STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075213	A. BUILDING _____ B. WING _____	C 04/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN HILL REHAB PAVILION	2028 BRIDGEPORT AVE MILFORD, CT 06460

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A COVID-19 Focused Survey was conducted on 4/2, 4/9 and 4/14/19 at Golden Hill to determine compliance with 42 CFR Part 483 Requirements for Long Term Care Facilities, including proper infection prevention and control practices to prevent the development and transmission of COVID-19. Additionally, complaint investigations CT27304, CT27321, CT27339, 27327 and 27356 were completed at that time. Deficiencies were cited as a result of this survey. Abbreviations which may be used throughout this document include the following: ADL ('s) - activities of daily living (bathing, dressing, toileting etc.) ADNS/ADON - Assistant Director of Nursing AIMS - Abnormal Involuntary Movement Scale AMA - against medical advice APRN - Advanced Practice Registered Nurse ATC - around the clock AVF - arteriovenous fistula (hemodialysis access site) BIMS- Brief Interview for Mental Status BUN - Blood Urea Nitrogen C-Diff - Clostridium Difficile (Colitis) CPAP - Continue Positive Airway Pressure CPR - Cardiopulmonary Resuscitation CT - computerized tomography cc - cubic centimeter (a measurement of volume) cm - Centimeter COP - Conservator of Person COPD - Chronic obstructive pulmonary disease CPAP - Continuous positive airway pressure (used for sleep apnea) CVA - Cerebrovascular Accident (stroke) DJD - Degenerative Joint Disease (osteoarthritis)	F 000		

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

Electronically Signed | 05/08/2020

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.

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DNS/DON - Director of Nursing
DTI - Deep Tissue Injury (pressure related)
DVT - Deep Vein Thrombosis (blood clot)
EMS - Emergency Medical Services
ED/ER - Emergency Department of acute care hospital
ESBL - Extended spectrum beta-lactamase
ESRD - End Stage Renal Disease
FSS/FSD - Food Service Director/ Food Service Supervisor
GERD - Gastroesophageal Reflux Disease
GI - gastrointestinal
I&O - fluid intake and output monitoring/measuring
IP - Infection Preventionist
IV - intravenous
INR - International Normalized Ratio (used to determine the clotting tendency of blood)
L/min - liters per minute
LCSW - Licensed Clinical Social Worker
lbs. - pounds
LPN - Licensed Practical Nurse
MAR - Medication Administration Record
MASD: moisture associated skin damage
MD - Medical Doctor
MDS - Minimum Data Set (interdisciplinary assessment tool)
MFP - Money Follows the Person
mg - milligrams
MI - myocardial infarction (heart attack)
mm/Hg - millimeters of mercury (unit used to measure blood pressure/oxygen saturation)
MMSE - Mini Mental State Examination
mmol/L - millimoles per liter
MRSA - Methicillin Resistant Staphylococcus Aureus
MDRO - Multi Drug Resistant Organisms
MVA - motor vehicle accident
NA - Nurse Aide

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F 000	Continued From page 2 OT - Occupational Therapist PASRR - Preadmission Screen Resident Review PEC- Physician's Emergency Certificate POA - Power of Attorney PPD - purified protein derivative (a skin test to check for TB) PPE - Personal Protective Equipment (used with isolation precautions) ppm - parts per million PT - Physical Therapist RAI - Resident Assessment Instrument (manual to complete the MDS) RCP - resident care plan RN - Registered Nurse SICU - Surgical Intensive Care Unit SLP - Speech-Language Pathologist SNF - Skilled Nursing Facility STAT - medical abbreviation for urgent or rush SW - Social Worker TAR - Treatment Administration Record TB - tuberculosis Ug/ml - micrograms per milliliter- a measurement of concentration UTI - urinary tract infection VRE - Vancomycin Resistant Enterococcus	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a	F 580		5/22/20

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F 580	Continued From page 3 deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).	F 580		

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F 580	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on review of the clinical record, facility documentation, facility policy, and interviews for 1 of 2 residents (Resident #2) reviewed for notification of change in condition, the facility failed to ensure that the resident's Conservator of Person (COP) was notified when the resident's condition changed, including orders for diagnostic testing, out of facility transfers, and changes in medications. The findings include: Resident #2 was admitted to the facility on 3/5/20 with diagnoses that included hypertension, cough, fever, and iron deficiency anemia. The nurse's note dated 3/6/20 at 9:29 PM identified Resident #2 was seen by the physician and new orders were obtained for a chest x-ray, EKG, and blood work to be drawn on Monday. The nurse's note failed to reflect that the resident's COP was notified of the new orders. The nurse's note dated 3/7/20 at 1:46 PM identified the chest x-ray result was abnormal and the APRN was notified. The APRN gave new order to send Resident #2 to the emergency room for a CT Scan of the chest. The nurse's note failed to reflect that the COP was notified of the chest x-ray result or the new order to transfer the resident to the hospital. The nurses note indicated a message was left for the Conservator of Estate to return call to the facility. The nurse's note dated 3/7/20 at 2:17 PM identified Resident #2 was transferred to the hospital at 1:10 PM.	F 580	The facility does not agree with the findings. It is alleged the facility failed to notify resident representative of changes as follows: It is stated that the facility failed to ensure that the resident #2's Conservator of Person was notified when the resident's condition changed. Resident number 2 no longer resides at the facility. Other residents have the potential to be affected by the same deficient practice. Actions taken: Licensed nursing staff educated by the Director of Nurses/ designee that any change of condition require MD notification, responsible party notification and documentation that MD and responsible party have been notified. Licensed nursing staff educated by Director of Nurses/ designee on role of Conservator of Person vs Conservator of Estate. Director of Nursing/ designee to conduct a random audit 4x weekly for 4 weeks, then 3x a week for 4 weeks, then weekly and PRN as indicated to check documentation exists to support that MD and responsible	

