STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075061	A. BUILDING _____ B. WING _____	**05/20/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
CASSENA CARE AT STAMFORD	**53 COURTLAND AVENUE STAMFORD, CT 06902**

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 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 1 resident (Resident #1) reviewed for infection control, the facility failed to ensure proper resident placement on a unit with residents known to have Covid-19. The findings include: Resident #1 was admitted on [DATE] with [DIAGNOSES REDACTED]. Resident #1 was responsible for him/herself. The quarterly minimum data set (MDS) assessment dated [DATE] identified Resident #1 was without cognitive impairment and required extensive assist with personal care. A nursing progress note dated 5/12/20 identified Resident #1 was tested for Covid-19 due to exposure. A subsequent nursing progress note dated 5/14/20 identified Resident #1 tested negative for Covid-19. The resident was notified of the result and advised of possible room change for cohorting purposes. A late entry nursing progress note dated 5/14/20 identified Resident #1 had tested negative for Covid-19 and remained on a designated Covid unit. Call placed to facility ombudsman for the facility with assist with moving the resident to a non-Covid unit. The ombudsman was notified on 5/14/20 at 9:45AM of the situation and the resident's refusal to be moved from his/her private room. The ombudsman indicated s/he would reach out to Resident #1 but the Resident was not accepting calls on the cell phone. Call placed to the Medical Director on 5/14/20 at 10:00AM and reported Resident #1 had tested negative for Covid with recommendations to move and resident refusal. Staff provided education risks and benefits of remaining on a Covid-19 unit. The resident continued to refuse and was responsible for him/herself. The care plan dated 5/19/20 identified Resident #1 had a behavioral problem related to [MEDICAL CONDITION] refusing to get out of bed at times. Interventions included the administration of medications as ordered and monitoring behavior episodes, attempt to determine underlying cause and document behavior and potential causes. The care plan also identified Resident #1 was at risk of Covid-19 related to pandemic outbreak with interventions that included providing education to resident and families regarding Covid-19 and report to physician any change in status including new onset fever, cough, runny nose, chest pain, body aches and shortness of breath. An observation on 5/19/20 during the tour on 11:50AM identified Resident #1 was in a private room on a designated unit for residents known to have Covid-19. The census at the time of observation was 128 with a capacity of 156. An interview on 5/19/20 at 12:10PM with the Regional Nurse Consultant identified Resident #1 had very challenging behaviors related to bi-polar and was responsible for him/herself. Several attempts were made to discuss safety concerns and encourage Resident #1 to move from her room to a unit where there were no known cases of Covid-19. Resident #1 repeatedly refused to move. The Regional Nurse Consultant identified the matter was discussed with the Medical Director who also determined Resident #1 should be moved off the unit dedicated to residents with known Covid-19 and onto a unit where there were no known cases of Covid-19. The Regional Nurse Consultant further identified the facility state resident representative had been attempting to reach Resident #1 phone to discuss the move but had not yet spoken to Resident #1 to his/her knowledge. The concern over refusal had not been discussed with Resident #1's psychiatrist. Nursing progress notes, mental health progress notes and physician progress notes [REDACTED].#1 exhibited occasional maladaptive behaviors with no documented discussion related to the need for a room change for resident safety related to Covid-19. Subsequent to surveyor inquiry the care plan was dated 5/20/20 was updated to include Resident #1's refusal to change rooms for cohorting purposes with interventions to educate resident on the increased risk of infection secondary to refusal of a room change. The facility policy dated 5/16/20 related to Cohorting for Covid 19 directed when there are only a few residents with Covid-19 in the facility, they may be cohorted on part of a unit, such as the end of the hallway (or a specific unit or wing or groups of rooms) as determined by the infection control preventionist and Medical Director. CDC guidance for resident placement recommends facilities could consider designating entire units within the facility, with dedicated healthcare personnel (HCP), to care for patients with known or suspected COVID-19 and a dedicated means that HCP are assigned to care only for these patients during their shift. The facility failed to ensure proper resident placement on a unit with residents known to have Covid-19.

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