STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075060	A. BUILDING _____ B. WING _____	05/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
SALMON BROOK REHAB AND NURSING	72 SALMON BROOK DRIVE GLASTONBURY, CT 06033

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, and interviews for one sampled Resident (R #2) reviewed for care and services, the facility failed to notify the Resident's responsible party of a change in medical treatment in accordance with facility policies. On 5/3/20 a clinical record review identified R #2 was admitted for long term care on 1/27/20. Admission [DIAGNOSES REDACTED]. The care plan dated 1/27/20 identified an Activity of Daily Living (ADL) deficit related to activity intolerance, limited mobility, pain, and right wrist fracture. A 5-day Minimum Data Assessment (MDS) assessment dated [DATE] identified R #2 was able to communicate with clear speech, able to make self-understood, was able to understand others, and cognitive patterns were assessed as severely impaired (BIMS of 5). The MDS identified R #2 required assistance of one with activities of daily living, walked independently with supervision, and mobility was without an assistive device. The MDS identified Occupational and Physical therapy services were provided over five days and started on 2/1/20. Review of progress note dated 3/5/20 at 10:28 PM identified R #2 denied pain or discomfort. Physician Assistant (PA) assessment dated [DATE] at 12:21 PM identified R #2 continued to work with Physical Therapy and denied pain post right wrist fracture with a plan for follow up in 2-4 weeks for reassessment. Progress notes dated 3/6/20 through 3/18/20 identified R #2 denied pain. PA note dated 3/18/30 at 11:28 AM identified an assessment of bilateral lower extremities and low back was completed. The assessment documented no discomfort. Review of the Medication Administration Record [REDACTED]. The MAR indicated [REDACTED]. The clinical record failed to reflect a nursing progress note was written to document assessment of pain location, cause, or potential contributing factors for the sudden unset of pain. Review of Advanced Practice Register Nurse (APRN) progress note dated 3/27/20 at 1:20 PM identified R #2 was seen at the request of nursing for report of right lower extremity pain. physician's orders [REDACTED]. Further review of the MAR indicated [REDACTED]. The MAR indicated [REDACTED]. Review of nursing progress notes dated 3/30/20 at 12:47 PM identified R #2 was alert, was medicated with PRN Tylenol for right hip pain once at 7:42 AM with no further concern was expressed about right hip pain. The note identified R #2 was assessed and observed in bed without evidence of pain. Therapy note dated 3/31/20 at 2:17 PM identified Person #1 was contacted by therapy for and update and progress post therapy session. Interview with Person #1 on 5/5/20 at 9:35 AM identified a window visit with R # 2 on 3/30/20 was shared. Person #1 identified a change in R #2's mental status was observed with increased confusion. Person #1 identified the change was reported to RN #1 by telephone on 3/30/20. Person #1 was informed by RN #1 that a new medication ([MEDICATION NAME]) was started on 3/27/20. Person #1 further identified a research of the medication side effects had prompted a second call to RN #1 on 3/30/20 to request the medication discontinued. Further review of the MAR indicated [REDACTED]. Interview, review of the clinical record, and review of the facility Change in Condition policy with RN #1 on 5/5/20 at 3:50 PM identified notification of a change in a Resident's treatment was a nursing responsibility. The Policy identified the Nursing Supervisor/Charge Nurse would ensure the notification was completed within 24 hours. The policy further identified the Nurse Supervisor/Charge nurse was responsible for ensuring the Resident's medical record information relative to the change was updated. Further review of the clinical record failed to reflect Person #1 was notified of the change in treatment with the new medication [MEDICATION NAME] timely and/or notified with report of an added [DIAGNOSES REDACTED].
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 observation, review of facility documentation, and interviews the facility failed to ensure strategies for optimizing the reuse of Personal Protective Equipment (PPE) was conducted in accordance with standards of infection prevention and infection control guidelines. The findings include: On 5/3/20 at 11:10 AM during tour of the facility's Coronavirus (COVID) precautions specified unit identified infection prevention and control strategies that included extended use and reuse of PPE. The tour was conducted in the presence of the Director of Nursing Services (DNS) and identified the facility issued PPE masks, protective eyewear, and clothing protection were misted between uses with a diluted hydrogen peroxide 50% : 50% water solution from a spray bottle prior to storage. She identified the PPE was removed, misted, and stored in the dirty room until reuse by staff working the COVID precautions unit. The dirty room was further identified as a Resident room just inside the entrance door to the unit. Inside the room there was a separate sink outside of the private bathroom for hand washing. To the left of the sink in a shallow cardboard box the storage of three face shields and two surgical masks were identified without the benefit of a protective covering such as brown paper bags. Behind the box was a brown paper bag with an N-95 mask inside. Above this section of the sink the paper towel dispenser was identified. Further inspection of the face shields, the cardboard storage box, and the brown paper bag identified the articles of PPE were labeled with a staff's name. Evidence of water staining on the articles stored to the left of the sink were identified from hand washing splashes or reaching for paper towels after hand washing. To the right of the sink a small wardrobe closet, containing three different types of clothing protection in storage. The yellow and blue isolation gowns as well as the white jumpsuit being stored were identified as single use disposable clothing protective equipment. Further inspection of the dirty room identified various poled devices used to store additional jumpsuit type isolation garments. The inside of unzipped jumpsuits were in close contact and touching the outside of the jumpsuit hung below. Several layers of jumpsuits were identified as hung from the hooks of two poles on wheels, identified as a devise use to hang bags of fluid when providing intravenous therapy (IV poles). Interview with CNA #2 on 5/3/20 at 11:12 AM identified her jumpsuit had a tear and she was observed taking off (doffing) her PPE. She identified it was her first time wearing the suit and she was unsure of the steps in doffing. Without the protective benefit of wearing gloves CNA #2 experienced potential cross contamination of her hands and uniform due to contact with the outside of the suit during doffing. On 5/3/20 at 11:20 AM the observation of CNA #3 doffing the jumpsuit resulted in potential cross contamination as she tried to protect her ungloved hands with a paper towel to touch the outside of the suit and remove her shoulders and arms. Review of facility documentation and policies the DNS on 5/3/20 at 11:55 AM identified the policy for Mask Reuse and Storage was developed with guidance from the Center for Disease and Prevention (CDC). The policy identified the mask would be reused until it became difficult to breathe through or become visibly soiled. The policy identified the mask would be sprayed with a non-toxic disinfectant i.e. Lysol or hydrogen peroxide to decrease bacteria prior to storage for next use, and the mask would be placed in a paper bag until next use. Further review of facility policies failed to reflect a policy for the disinfection and reuse of the disposable clothing protective gear (yellow/blue isolation gowns and/or white jumpsuit). The policy for mask reuse was further identified as developed from a CDC document titled Decontamination and Reuse of Filtering Face Piece Respirators. The research in the document identified use of vaporous hydrogen peroxide and the practice of spraying or misting a mask with hydrogen peroxide did not meet decontamination criteria and/or was identified an approved

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 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) disinfectant. The facility failed to use an approved disinfectant for decontamination of reusable PPE and failed to ensure strategies for optimizing the reuse of PPE.