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F 580	Continued From page 5 The nurse's note dated 3/7/20 at 8:30 PM identified Resident #2 returned to the facility from the hospital after being evaluated for a positive PPD (a skin test to check for tuberculosis). The initial chest x-ray prior to transfer to the hospital identified a right lower lung effusion. The chest x-ray performed at the hospital indicated a negative result, no consolidation/infiltrates noted. The APRN and DNS were made aware of Resident #2's returned to the facility. The nurse's note failed to reflect that the COP was notified of Resident #2's returned to the facility. The nurse's note dated 3/9/20 at 2:48 AM identified LPN #7 explained to Resident #2 that a urinalysis was needed and Resident #2 refused. The nurse's note failed to reflect that the COP was notified of Resident #2's refusal of the urinalysis or the order for the urinalysis. The nurse's note dated 3/9/20 at 12:53 PM identified Resident #2 refused the ordered blood work. The nurse's note failed to reflect that the COP was notified of Resident #2's refusal of blood work. The MDS dated 3/10/20 identified Resident #2 had mildly impaired cognition and required extensive assistance with personal hygiene. A physician's order dated 3/28/20 directed Resident #2 is on skilled care for observation related to presumptive Coronavirus, pulmonary monitoring, and droplet precautions. The nurse's note dated 3/28/20 at 3:16 PM identified Resident #2 was found on the floor at approximately 2:00 PM. The nurse's note identified a message was left for the Conservator	F 580	party notification occurred. Findings to be reported to QAPI committee monthly and updated as indicated. Compliance date: 5/22/2020	

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F 580	Continued From page 6	F 580		

of Estate to call the facility. The nurse's note failed to reflect that the Conservator of Estate was notified or updated regarding the fall. The nurse's note failed to reflect that the COP was notified of the fall.

The nurse's note dated 3/31/20 at 4:00 PM identified RN #2 was called to the resident's room regarding Resident #2 temperature of 101.4 F and observed with shallow breathing. Lungs were clear to auscultation. The APRN was notified with new orders to administer oxygen as needed when oxygen saturation is < 92%, obtain a chest x-ray, swab for influenza and obtain blood work. The nurse's note identified a message was left for the COP to call the facility. The nurse's note failed to reflect that the COP was notified or updated regarding the resident's fever, shallow breathing, and new orders.

A physician's order dated 3/31/20 directed to administer oxygen at 2 Liters per minute via nasal cannula as needed if oxygen saturated is < 92% on room air.

The nurse's note dated 3/31/20 at 10:00 PM identified new orders for Avelox (medication used to treat infection) 400 mg by mouth every day for 10 days. The nurse's note identified a message was left for the Conservator to call for update. The nurse's note failed to reflect that the COP was notified or updated regarding the chest x-ray result and new order.

A physician's order dated 3/31/20 directed to administer Moxifloxacin (Avelox) 400 mg tablets by mouth daily times 10 days.

The nurse's note dated 4/1/20 at 9:02 AM

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F 580	Continued From page 7 identified Resident #2 is on antibiotic for pneumonia, is on droplet precautions, influenza swab was done, and Resident #2 refused blood work. Oxygen is in place. The nurse's note failed to reflect that the COP was notified of the antibiotic order, droplet precautions, influenza swab being obtained, and Resident #2's refusal of blood work. The nurse's note dated 4/1/20 at 6:32 PM identified Resident #2 was alert, had a dry cough noted, no labored breathing, oxygen saturation 94% with oxygen via nasal cannula, lung sounds diminished in all fields, and temperature 100.2 F. Resident #2 denied body aches, headache, gastro-intestinal upset, droplet precautions maintained, and COVID-19 test pending. The nurse's note failed to reflect that the COP was notified of the new order for COVID-19 test, or that the test was pending. The care plan, updated on 4/2/20, identified Resident #2 is at risk for respiratory complications related to a possible exposure to COVID -19 and related to increase risk factors and advanced age. On 4/2/20 Resident #2 tested positive for COVID-19. Interventions included to complete respiratory risk assessments and monitor respiratory status for at least 14 days or as ordered. Isolate in room, medications as ordered. Notify the physician for transfer to hospital as with any acute respiratory illness. Use principles of infection control and universal/standard precautions. The nurse's note recorded as a late entry on 4/3/20 at 12:41 PM identified a note dated 4/2/20 at 12:25 PM identified RN #1 was called to unit at 9:25 AM and identified Resident #2 was lying in	F 580		

