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 _____	06/10/2020

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 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 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. The findings include: a) Observation on [DATE] at 11:00 AM with the Director of Nurses (DON) identified that a staff member entered the lobby area with a cloth face mask, opened the door and entered a COVID-19 negative unit, and proceeded down the hallway. Interview on [DATE] at 11:02 AM with the staff member identified that she was a cook, and that although she was aware that she should be wearing a surgical face mask on a resident unit, she was unaware if surgical masks were available upon entrance to the facility. Interview with the Director on Nurses on [DATE] at 11:03 AM identified that although staff do wear their cloth facemask's upon entering the building at times, when they are screened at the front door they are required to obtain a surgical mask, and that there were 2 boxes of surgical masks available at the front desk. Review of Centers for Disease Control (CDC) guidelines identified that all health care personnel are required to wear surgical masks while in the facility, and that cloth face masks are not considered personal protective equipment because capability to protect the health care provider is unknown. b) Observation on [DATE] at 12:00 PM on the COVID-19 positive unit identified a personal protective equipment storage area where staff kept their N95 masks and face shields for re-use, in large brown paper bags labeled with the staff members name. Observation of 3 brown paper bags identified that the face shield and N95 were loosely stored next to each other in the paper bag without any coverings. Interview with the Director of Nurses on [DATE] at 12:00 PM identified that the facility re-uses the N95 masks and the face shields. Each staff member gets 1 N95 mask and face shield per week due to a limited supply. She further identified that the face shields are disinfected at the end of the shift and should be placed in a bag. The N95 should be stored in a separate paper bag once doffed, and then both bagged items are stored in the large paper bag to prevent cross contamination. The DON identified that she would be re-educating the staff on proper storage of the face shields and N95's. Review of the CDC guidelines identified that when face shields and N95's are utilized for extended use, the face shield should be stored in a plastic container, and the N95 should be stored in a paper bag. c) Resident #1 had [DIAGNOSES REDACTED]. An admission minimum (MDS) data set [DATE] identified that the resident had severe cognitive impairment, and required extensive assistance with activities of daily living. Review of physicians orders dated [DATE] identified that the resident was a nurse pronouncement upon death, do not resuscitate, do no intubate and a do not hospitalize. Review of nurse's notes dated [DATE] at 2:20 PM identified that the resident had an episode of unresponsiveness, oxygen was applied, and the family was notified and declined a hospital transfer. The resident was assessed by the Advance Practice Registered Nurse (APRN) and returned to baseline mentation in about 15 minutes, and a hospice consult was ordered. Further nurse's notes on [DATE] at 4:55 PM identified that the resident was not breathing, had no pulse and the residents pupils were fixed and dilated, and was pronounced expired at 4:15 PM. Interview with Person #1 (funeral home staff) on [DATE] at 12:00 PM identified that he/she received a phone call from the facility that Resident #1 had expired. Person #1 inquired if the facility had any COVID-19 cases and was told there were no cases of COVID-19 in the building. He/she further inquired if the body was located in the holding room and was told that the holding room was full of stuff and there was no gurney to transport the body. Person #1 stated that he/she arrived at the building, was let in through the front door, onto the nursing unit and then directed to the resident's room where he/she wrapped the body without staff help and transported the body out of the building. Interview with the previous administrator on [DATE] at 10:35 AM identified that she received a call on [DATE] from the funeral director regarding Resident #1's body removal on [DATE], she went to the holding room, and found it empty and contained only a gurney. Interview with the Director of Nurses (DON) on [DATE] at 11:30 AM identified that she had been informed that the administrator had received a call from the funeral home in regards to Resident #1's body removal on [DATE]. The DON stated that on [DATE] the facility had eight (8) residents who were transferred to the hospital and diagnosed with [REDACTED]. She further identified that the staff should be following the guidelines set in place for COVID-19 by the CDC for body removal. The guidelines involved placing the decedent in the holding room, and ensuring that the funeral home had the most direct route to get to the decedent. The DON stated that the body should have been taken to the holding room, and the funeral home should have been directed to go to the outside door of the unit where he/she could avoid walking through the nursing unit. She further identified that she had educated her supervisory staff of the new guidelines for body removal prior to this incident. Interview with Registered Nurse (RN) #1 on [DATE] at 12:30 PM identified that she was the nursing supervisor on [DATE], and had pronounced Resident #1 deceased . RN #1 was told by Licensed Practical Nurse (LPN) #1 that the resident could not go to the holding room because the room was full of things, so the decedent was left in the resident's room for the funeral home to pick up. RN #1 further identified that she did not check the holding room, and stated that she was unaware that the procedure for body removal had changed in response to COVID-19. RN #1 stated that she was educated on [DATE] of the new guidelines. Interview with LPN #1 on [DATE] at 4:09 PM identified that he received a call from the funeral home who inquired if there were any cases of COVID-19 in the building, to which he informed the funeral home that there were. The funeral home inquired about where the decedent was located, and LPN #1 stated that Resident #1 was still in his/her bed in the resident room. The funeral home requested that the body be moved to the holding room, but LPN #1 informed the funeral home that the holding room was full of resident belongings (he had checked the holding room previously in the shift and saw 3 bags full of resident belongings). He further identified that the gurney was in the holding room. LPN#1 stated that when a resident expires, he generally will keep the resident in the room until the funeral home picks the decedent up. LPN #1 was not aware that the CDC had put out guidelines in regards to COVID-19 for body removal, and was educated the next day that the decedent should be taken to the holding room and the funeral home would use the closest entrance/exit to prevent the funeral home staff from entering the resident units. Furthermore LPN #1 stated that if he was aware of the guidelines he would have taken the resident belongings out of the holding room and placed Resident #1 in the holding room. Further interview with the DON on [DATE] identified that they had not updated the current policy to reflect the CDC body removal guidance in response to COVID-19. Review of a blast fax ,[DATE] sent to all nursing facilities on [DATE] from the state health department identified that in order to adhere to Centers for Disease Control (CDC) guidelines, the decedent should be placed in the holding room to prevent the funeral home from walking through the halls located in resident areas to obtain the body. The blast fax further identified that the facility will implement the most direct route from the entrance that will be used to the holding room. The facility should discuss the plan for the body removal prior to the funeral home arriving at the facility, and should be sure all staff are aware of the procedures.

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.