STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075438	A. BUILDING _____ B. WING _____	**08/24/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ORCHARD GROVE SPECIALTY CARE CENTER, LLC	**5 RICHARD BROWN DRIVE UNCASVILLE, CT 06382**

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 a review of the clinical record, staff interviews, and a review of the facilty policy for one of three residents (Resident # 1), reviewed for room change notification, the facilty failed to notify a resident's responsible party of a room change. The findings include: Resident (R) #1 was admitted to the facilty on 1/5/19 with [DIAGNOSES REDACTED]. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified severe cognitive impairment and had moderate impaired cognitive skills for decision making. The nursing progress note dated 8/17/20 at 12:48 PM identified R#1 was admitted to the hospital with [REDACTED].#1 returned from the emergency room at 11:30 AM and was moved to a new room, placed on droplet precautions and quarantined for 14 days. Review of the social service and nursing progress notes for August 2020 failed to document that R#1's conservator of person was notified of the room change on 8/18/20. Interview with Social Worker (SW) #1 on 8/24/20 at 1:22 PM identified R#1's conservator of person was not notified of the room change because she was on vacation. SW #2 did not know R#1 had moved because she was new and still learning. SW#1 identified all residents who return from the hospital are placed on the COVID-19 precaution unit for a 14-day observation period. SW#1 indicated the social worker usually notified residents and responsible parties of room changes however, the nurse was responsible to notify the resident, the responsible party and document the notification in the medical record when the SW was not available. Additionally, SW #1 identified the social worker was required to document follow up adjustment notes for 3 days after the room change and this was not completed. Interview with SW #2 on 8/24/20 at 1:30PM identified SW#2 was not aware R#1 returned from the hospital and moved to a different room. SW #2 indicated room changes are discussed in morning meeting and she did not recall discussing the room change, and was not notified by the nursing staff. SW#2 indicated she did not notify R#1's conservator or follow up with R#1 related to the room change adjustment after she noted R#1 was moved, however, subsequent to surveyor inquiry, SW #2 identified she would call R#1's conservator of person and would follow up with R#1. Interview with the Corporate Nurse (RN #2) on 8/24/20 at 1:34 PM identified it was the responsibility of the social worker to notify the responsible party of room changes and if the social worker was not available, or if the room change occurred on an alternate shift, the nurse or supervisor should notify the family and leave a message to notify the social worker. Interview with LPN #1 on 8/24/20 at 2:46 PM identified R#1 returned from the hospital on [DATE] and was moved into a new room to quarantine for 14 days while staff monitored for signs and symptoms of COVID -19. LPN #1 indicated she did not notify R#1's responsible party of the room change because the social worker was responsible to notify the family and she thought that was already completed. Review of the facilty policy entitled Room Transfer/Roommate Change identified the facilty would notify the resident and responsible party when there was a room transfer. The notification of room transfers and follow up documentation regarding the resident's adjustment to the room change would be documented in the social service notes that was part of the medical record. Additionally, the policy identified when available, social services would notify a resident and/or a responsible party of a room transfer.
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** Based on observations, staff interviews, a review of facilty documentation and a review of the facility policy for one of two residents (Resident #1 and #2), reviewed for transmission-based precautions, the facilty failed to ensure eye protection was accessible and worn when providing care to a resident on transmission based droplet precautions, and failed to perform hand hygiene and store eye protection according to infection control standards of practice. The findings include: Resident (R) #4 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The laboratory results dated [DATE] identified COVID-19 was not detected. The physician's orders dated 7/30/20 directed [MEDICAL TREATMENT] three times a week on Monday, Wednesday and Friday. R#5 was admitted to the facilty on the observation unit on 8/20/20 with [DIAGNOSES REDACTED]. The laboratory result dated 8/20/20 identified COVID-19 was not detected. The transmission-based precaution sign entitled droplet and contact precautions posted outside of R#4 and R#5's room on the COVD-19 observation unit directed staff to wear a facemask, eye protection, gown and indicated everyone must clean their hands before entering and upon leaving the room. Observation and interview with NA #1 on 8/24/20 at 10:23AM on the COVID-19 observation unit identified NA #1 standing inside R#4's room and was not wearing a face shield or eye protection. NA #1 walked out of the room with a bag and discarded it in the soiled utility room and performed hand hygiene. Additionally, NA #1 identified R#1 was on isolation precautions on the observation unit because R#4 goes to [MEDICAL TREATMENT] three times a week and NA #1 indicated she had just provided incontinent care to R#4 and changed his/her bed. Further, NA#1 indicated she did not wear a face shield while providing care to R#4 and should have, however there were no shields available in the cart outside of the room and while she should have looked in another cart on the floor she did not because she wanted to take care of R#4. Observation of NA #1 on 8/24/20 at 10:25AM identified NA#1 put on a gown, gloves and face shield and entered R#5's room after NA #2 requested assistance with repositioning R#5. Upon leaving the room NA #2 removed the shield in the hall and proceeded to clean the face shield without the benefit of wearing gloves and did not wash her hands. Additionally, NA #1 opened the clean Personal Protective Equipment (PPE) cart and removed a new gown and proceeded into R#6's room and did not wash hands. Interview with NA #1 identified she did not wash her hands because she was not thinking and wanted to get everything done before her partner went to lunch. Subsequent to surveyor inquiry NA #1 washed his/her hands. Observation on 8/24/20 at 10:30AM identified NA #2 outside R#5's room sanitizing her face shield. Subsequent to cleaning the shield NA #2 placed the unlabeled face shield on top of the clean PPE cart without the benefit of a bag and walked away. Interview with NA #2 identified she stored her shield on top of the PPE cart and discarded it at the end of the day. Additionally, NA #1 identified she did not label the face shield with her name because it was clean and placed it on the cart outside of her room assignments and knew where it was located. Interview with NA #1 on 8/24/20 qt 10:35 AM identified she stored her shield on top of the clean linen cart because there is no other place to store the shields. Interview with the Director of Nursing (DNS) on 8/24/20 at 10:48 AM identified NA #1 should have washed her hands before obtaining the clean gown from the PPE cart. Subsequently, the DNS removed the contaminated PPE cart and NA #1 was educated on the proper removal of PPE including the face shield and hand hygiene. Additionally, the DNS identified the staff should label the shields with their names and store the sanitized shields in the bottom drawer of the clean PPE cart. Furthermore, the DNS identified she was going to change the process and request staff to store the shields in a bag in a separate location. Interview with The RN Supervisor (RN#1) on 8/24/20 at 2:09 PM identified she was responsible to stock the PPE carts on the observation unit and stocked the carts on 8/24/20 at approximately 10:00 AM with face masks and gowns and did not stock the cart with face shields because she did not check to see if they were needed. Review of the inservice education form dated 8/24/2020 identified NA #1 and NA #2 were educated on PPE removal and hand hygiene. Review of the hand hygiene competency tool dated

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

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) 8/24/2020 identified NA#1 was observed by RN #4 washing her hands correctly. Review of the policy entitled handwashing identified all staff would wash their hands after handling contaminated items or equipment. Review of the policy entitled Interim infection control recommendations for patients with suspected or confirmed coronavirus disease 2019 identified health care providers should take care not to touch their eye protection and if they do touch the eye protection perform hand hygiene immediately. Additionally, the policy directed to wear gloves whenever touching patients, intact skin, surfaces or articles that were near the patient such as medical equipment.