STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075253	A. BUILDING _____ B. WING _____	**10/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
HARRINGTON COURT	**59 HARRINGTON CT COLCHESTER, CT 06415**

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 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation and staff interviews for one sampled resident, R#2 reviewed for accidents, the facility failed to complete neurological and vital signs per facility policy after a fall. R#2 was admitted on [DATE] with [DIAGNOSES REDACTED]. The occupational therapy discharge summary dated 3/11/2020 identified R #2 achieved his/her highest level of function and was could independently transfer from the bed to wheelchair and wheelchair to toilet and complete all activities of daily living. Additionally, the note identified R #2 could walk short distances by him/herself in the room with a 4 wheeled walker with a seat for safety so R #2 could sit as necessary. The significant change minimum data set assessment ((MDS) dated [DATE] identified intact cognition, and R#2 could transfers, walk and toilet him/herself independently. Additionally, R#2's balance was not steady but he/she was able to stabilize without staff assistance with an assistive device and used a wheelchair for mobility. Further, R#2 was continent of bowel and bladder. The RCP dated 4/2/2020 identified R#2 was at risk for falls and interventions included to remind R#1 to use call light, place call bell within reach , keep personal items within reach and assess changes in medical status as needed and remind resident to sit at edge of bed before attempting to get out of bed. Further the RCP dated 4/2/2020 identified R#2 had a problem with activities of daily living secondary to a stroke and interventions included independent in his/her room with a rolling walker and required supervision for ambulation in hall with a 4 wheeled walker and was could use the bathroom by him/herself using the wheelchair. The nurse's notes dated 5/1/2020 at 4:45AM identified R#2 was found on the floor and assessed by RN #2. Additionally, the note indicated R#2 was walking to the bathroom and slipped and fell and did not hit his/her head or lose consciousness. Further, R#2 sustained fell on to the right hip and shoulder and sustained three linear abrasions to the right scapula. The interact change in condition form dated 5/1/2020 at 5AM identified vitals 155/104, P90, R 20 and Temp 96.6 and oxygen saturation 96%. The nurses note dated 5/1/2020 at 10AM identified R#2 reported severe pain and a stat X-ray was ordered. Additionally R#2's vital signs at 8:57AM included BP 169/95, P87, R16, T 97.0 oxygen saturation 97%. The nurse's progress note dated 5/1/2020 at 2:06PM identified R#2 was transferred to the hospital for an evaluation (9 hours and 21 minutes after the fall). Review of the clinical record on 10/8/2020 failed to document a neurological and vital sign assessment after the fall according to the facility policy. Interview with LPN #2 on 10/7/2020 at 2:01PM identified the neurological vital assessment should have been done and documented on a paper form and could not remember if it was done. Additionally, LPN #2 identified the neurological and vital signs assessment is completed every half hour x 2 and then every hour x 4 hours. Interview with LPN #3 on 10/8/2020 at 1:56PM identified she was the 7-3 shift nurse on 5/1/2020 after R#2 fell and she thought she completed the neurological vital signs assessment but was not sure and indicated the assessment is completed after every unwitnessed fall every 30 minutes for 4 hours, then every 1 hour x 4 hours and every 4 hours x 24 hours. Additionally, LPN #3 indicated the assessment is completed on paper form and not kept in the electronic medical record. Interview with DNS #1 on 10/14/2020 at 10:52AM identified he/she thought the nurses completed the neurological and vital signs assessment, however, DNS #2 could not find the neurological assessments or vital signs form documented in the medical record and would have expected the neurological and vital signs assessment to be completed and documented according to the facility policy. The facility policy entitled Falls Management identified a neurological evaluation would be performed for all unwitnessed falls and witnessed falls with an injury to the head or face. Additionally, the neurological evaluation would be performed every 15 minutes for two hours, every 30minutes for two hours, every 60 minutes for four hours and every 8 hours until at least 72 has lapsed.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** TAG NEEDS DELETED-(NAME)I do not know how to delete this tag.This is the one EPI and(NAME)said no to. Based on observations review of clinical records and facility policies for review of infection control practices, the facility failed to properly disinfect eye protection on an exposed observation unit. The findings include: R # 1 was admitted on [DATE] with [DIAGNOSES REDACTED]. The physician order [REDACTED].#1 on incentive spirometery, and provide education related to smoking cessation, energy conservation, and exercise. The COVID care plan dated 9/23/2020 identified R#1 had a known COVID-19 exposure and was at risk for developing COVID-19 and interventions included patient specific contact and airborne precautions. The COVID lab test dated 9/30/20 identified R#1 was negative for COVID 19. Observation with RN #1 on 10/5/2020 at 9:20AM on the exposed floor identified RT#1 left R #1's room and walked down the hall to the physical therapy room without cleaning his/her face shield. Interview with RT#1 identified h/she was teaching R#1 how to use his/her incentive spirometer and did not clean his face shield when he left the room because the facility had stopped that practice and he was not sure when or why this practice stopped. Further, RT #1 identified he/she provided care throughout the building on all units including the COVID positive floors sometimes cleaned his/her face shield when a solution was available outside of the room but did not clean it on a regular basis. Interview with the Infection Control Nurse RN#1 on 10/5/2020 at 9:25AM identified the facility received guidance from the corporate several weeks ago that it was no longer necessary to disinfect eye protection between residents and rooms regardless of cohort. Additionally, RN #1 identified staff were required to clean the shields if they were soiled and at the end of the shift. Further RN #1 indicated the staff clean the eye protection in the disinfecting room near the main entrance of the facility and place the shield in a paper bag with their name and leave it in the designated storage area. Interview with the DNS on 10/5/2020 at 10AM identified staff were only required to clean their face shields at the end of the shift and place in a paper bag for storage. Additionally, the DNS identified updated guidance was received on 8/30/2020 from corporate that identified staff no longer were required to disinfect face shields or eye protection between residents and rooms. Review of the facility procedure to disinfect face shields goggles and protective eyewear dated 8/30/2020 identified to follow PPE guidance for extended wear of eye protection. Additionally, if protective eyewear was to be removed, always remove outside the patient's room, remove protective eyewear anytime the eye wear becomes potentially soiled or contaminated and it was not necessary to remove and clean and disinfect protective eyewear between every patient encounter. Further, the policy directed to refer to the guidance located in the personal protective use, reuse and extended use of PPE document for additional information. Review of the document entitled Personal Protective Equipment: Use, Reuse, and extended use identified in buildings where COVID- 19 was confirmed staff must wear eye protection and (goggles, face shields or approved safety glasses) and disinfect for reuse. Additionally, patient specific contact and airborne precautions required eye protection. Further, the policy identified face shields, goggles and protective eyewear can be safely cleaned and sanitized using an EPA approved product and failed to identify when the eye protection was required to be sanitized.

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.