| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 075201 | A. BUILDING _____ B. WING _____ | 06/08/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| REGALCARE AT WEST HAVEN | 310 TERRACE AVE WEST HAVEN, CT 06516 |

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 0684<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | **Provide appropriate treatment and care according to orders, resident's preferences and goals.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observations, review of facility documentation, review of facility policy, and interviews, for one Resident, (Resident #3), observed on the COVID-19 transitional unit, the facility failed to ensure a current physician's orders [REDACTED]. The findings include: Resident #3's [DIAGNOSES REDACTED]. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #3 was moderately cognitively impaired and required extensive assistance with bed mobility and transfers and limited assistance with eating. The nurse's note dated 5/8/2020 identified that Resident #3's nebulizers were on hold. The Resident Care Plan (RCP) dated 6/1/2020 identified an altered respiratory status. Interventions directed to monitor respiratory status, administer medications as ordered. The physician's as of orders dated 6/1/2020 identified [MEDICATION NAME]-[MEDICATION NAME] 0.5-2.5 inhale every four hours for [MEDICAL CONDITION] and [MEDICATION NAME] nebulization solution were both on hold. Observation and interview on 6/8/2020 at 1:42 PM with the Director of Nurses (DNS) on the Transitional Unit (monitoring for new admissions, residents who may have been exposed, residents recovered, residents who leave for medical reasons) identified a nebulizer machine in use. Licensed Practical Nurse (LPN) #1 was observed coming down the hall and entered Resident #3's room wearing a face shield, N95 mask, yellow disposable gown, and gloves. Resident #3 was noted with a nebulizer in place and the curtain between Resident #3 and Resident #4 was noted to be open. Interview with Respiratory Therapist #1 on 6/8/2020 at 1:44 PM identified that Resident #3 was no longer on a nebulizer treatment and that there were only two residents on another unit who received nebulization. Respiratory Therapist #1 identified that all nebulization treatments on Resident #3's unit were on hold. Interview with LPN #1 on 6/8/2020 at 1:46 PM identified that he/she administered a nebulizer treatment to Resident #3 because there was a physician's orders [REDACTED]. Interview and review of physician's orders [REDACTED].#3 did not have a current physician's orders [REDACTED].<br>Re-interview with Respiratory Therapist #1 on 6/8/2020 at 2:43 PM identified that Resident #3 had a previous order for nebulizers, but did not have a current physician's orders [REDACTED]. Respiratory Therapist #1 identified that since Resident #3 was on the Transition Unit, he/she should have only received an inhaler, not a nebulizer. The facility nebulizer policy identified that nebulizer therapy was an aerosol, water in a particulate form or mist and all aerosol treatments would be given by air unless specified by a physician's orders [REDACTED]. |
| F 0880<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | **Provide and implement an infection prevention and control program.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observations, review of facility documentation, review of facility policy, and interviews, for one Resident, (Resident #3), observed on the COVID-19 transitional unit, the facility failed to maintain appropriate Personal Protective Equipment (PPE) and failed to administer an aerosolized procedure according to CDC guidelines during the COVID-19 pandemic. The findings include: Resident #3's [DIAGNOSES REDACTED]. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #3 was moderately cognitively impaired, required extensive assistance with bed mobility and transfers and required limited assistance with eating. The nurse's note dated 5/8/2020 identified that Resident #3's nebulizers were on hold. The Resident Care Plan (RCP) dated 6/1/2020 identified an altered respiratory status. Interventions directed to monitor respiratory status, administer medications and puffers as ordered. The physician's as of orders dated 6/1/2020 identified [MEDICATION NAME]-[MEDICATION NAME] 0.5-2.5 inhale every four hours for [MEDICAL CONDITION] and [MEDICATION NAME] nebulization solution were both on hold. Observation and interview on 6/8/2020 at 1:42 PM with the Director of Nurses (DNS) on the Transitional Unit (monitoring for new admissions, residents who may have been exposed, residents recovered, residents who leave for medical reasons) identified a nebulizer machine in use. Licensed Practical Nurse (LPN) #1 was observed coming down the hall and entered Resident #3's room wearing a face shield, N95 mask, yellow disposable gown, and gloves. Resident #3 was noted with a nebulizer in place and the curtain between Resident #3 and Resident #4 was noted to be open. LPN #1 was questioned as to why the curtain had been opened during an aerosolized nebulizer procedure when he/she entered the room and was now closed. LPN #1 identified that the curtain had been closed prior to entering the room despite the observation by the surveyor and DNS. LPN #1 then went down the hall without removing her PPE, went behind the nurse's station desk, and entered the medication room. Interview with Respiratory Therapist #1 on 6/8/2020 at 1:44 PM identified that Resident #3 was no longer on a nebulizer treatment and that there were only two residents on another unit who received nebulization. Respiratory Therapist #1 identified that all nebulization treatments on Resident #3's unit were on hold.<br>Re-interview with LPN #1 on 6/8/2020 at 1:46 PM identified that he/she administered a nebulizer treatment to Resident #3 because there was a physician's orders [REDACTED]. Interview and review of physician's orders [REDACTED].#3 did not have a current physician's orders [REDACTED]. Re-interview with the DNS on 6/8/2020 at 2:25 PM identified that both Resident #3 and Resident #4 were previously on the COVID-19 positive unit, had refused testing and were on the transition unit because of the potential of exposure and refusal of testing. The DNS identified that LPN #1's last PPE in-service had occurred on 5/29/2020. Re-interview with Respiratory Therapist #1 on 6/8/2020 at 2:43 PM identified that Resident #3 had a previous order for nebulizers but did not have a current physician's orders [REDACTED]. Respiratory Therapist #1 identified that since Resident #3 was on the Transition Unit, he/she should have only received an inhaler, not a nebulizer. Respiratory Therapist #1 identified that during aerosolized nebulizer procedures, Resident #4 should not have been in the room during the procedure, no one should enter the room for 30 minutes following the procedure due to the nature of aerosolized procedures (airborne,) and that closing the curtain did not matter due to nebulization being an aerosolized procedure (airborne). Additionally, LPN #1 should not have worn her PPE coming out of the room, down the hall and into the medication room, and that CDC PPE guidelines identified he/she should have discarded the PPE on leaving the room. The facility nebulizer policy identified that nebulizer therapy was an aerosol, water in a particulate form or mist and all aerosol treatments would be given by air unless specified by a physician's orders [REDACTED]. |

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.