

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER 075377	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/15/2020
NAME OF PROVIDER OF SUPPLIER WEST RIVER REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP 245 ORANGE AVENUE MILFORD, CT 06460	
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 0686 Level of harm - Minimal harm or potential for actual harm Residents Affected - Few	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</p> <p>Based on observations, review of facility documentation, review of facility policy, and interviews, the facility failed to ensure a comprehensive wound assessment was conducted by a Registered Nurse (RN). The findings include: Resident #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 was without cognitive impairment, required extensive assistance with bed mobility, toilet use, and personal hygiene, and was dependent on staff for transfers. The Resident Care Plan (RCP) dated 9/2/20 identified [MEDICAL CONDITION] of the right lower limb. Interventions directed to administer antibiotics. Review of the facility wound documentation dated 9/7/20 and 9/9/20 identified Resident #1 had the following wounds: Right shin, unspecified ulcer that measured 1.0 cm x 0.5 cm x 0.1 cm on 9/7/20 at 5:18 PM. Right shin ruptured blister that measured 6.5 cm x 3.5 cm on 9/7/20 at 5:16 PM. Right ankle unspecified ulcer that measured 1.0 cm x 1.0 cm x 0.1 cm on 9/7/20 at 5:12 PM. Abrasion, right second toe on 9/7/20 at 5:13 PM. Coccyx, unspecified ulcer that measured 3 cm x 3 cm x 0.1 cm on 9/9/20 at 4:12 PM. Interview and review of facility documentation with Licensed Practical Nurse (LPN) #1 on 9/15/20 at 11:30 AM identified that the wound physician did not attend wound rounds with LPN #1 on 9/7/20 when Resident #1's weekly wound documentation occurred. LPN #1 identified that although he/she informed the RN Supervisor of a change in Resident #1's wounds and that he/she was measuring Resident #1's wounds, the RN Supervisor never assessed Resident #1's wounds on 9/7/20 or on the day of Resident #1's discharge 9/9/20 at 1:30 PM. LPN #1 identified that he/she was aware of the need for an RN to conduct the wound assessment. Interview with the Director of Nurses (DNS) on 9/15/20 at 12:35 PM identified that he/she thought there was a waiver in place, due to the COVID-19 virus, allowing LPN #1 to assess Resident #1's wounds. Subsequent review of the waiver failed to identify that LPN #1 was permitted to conduct a wound assessment under the COVID-19 waiver.</p>		

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.