM to 3:00 PM shift and he/she did not have time to give the resident a shower because they did not have enough staff. c. Resident #3 had [DIAGNOSES REDACTED]. An admission MDS dated [DATE] identified that Resident #3 had severely impaired cognition, required extensive assistance with ADLS's and bathing, and was occasionally incontinent of bladder. Review of an ADL record from 8/24/20 to the current date failed to identify that Resident #3 had received a shower. Review of the unit shower sheet identified that Resident #3's shower day was Thursday on the 7:00 AM to 3:00 PM shift. Interview with NA #3 on 9/25/20 (a Thursday) at 1:45 PM identified that Resident #3's shower day was Thursday on the 7:00 PM to 3:00 PM shift, but he/she had not had time to give the resident the shower because there was a call out, and he/she had picked up extra residents on his/her assignment. Interviews with the NAs that work on Resident #1, #2, and #3's unit identified that the residents frequently miss showers due to lack of time and lack of staffing. The NAs identified that they have informed the charge nurses and supervisors that they are unable to get the showers done on some days. Interview with Registered Nurse (RN) #1 on 9/25/20 at 2:30 PM identified that he/she has been told by the NAs on the unit that they cannot get the showers done. He/She further identified that he/she tells the NAs to give a really good bed bath and make sure the resident's hair gets washed. He/She further identified that he/she had not informed anyone in management as he/she assumed that they were

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 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) aware. Interview with the Director of Nurses (DNS) on 9/25/20 at 3:00 PM identified that the residents should receive their scheduled weekly showers. He/She was unaware that some residents were not receiving their scheduled showers. He/She further stated that the units are staffed appropriately, both number wise and acuity wise. The DNS further identified that if staff were having trouble finishing the assignments, they should inform the charge nurse. The DNS identified that they recently had staff meetings where the staff had mentioned concerns in relation to staffing, and needing more help. The DNS stated that they are actively trying to recruit. The facility stated that they did not have a specific policy for showers.
F 0842 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** Based on clinical record review, review of facility documentation, and interviews, for six of six residents (Residents #4, #5, #6, #7, #8, and #9) reviewed for a room change, the facility failed to ensure a complete and accurate medical record was maintained. The findings include: a. Resident #4's face sheet identified that the responsible party was a conservator. Review of an action summary form dated 9/4/20 identified that Resident #4 had a room change. b. Resident #5's face sheet identified that his/her responsible party was a family member. Review of the nurses notes on 8/24/20 identified that Resident #5 had a room change. c. Resident #6's face sheet identified that his/her responsible party was a family member. Review of an action summary form identified that Resident #6 had a room change on 8/24/20. d. Resident #7's face sheet identified that his/her responsible party was a family member. Review of an action summary form identified that Resident #7 had a room change on 8/26/20. e. Resident #8's face sheet identified that his/her responsible party was a family member. Review of an action summary form identified that Resident #8 had a room change on 9/10/20. f. Resident #9's face sheet identified that his/her family member was the responsible party. Review of an action summary form identified that Resident #9 had a room change on 9/10/20. Review of Resident #4, #5, #6, #7, #8, and #9's medical record failed to identify that the responsible parties were notified of the room changes and that the residents were monitored for adjustment after the room change. Interview with the Social Worker on 9/24/20 at 2:00 PM identified that Resident #4, #5, #6, #7, #8, and #9 all had room changes. He/She further stated when a room change occurs, it is his/her responsibility to notify the families and document such in the medical record. He/She further identified that he/she had been extremely busy, and although he/she notified all the family members of the room change, he/she had not documented in the medical record. The Social Worker further identified that when a room change occurs he/she is responsible for ensuring that the resident is adjusting well to the change and to document such in the clinical record. He/She stated that he/she made all of those visits but did not document them in the clinical record. Interview with the Director of Nurses on 9/24/20 a5 3:50 PM identified that it is the responsibility of the Social Worker to inform the responsible parties of room changes, to monitor the residents adjustment for 72 hours after the room change, and then to document in the clinical record. Review of the room transfer policy identified that the responsible party will be notified and the Social Worker will follow up with the resident after the room change was made.