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F 580	Continued From page 8 bed without respiration, and staff are unable to obtain apical pulse. Resident #2 is a full code, 911 was initiated, chest compression/air high flow started. At 9:40 AM, 911 in the building, chest leads placed by 911 personnel and indicated asystole. EMS call to Medical Director at approximately 9:45 AM, 911 personnel pronounced Resident #2 expired. The APRN was notified, call placed to conservator and message left with request for call back. Call placed again to Conservator of Estate and Conservator of Person and updated on Resident #2 status. An interview and clinical record review with RN #1 on 4/9/20 at 3:35 PM indicated he/she notified both Conservator of Estate and Conservator of Person when Resident #2 expired. RN #1 indicated he/she notified both conservators because the names in the chart listed both parties as the conservators. RN #1 indicated when there is a change in resident condition the nurses should notify the responsible party/families. RN #1indicated the nurses are responsible to follow up with making sure the responsible party/families are updated. An interview with LPN #1 on 4/15/20 at 9:32 AM identified it is his/her usual practice to notify the family when there is a change in resident condition. LPN #1 indicated he/she usually will follow through during the shift to make sure that the families are aware of what is going on with their loved ones. An interview with LPN #2 on 4/15/20 at 10:06 AM identified he/she notified RN #1 regarding Resident #2's temperature of 100.2 F. Additionally, LPN #2 indciated RN #1 performed the Covid-19 test on the resident. LPN #2	F 580		

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F 580	Continued From page 9	F 580		

indicated he/she did not notify the resident's family regarding the temperature of 100.2 F due to the facility protocol that read 100.4 F and above is considered a temperature. LPN #2 identified the Conservator of Estate is for finance, and Conservator of Person is responsible for medical issues. LPN #2 indicated the nurses are responsible to notify the supervisor and the responsible party with change in resident condition.

An interview with LPN #4 on 4/15/20 at 11:04 AM identified he/she left a message for the Conservator of Estate to call the facility and he/she informed the in-coming nurse to notify the conservator that Resident #2 was found on the floor. LPN #4 indicated that he/she is aware of the difference between Conservator of Estate/Person and that on 3/28/20 the COP was not listed on the face sheet, only one person was listed and that was the Conservator of Estate.

An interview with LPN #5 on 4/15/20 at 11:49 AM identified if he/she did not document that the family was notified of the refusal of blood work, that means he/she did not call or notify the family. LPN #5 indicated that the APRN was notified. LPN #5 indicated the facility protocol is to notify the family or conservator with new orders and change in resident condition.

An interview with RN #3 on 4/15/20 at 1:43 PM indicated he/she is an agency nurse. RN #3 indicated he/she spoke to the Conservator of Person when Resident #2 returned from the hospital, however, he/she does not know why the conversation was not documented.

An interview with RN #6 on 4/15/20 at 2:38 PM

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F 580	Continued From page 10	F 580		

indicated he/she called the COP and left a message to call facility for an update regarding Resident #2's temperature of 101.4 F, new orders for a chest x-ray, flu swab, and blood work. RN #6 indicated no call was returned from the COP.

An interview with Person #7 on 4/21/20 at 3:05 PM indicated he/she is the COP for Resident #2. Person #7 indicated he/she received only 2 calls from the facility since Resident #2 was admitted. The two calls were on 3/31/20 and 4/2/20. Person #7 indicated he/she received a phone call on 3/31/20 from a Greenwich number which was unfamiliar, and he/she did not answer. Person #7 indicated on 4/2/20 around 11:25 AM he/she received a call from that same number from Greenwich that he/she had received on 3/31/20. Person #7 indicated he/she received 3 consecutive calls from the Greenwich number and answered the phone the third time. Person #7 indicated that a male nurse informed him/her that they were calling from the facility to report that Resident #2 has died. Person #7 indicated he/she asked the nurse what happened and was Resident #2 sick. The nurse indicated that when he/she went into the room Resident #2 was unresponsive and although staff attempted to resuscitate, and called 911, the resident died.

Review of the Facility Change in a Resident's Condition or Status policy identified the facility shall promptly notify the resident, his or her attending physician, and representative (sponsor) of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care, billing/payments, resident rights, etc.). Unless otherwise instructed by the resident, a nurse will notify the resident's representative when: The resident is involved in any accident or

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F 580	Continued From page 11 incident that results in an injury including injuries of an unknown source; there is a significant change in the resident's physical, mental, or psychosocial status; a decision has been made to discharge the resident from the facility; and/or it is necessary to transfer the resident to a hospital/treatment center. The facility failed to notify Resident #2's COP when the resident had changes in his/her medical condition, was placed on oxygen, was sent to the hospital for evaluation and returned, was tested for Covid 19, and was placed on antibiotic for infection.	F 580		