STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075328	A. BUILDING _____ B. WING _____	09/01/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WATROUS NURSING CENTER	**9 NECK ROAD MADISON, CT 06443**

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 0812 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** Based on observations and interviews, the facility failed to ensure that the dietary staff utilized hair coverings during food preparation. The finding includes: Observations with the Administrator on 9/1/20 at 11:45 AM identified the Director of Dietary services in the kitchen preparing for lunch without a beard covering but wearing a surgical mask that only covered half of the facial hair. An interview with Director of Dietary on 9/1/20 at 11:48 AM indicated he was doing lunch prep. The Director of Dietary indicated he/she should have put a beard guard on but had forgotten. The Director of Dietary placed a beard guard over his full beard after surveyor inquiry. An interview with the Administrator on 9/1/20 at 11:50 AM identified that the Director of Dietary should have had on a beard covering when he/she was in the kitchen. The Administrator further identified that he/she expects all staff in dietary to wear a hair net, beard covering and a surgical mask. Review of the facility's policy regarding dietary staff, identified that it was every employee's responsibility to protect the health of the residents. This includes the donning of a hair net for all exposed hair and a beard guard is included in this requirement.
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 observation, review of the clinical record, facility documentation, facility policy, and interviews for four sampled residents (Residents # 1, 2, 3, & 4) reviewed for Infection Control, the facility failed to follow standard protocols and procedures for infection control. The findings include: A. Resident #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A quarterly MDS assessment dated [DATE] identified the resident had intact cognition, did not have behaviors, required limited assistance with bed mobility and dressing, required supervision with ambulation and was continent of bowel and bladder. A nurse's note dated 8/21/20 at 3:36 PM identified that Resident #1's daughter was contacted to report that the resident had an appointment with an allergist on 8/26/20. A physician's orders [REDACTED]. A nurse's note dated 8/27/20 at 8:02 AM identified that at 4:15 AM resident was covered from head to toe with [MEDICATION NAME] cream for lice. The note further identified that Resident #1 would need to be showered between 12:15 PM and 4:15 PM and that the application of the cream would need to be repeated in one week. A nurse's note dated 8/27/20 at 10:21 PM identified that Resident #1 was showered, and his/her room was cleaned. The note further identified that Resident #1 continued to complain of itching and was medicated twice during shift with fair effect. A nurse's note dated 8/28/20 at 2:15 PM identified that the daughter was contacted and updated that Resident #1 was status [REDACTED]. The physician was notified, and a treatment was ordered. Observations during tour with the DNS and Administrator on 9/1/20 at 9:00 AM identified Resident #1 had an empty isolation cart outside of his/her entrance of room. There wasn't a sign posted indicating what type of isolation precautions resident #1 was on. The DNS removed the isolation cart from outside of the room and indicated that Resident #1 was no longer on precautions. An interview with the DNS on 9/1/20 at 9:00 AM identified that Resident #1 was on isolation precautions for lice but was taken off isolation precautions on 8/28/20 after the first shower. The DNS identified that staff did not get the message and the isolation cart outside of the room was not removed. Interview with the DNS on 9/1/20 at 1:15 PM indicated that Resident #1 was sent to the Allergist on 8/26/20 for a rash all over his/her body and was given a [DIAGNOSES REDACTED].#1 was placed on precautions on 8/26/20 when she/he returned from the appointment with the allergist. The DNS indicated Resident #1 was showered on 8/27/20 and believes she/he removed the isolation precautions on 8/28/20 but did not have any documentation. The DNS indicated she/he did not believe Resident #1 had lice and she/he did not remove the roommate (Resident #2) but treated the roommate with the [MEDICATION NAME] cream, who was also scheduled for a second treatment a week later. The DNS indicated she/he should have kept Resident #1 on precautions until after the second treatment and noted that she/he would place Resident #1 back on isolation precautions. A review of the clinical record and subsequent interview with the DNS on 9/1/20 at 1:30 PM, failed to provide documentation that Resident #1 was on isolation precautions from 8/26/20 through 9/1/20 (date of observation). A facility policy for Isolation precaution for Pediculosis was requested but none was provided. The DNS indicated she/he would contact the corporate office for a policy. B. Resident #2 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A quarterly MDS assessment dated [DATE] identified the resident had intact cognition, no behaviors, required limited assistance with bed mobility, dressing, toilet use and personal hygiene. The assessment further noted that the resident did not ambulate, was occasional incontinent of bladder and always continent of bowel functioning. A physician's orders [REDACTED]. Repeat in one week. The nurse's note dated 8/27/20 at 8:00 AM identified that at 4:15 AM Resident #2 was covered from head to toe with [MEDICATION NAME] cream. Resident #2 was due to be showered between 12:15 PM and 4:15 PM. The nurse's note dated 8/27/20 at 10:05 PM identified Resident #2 was showered in the evening, room and belongings cleaned. Observations during tour with the DNS and Administrator on 9/1/20 at 9:00 AM identified Resident #2 had an empty isolation cart outside of his/her entrance of room. There was no sign posted indicating what type of precautions resident #2 was on. The DNS removed the isolation cart from outside of the room at that time indicating Resident #2 was off precautions as of 8/28/20. An interview with the DNS on 9/1/20 at 9:00 AM indicated Resident #2 was on precautions for lice but was removed off isolation