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 regarding Personal Protective Equipment (PPE) and screening. The findings include: a. Observation on 9/24/20 at 11:30 AM identified that a Nurse Aide was in a room, with a droplet precaution sign on the door, with eye protection and surgical mask, but he/she failed to be wearing an isolation gown in the room. Interview with the Director of Nurses (DNS) on 9/24/20 at 11:30 AM identified that the resident was under observation because he/she had gone to a doctor's appointment, and that the policy was for all staff to wear isolation gowns in droplet precaution rooms. Review of the droplet precautions policy identified that staff that are in a droplet precaution room must wear an isolation gown. b. Observation on 9/24/20 at 1:15 PM identified a van driver wheeling a resident in a wheelchair into the building through the front door and then proceeded to the front desk. The receptionist handed an envelope to the driver and the driver exited the building. The driver was not screened by the receptionist. Interview with the receptionist on 9/24/20 at 1:20 PM identified that he/she assumed the driver was screened when the resident was picked up by the driver, although he/she could not find the information in the screening binder. Interview with the DNS on 9/24/20 at 1:45 PM identified that the transportation drivers do not enter the facility and that the residents are brought out to the transportation vehicle and a staff member goes outside to retrieve the resident upon return from the appointment. The DNS stated that the van driver did not need to be screened when he came into the building because he did not go past the receptionist's desk. The DNS further identified that the van drivers do not have to be screened because they do not enter the building, (although the drivers are in the van with the resident on the way to the appointment, and assist the resident in the van and take the resident out of the van). Furthermore, the DNS did not have knowledge of how the transportation companies were screening their employees, and if the employees of the transportation company are tested for Covid 19. Review of the screening policy identified that an active screening process must be conducted for all persons who enter the building. Subsequent to surveyor inquiry on 9/24/20 the facility contacted the transportation companies to inquire about screening practices, and will now have the van drivers screened before the resident goes in the van with the driver. c. Interview with the Central Supply Clerk (CSC) on 9/24/20 at 12:30 PM identified that the facility is currently using only the yellow washable isolation gowns which are good for 150 washes, but he/she was unsure how the facility was tracking the number of washes, and he/she assumed that the laundry staff was tracking the washes. Observation of the yellow observation gowns with the CSC on 9/24/20 at 1:00 PM identified that there was a grid inside the gown with 75 boxes, with instructions to mark in the grid every time the gown is used (the grid had no entries). The CSC identified that he/she thought the gowns were good for 150 washes, but she was not aware of the grid on the gowns with 75 boxes to be checked off with each wash. Subsequent interview identified that the CSC had called the manufacturer and the gowns were only good for 75 washes. The CSC identified that the gowns had been in use since 6/29/20 (85 days, at least 85 washes, 10 washes over the recommended washes). Interview with the Laundry Supervisor on 9/24/20 at 2:45 PM identified that he/she did not know how many washes the yellow gowns were good for, he/she was not tracking washes, and had assumed that someone would let him/her know when the gowns needed to come out of circulation. Interview with the DNS on 9/24/20 at 1:30 PM identified that all of the yellow isolation gowns would be taken out of circulation and replaced and the laundry would come up with a system to track the washes. d. Observation of the Covid 19 observation unit on 9/24/20 at 1:35 PM identified white isolation gowns in the isolation carts. Interview with the DNS on 9/24/20 at 1:35 PM identified that he/she was unaware that there were white isolation gowns in circulation, and was unsure how washings were tracked. Interview with the CSC on 9/24/20 at 1:45 PM identified that he/she thought only yellow isolation gowns were in circulation, and was unsure of how many washes the white gowns were good for, and how long they had been in use at the facility. Review of the manufacturer's guidelines with the CSC identified that the gown was good for 25 washes. Interview with the laundry supervisor on 9/24/20 at 2:45 PM identified that he/she did not know how many washes the white gowns were good for, she was not tracking washes, and assumed that someone would let her know when the gowns needed to come out of circulation. Interview with the DON on 9/24/20 at 2:00 PM identified that all of the white gowns would be taken out of circulation and the facility would come up with a system to track washes.