STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075377	A. BUILDING _____ B. WING _____	10/07/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WEST RIVER REHAB CENTER	**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 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 observations, clinical record review, review of facility documentation, review of facility policy, and interviews, for five of five sampled residents (Residents #3, 4, 5, 6, and 7) reviewed during the facility infection prevention tour, the facility failed to ensure dining activities were suspended during a COVID-19 outbreak. The findings include: a. Resident #1 was discharged from the facility on 10/5/20, admitted to the hospital and tested positive for COVID-19. b. Resident #3's [DIAGNOSES REDACTED]. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #3 had long and short term memory problems and was totally dependent on staff for Activities of Daily Living (ADL's) including wheelchair mobility. c. Resident #4's [DIAGNOSES REDACTED]. The quarterly MDS assessment dated [DATE] identified Resident #4 was severely cognitively impaired and required extensive assistance with transfers and wheelchair mobility. d. Resident #5's [DIAGNOSES REDACTED]. The quarterly MDS assessment dated [DATE] identified Resident #5 was severely cognitively impaired, required extensive assistance with transfers, and was dependent on staff for wheelchair mobility. e. Resident #6's [DIAGNOSES REDACTED]. The annual MDS assessment dated [DATE] identified that Resident #6 was severely cognitively impaired and required extensive assistance with transfers, required extensive assistance for ambulation, and was dependent on staff for wheelchair mobility. f. Resident #7 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The nurse's note dated 10/5/20 at 9:38 PM identified that Resident #7 was confused and disoriented to place and time. Additionally, Resident #7 was on droplet precautions for 14 days due to facility protocol. The nurse's note dated 10/6/20 at 5:22 PM identified notification that a resident tested positive for COVID 19 at the hospital and all group activities were canceled. The Resident #7's Care Plan (RCP) dated 10/7/20 identified Psychosocial well-being, potential risk for mental distress, and alteration in mood state and psychosocial well-being secondary to the changes and restrictions. Interventions directed to avoid group situations such as communal dining and group activities and implement changes and restrictions on visitation, group meetings, activity program restrictions as recommended by the CDC and the state survey agency. The nurse's note dated 10/7/20 at 11:59 AM identified that Resident #7 was confused and expressed frustration regarding being on observation. Education was provided that all new admissions were placed on precautions and updated that there were no group activities at all. Observation, interview, and review of facility policy with the Director of Nurses (DNS) on 10/7/20 at 12:40 PM in the second floor lounge, identified Residents #3, #4, #5, #6 and #7 eating lunch without the benefit of masks. Resident #3, #5 and #6 were seated alone at individual tables. Resident #4 was seated at the same table and directly across from Resident #7 who was considered a person under investigation for COVID-19. Interview with the DNS identified that the lounge should not have been used for lunch due to the instance of a positive case of COVID-19. The DNS identified that all residents should have been quarantined to their rooms and that communal dining and activities had been suspended. The DNS identified that he/she would be looking into which staff had initiated communal dining. Re-interview with the DNS on 10/7/20 at 2:30 PM identified that although both Resident #4 and Resident #7 had wandered out of their rooms into the dining room she was unable to explain how the residents were provided meal trays.

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.