STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075138	A. BUILDING _____ B. WING _____	**08/15/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BLOOMFIELD HEALTH CARE CENTER	**355 PARK AVENUE BLOOMFIELD, CT 06002**

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 observations, clinical record review, review of facility documentation, review of facility policy, and interviews for one of three sampled residents (Resident #1) reviewed for notification of change, the facility failed to inform the conservator when the resident had a change in anti-hypertensive medication. The findings include: Resident #1's [DIAGNOSES REDACTED]. Review of Resident #1's medical record identified Person #2 as Resident #1's emergency contact #1 and conservator and Person #1 and next of kin. A physician's orders [REDACTED]. The physician's orders [REDACTED]. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 was without cognitive impairment, noted it was very important to have family or close friends involved in discussions about his/ her care. The MDS assessment also noted the resident was occasionally incontinent of urine and noted the utilization of an antihypertensive medication. Resident #1's Medication Administration Record [REDACTED].M. on 6/4-6/7/2020. The MAR indicated [REDACTED].M. daily from 6/8 through 7/13/2020. A review of Resident #1's clinical record documentation of vital signs identified an increase of the resident's blood pressure from 100/70 on the day of admission to the facility (6/3/20), to 147/92 (Normal Range 120/80) on 6/5/2020 and 144/87 on 6/7/2020. Review of Resident #1's clinical record and interview with the Director of Nursing Services (DNS), Assistant Director of Nursing Services (ADNS) and Administrator on 8/15/2020 at 2:45PM failed to identify evidence that Resident #1's conservator was notified when the resident's treatment was modified. The ADNS identified the Power of Attorney (POA) or conservator should have been notified of the change in the resident's treatment and communication of the notification should have been documented in the resident's clinical record. A review of the facility's Physician notification/Family notification policy indicated the facility will inform the resident, resident's physician and the resident's family/legal representatives when there is a need to alter treatment significantly.
F 0622 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, review of facility documentation, review of facility policy, and interviews for one sampled residents (Resident #1) reviewed for transfer and discharge requirements, the facility failed to communicate all the resident's medication allergies [REDACTED]. The findings include: Resident #1's [DIAGNOSES REDACTED]. The admission MDS assessment dated [DATE] identified Resident #1 was without cognitive impairment, noted it was very important to the resident have family or close friends involved in discussion about his/ her care. The MDS assessment also noted the resident was occasionally incontinent of urine. The Resident Care Plan (RCP) dated 6/11/2020 identified Resident #1 had allergy to [MEDICATION NAME], [MEDICATION NAME] and [MEDICATION NAME]. Interventions directed to avoid known allergens and document the allergy as per policy. A review of Resident #1's medical record documentation of the transition of care from the acute care facility dated 6/3/2020 identified Resident #1's allergies [REDACTED]. The physician's orders [REDACTED].#1's allergies [REDACTED]. The nurse's note dated 7/14/2020 at 11:30AM identified Resident #1 was sent to an area hospital emergency room secondary to physical aggression toward staff and could not be redirected. Review of the Situation Background Appearance and Review (SBAR) communication form dated 7/14/20 at 11:30A.M. identified Resident #1's allergies [REDACTED]. The Reportable Event form and Medication Incident Report dated 7/24/2020 indicated the facility was notified by Resident #1's family member that Resident #1's allergies [REDACTED]. The report also noted the hospital administered medications to Resident #1 which he/she had an allergy. Further review of the medication incident report identified education in-service of staff was completed. Inservice outlined directed that the admitting nurse is responsible for making sure that all allergies [REDACTED]. The facility did not provide an Admission Discharge policy. Interview and clinical record review with the DNS, ADNS and Administrator on 8/15/20 at 2:45 P.M. identified all of Resident #1's allergies [REDACTED]. [REDACTED].#1's medical record upon admission. The DNS indicated it was the responsibility of the Nursing Supervisor to transcribe medications and allergies [REDACTED]. In an interview with Registered Nurse (RN #2) Nursing Supervisor on 8/21/2020 at 1:05 P.M. identified she completed the SBAR for Resident #1's discharge to the hospital. RN #2 also indicated that when transferring a resident to the hospital allergies [REDACTED]. RN #2 further indicated that the SBAR and the MAR indicated [REDACTED]. RN #2 also indicated she transcribed Resident #1's allergies [REDACTED]. In an interview with RN #1 (Admitting Nursing Supervisor) RN #1 identified he/she could not recall the resident or transcribing the allergies [REDACTED].

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE