STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075069	A. BUILDING _____ B. WING _____	**08/31/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
REGALCARE AT GREENWICH	**1188 KING STREET GREENWICH, CT 06831**

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 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.** Based on observations, review of facility policy, and interviews the facility failed to all resident call lights were functioning. The findings include: Observation on 8/31/20 at 9:30 AM through 9:45 AM on B wing identified a call light to a resident room was sounding for approximately 15 minutes. Interviewed NA #1 on 8/31/20 at 9:46 AM identified the call light was broken. Review of the maintenance request book on B wing, located at the nurse's station, identified entries for repair of broken call lights, for two different rooms on 8/29/20 and 8/31/20. Observation on 8/31/20 at 9:46 AM identified the residents in the rooms identified in the maintenance book with broken call lights did not have a way to call for assistance. Observation on 8/31/20 between 9:47 AM through 10:27 AM with the ADNS, RN #1 and 2 National Guards identified the following: a. Damaged, broken and/or missing call light cords on B wing in room's # B1-W, B4-D, B5-D, B8-W, B10-D, B11-D, and B14. b. Damaged, broken and/or missing call light cords on the Middle wing in room's #A22-D, B17-W, B18-W, B19-W, and B20-D. Review of the maintenance request book on A wing and B wing failed to reflect a request to repair the damaged, broken and/or missing call light cords. Interview with the Maintenance Supervisor on 8/31/20 at 9:49 AM identified he was not aware of the broken call lights or the damaged, broken and/or missing call light cords. The Maintenance Supervisor indicated that maintenance of the facility is ongoing, and there is a maintenance request book on each unit at the nurse's station, which is checked in the morning, and the staff records what needs to be fixed and/or repaired. If there is an emergency or safety related concern, the staff members are responsible to call maintenance department immediately. The Maintenance Supervisor indicated that he worked on 8/29/20 and checked the maintenance request book and there was no request to fix call lights. Additionally, he identified he will check all the call lights in the rooms and repair as needed. Interview with RN #1 on 8/31/20 at 10:19 AM identified he was not aware of the broken call lights or the damaged, broken and/or missing call light cords. RN #1 identified that staff can document any environmental concerns and/or repair request in the maintenance request book that is located at each nurse's station. Interview with the ADNS on 8/31/20 at 10:38 AM identified she was not aware of the broken call lights or the damaged, broken and/or missing call light cords. The ADNS indicated each nurse's station has a maintenance request book and the staff records what needs to be fixed and/or repaired. The ADNS indicated if she was aware of the broken call lights, she would have guided the staff to put hand bells in the room until the maintenance department fixed the call lights and indicated going forward, the facility will provide in-service to the nursing staff and an audit will be done. Interview with the DNS on 8/31/20 at 10:43 AM identified she was not aware of the broken call lights or the damaged, broken and/or missing call light cords. The DNS indicated there is a maintenance request book on each nurse's station and the staff are aware to document any concerns or repairs. The DNS indicated it is the responsibility of the maintenance department to oversee the repairs. She indicated going forward the facility will provide an in-service for the nursing staff and housekeeping. Subsequent to surveyor inquiry the Maintenance Supervisor repaired and replaced the damaged, broken and/or missing call lights and cords. Interview with the Maintenance Supervisor on 8/31/20 at 3:10 PM identified he does preventative maintenance and checks the call lights every 3 months. He indicated he checked all the call lights 2 months ago, although he did not document or keep a record. The Maintenance Supervisor indicated he is the only person in that department and going forward he will document and keep a record of the repairs. Review of the Answering a Call Light policy identified the purpose of this procedure is to respond to the resident's requests and needs. Be sure the call light is plugged in at all times. When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident. Report all defective call lights to the nurse supervisor promptly. Review of the Director of Environmental Services job description identified the primary purpose of your position is to develop and implement facility maintenance, laundry and housekeeping policies and procedures in an efficient, cost-effective manner to safely meet residents needs in compliance with Federal, State and Local requirements. As the Director of Environmental Services, you are responsible for overseeing all aspects of the physical plant and assuring that all systems are running at peak performance 24 hours a day, 7 days a week. Repair or supervise the repair of any equipment that is in need of repair. Identify any equipment malfunction and report to administrator.
F 0886 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	Based on review of facility documentation, facility policy and interviews the facility failed to perform weekly Covid-19 staff testing according to established requirements. The findings include: Review of the covid 19 staff weekly testing data dated 7/9/20, 7/16/20, 7/23/20, 7/30/20, and 8/7/20 indicated the facility failed to test 100% of staff weekly for at least 2 consecutive weeks. Interview on 8/31/20 at 1:21 PM with RN #1 identified she did not start a list for staff covid 19 weekly testing. RN #1 indicated she had spoken to epidemiology and was advised they can stop the weekly testing, however, RN #1 indicated she did not inform epidemiology that 100% of facility staff had not been tested . Interview and facility documentation review on 8/31/20 at 1:30 PM with the ADNS identified she was aware that all staff were not tested for covid-19 weekly as required. The ADNS indicated the facility is doing everything to get all the staff tested as required per the executive order and indicated the facility is continuing to provide education to the staff and encourage testing. Interview and facility documentation review on 8/31/20 at 2:30 PM with the DNS identified she was not aware that 100% of staff were not tested for covid 19 as required. The DNS indicated the facility will provide education that weekly testing is an order from the Governor, additionally, the facility has hired a new infection control nurse that will oversee the department. Review of the State of Connecticut Department of Public Health Covid-19 infection control and testing guidance for nursing homes identified: CDC recommends repeat testing of all previously negative staff and resident until no new cases of Covid-19 are identified for 14 days. CMS similarly recommends weekly testing of all staff and testing of all residents until all residents test negative. Consistent with CDC and CMS, DPH also recommends weekly retesting of previously negative resident and staff until no new cases are identified for 14 days. Nursing Homes should document their testing plans, as well as dates and testing results. To conform with CMS guidance, nursing homes that do not have a plan in place should immediately begin to develop a strategy to implement regular testing of staff. DPH is available to assist nursing homes in formulating their plans.

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.