precautions on 8/28/20 the day after she/he was showered. The DNS indicated she/he was treating Resident #2 because she/he was the roommate of Resident #1. An interview with the DNS on 9/1/20 at 1:20 PM identified she/he removed the isolation precautions on 8/28/20 the day after the shower but did not have any documentation to clarify the dates. The DNS indicated she/he should have kept Resident #2 on precautions until after the second treatment. The DNS indicated she/he will place Resident #2 back on isolation precautions. Interview and clinical record review with the DNS on 9/1/20 at 1:45 PM, failed to provide documentation that Resident #2 was on isolation precautions from 8/26/20 through 9/1/20 (day of observation). Although requested, a facility policy for Isolation precaution for Pediculosis was not provided. DNS indicated she/he would contact the corporate office for a policy. C. Resident # 3 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The care plan dated 8/25/20 identified a psycho-social care plan for isolation and noted that the resident was at risk for loneliness, anxiety, and increased sadness, related to isolation precautions implemented due to COVID 19. A 5-day MDS assessment dated [DATE] identified the resident had moderate cognitive impairment, required limited assistance for bed mobility, extensive assistance for transfers and limited assistance for ambulation. Observation on 9/1/20 at 11:15 AM identified an isolation sign posted at the doorway to the resident's room and a three draw isolation cart that was empty also placed at the doorway. A certified occupational therapy assistant (COTA #1) entered Resident #3's room wearing a surgical mask and gloves. COTA #1 was not wearing a face shield or gown as the sign directed. COTA #1 was with Resident #3 sitting on the other side of the room in a bedside chair next to the window with the door partially closed. COTA #1was standing directly in front of Resident #3 (within 3 feet) and Resident #3 was not wearing a mask. An interview with COTA #1

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 -** Few	(continued... from page 1) on 9/1/20 at 11:20 AM indicated she/he did not wear a face shield or a gown in the room because there wasn't one in the isolation cart next to the door and she/he would have to go get the personal protective equipment (PPE) supplies. COTA #1 indicated she/he was aware prior to going into the room that Resident #3 was on isolation precautions because he/she was a new admission and is on COVID-19 isolation precautions for 14 days. COTA #1 indicated she/he was only going to be in the room for a few minutes. After surveyor inquiry COTA #1 went and retrieved the necessary supplies and filled the isolation cart. COTA #1 re-entered Resident #3's room with a face shield, surgical mask, gown and gloves. An interview with the Administrator on 9/1/20 at 11:25 AM noted his/her expectation was that all staff members wear a face shield, surgical mask, gown and gloves when entering a resident's room and remove all PPE prior to leaving the room when a resident is within the 14 day quarantine period and has signage denoting that the resident is on precautions and the PPE required. An interview with the DNS on 9/1/20 at 2:35 PM noted that new admissions were placed on the presumptive unit and are placed on isolation precautions for 14 days. The DNS indicated Resident #3 was on isolation precautions and any staff member that enters the room should put on a face shield, surgical mask, gown and gloves prior to entering the room and remove all items before leaving the room. The DNS indicated it was her/his responsibility to fill the isolation carts daily, but the supervisors also have access to supplies and can refill them as needed. The DNS failed to provide the facility's policy on isolation precautions related to COVID-19. D. Resident # 4 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. An admission MDS assessment identified the resident had moderate cognitive impairment, required extensive assistance with bed mobility and supervision with transfers and ambulation. A nurse's note dated 8/11/20 at 11:09 PM identified that Resident #4 had diarrhea x 3 in the evening and the laboratory faxed over results of a stool sampled that indicated it was positive for [MEDICAL CONDITIONS] and the APRN was notified and new orders were obtained. It further noted that contact precautions were maintained. A physician's orders [REDACTED]. A Physician's progress note dated 8/12/20 indicated Resident #4 had diarrhea over the weekend, altered mental status, fatigue, weakness, and a fever 101.6. The care plan dated 8/20/20 identified the resident had [MEDICAL CONDITION] with interventions that included; give antibiotics as ordered, contact precautions, and provide incontinent care as needed. A physician's orders [REDACTED]. Observations with the Administrator on 9/1/20 at 11:30 AM identified Resident #4 had an empty isolation cart outside of the doorway and a contact precaution sign on the door. LPN #1 had nursing supplies in her/his hands and entered Resident #4's room wearing a surgical mask and gloves. An interview with LPN #1 on 9/1/20 at 11:35 AM indicated that Resident #4 was on contact precautions because he/she had [MEDICAL CONDITION]. LPN #4 indicated she did not wear a gown in the room because she/he was not going to be touching Resident #4's stool. LPN #1 indicated she was taking care of his [DEVICE] and feeding supplies. LPN #1 identified that Resident #4 had a stool sent out to be tested to see if Resident #4 still had [MEDICAL CONDITION] and results were pending. An interview with the Administrator on 9/1/20 at 11:40 AM indicated Resident #4 was currently on contact precautions and he/she would expect all staff members to wear a surgical mask, gown and gloves when entering the room and take all PPE off before exiting the room. An interview with the DNS on 9/1/20 at 2:40 PM indicated Resident #4 was on contact precautions for [MEDICAL CONDITION]. The DNS identified that she/he would expect all staff to don a surgical mask, gown and gloves before entering the room and remove all PPE before exiting the room. In addition, the DNS identified that if there was a potential for splashing, staff should wear booties. The facility failed to ensure that staff donned the appropriate PPE for a resident on contact precautions.