STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075438	A. BUILDING _____ B. WING _____	**06/14/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ORCHARD GROVE SPECIALTY CARE CENTER, LLC	**5 RICHARD BROWN DRIVE UNCASVILLE, CT 06382**

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 0725 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, a review of the facilty documentation and staff interviews for 3 of 8 residents (Resident #1, Resident #2 and Resident #3) reviewed for dining services, the facilty failed to provide sufficient staff and implement policies and procedures for staffing strategies during an emergency (COVID-19 pandemic) to ensure adequate and timely assistance was provided to residents who required supervision and/or assistance with meals. The findings include: a. Resident (R) #1 was admitted to the facilty on 10/4/17 with [DIAGNOSES REDACTED]. The annual Minimum Data Set ((MDS) dated [DATE] identified severe cognitive impairment and required extensive assistance of one person for dressing, toilet use, personal hygiene and eating, and was dependent for bathing. The individualized resident assessment dated [DATE] identified R #1 ate a regular diet and could eat with set up and assistance. A physician's orders [REDACTED]. Observation of the first-floor assisted dining room on 6/14/20 at 9:00 AM identified plates of food on 4 tables, covered, and staff were not in the dining room. R#1 was sitting at a table by him/herself with a mask covering his/her face. The meal ticket identified R #1 required supervision. R #1 held a peeled uneaten banana in his/her right hand, a bowl of cheerios and a bowel of chopped fruit in front of him/her on the table absent silverware. Interview with NA #2 on 6/14/20 at 9:05 AM identified R #1 was in the dining room without staff supervision because he/she was not a choking hazard and only required cues to eat his/her meals. Additionally, NA #2 identified staff were not in the dining room because they were still getting residents up and out of bed. Interview with the RN #1 (Nursing Suoervisor), on 6/14/20 at 9:05 AM identified breakfast service was late because a nurse aide called out and another nurse aide was 45 minutes late for work. Observation at 9:10 AM identified 8 residents in the dining room with two staff members who began to feed and assist the residents with dining. Observation of R #1 between 9:00 AM and 9:30 AM identified R#1 attempted to intermittently feed him/herself without the benefit of a staff member cuing or assisting him /her. Additionally, R #1 did not know how to remove the face mask or get the food to his/her mouth. Observation at 9:30 AM identified NA #1 removed the mask and provided R #1 with a spoon to eat his/her food, and left the table without cuing resident. Observation at 9:55AM identified the Director of Nursing (DON) feeding R #1 and indicated a speech therapy consult would be ordered because R #1 may need to be fed his/her meals instead of cues. Interview with NA #1 on 6/14/20 at 10:15 AM identified the kitchen staff left the plates of covered food in the dining room prior to 9:00 AM. NA #1 further identified there was not enough staff to assist in the dining room and he/she was assisting other residents with care and that is why residents were not fed timely. Additionally, NA #1 identified there was typically 3 or more staff members assigned to assist with feeding and there was only 2 NA's due to call outs and staffing issues. Additionally, NA #1 identified he/she was late to assist in the dining room because she had been assigned an entire wing of 16 residents (7 residents more than outlined in the facilty assessment for staffing plan). Additionally, NA #1 indicated 6 residents were dependent for transfers and had to be lifted out of bed using a Hoyer lift and she was doing the best she could. b. Resident #2 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The quarterly MDS dated [DATE] identified severe cognitive impairment, extensive assistance of two staff members for bed mobility, transfers, personal hygiene and dressing and extensive assistance of one staff member for feedings. The physicians order dated 5/27/20 directed to provide R #2 with a puree diet and honey thick liquids, a lipped plate, marron spoon and supervision in the dining room for all meals The care plan dated 6/4/20 identified R #2 was at risk for alteration in nutrition related to dementia. Interventions included to provide adaptive equipment as ordered. The care plan further identified R#2 had a self-care deficit and required assistance with self-care tasks secondary to weakness and impaired mobility. Interventions included to provide R #2 with a meal set up and assistance at each meal. Observation of R #2 on 6/15/20 at 9:15 AM identified R #2 was eating a thickened drink with a regular spoon. R #2's clothing protector was covered with liquid and the thickened drink was running down his/her chin. Additionally, pureed eggs and french toast was noted on a regular vs lipped plate and the eggs were smeared on R #2's right hand. NA #1 was sitting at R #2's table feeding another resident. Observation at 9:20 AM identified R #2 was not eating, and his/her eyes were closed. Observation at 9:35AM (35 minutes after the food was noted in front of R #2) identified NA #1 attempted to feed R #2 who would not eat because he/she was sleeping. Interview with NA #1 at 9:35AM identified she was unable to assist R #2 earlier because she was assisting another resident and did not have enough help. Additionally, NA #1 did not know why R #2 did not have his adaptive equipment and indicated it was the kitchen staff's responsibility to provide each resident with adapative equipment. c. R #3 was admitted to the facilty on 5/8/14 with [DIAGNOSES REDACTED]. The quarterly MDS dated [DATE] identified severe cognitive impairment and required extensive assistance for bed mobility, extensive assistance of one person for personal hygiene and eating, and was dependent for transfers and toilet use. The care plan dated 4/2/20 identified a self-care deficit and interventions that included to provide R #3 with a meal set up and assistance with each meal. The physicians order dated 5/27/20 directed to provide R #3 a puree diet with nectar thick liquids and to be out of bed for all meals in the dining room for supervision. Observation of R #3 on 6/14/20 from 9:00 AM to 9:35 AM identified R #3 sat at the table with a plate of covered food in front of him/her and was not provided assistance to eat and did not feed him/herself. Observation on 6/14/20 at 9:35 AM identified the DON entered the dining room and began to feed R #3 pureed eggs and french toast that had been sitting in front of the resident for greater than 30 minutes without the benefit of reheating. Interview with the DON on 6/14/20 at 10:00 AM identified breakfast begins at 8:00 AM and during the week there are usually 5 staff members in the dining room and included the receptionists who are nurse aides, therapy and administrative staff, and indicated these staff members were not available on the weekend. The DON further identified the food should have been left in a warmer until the resident was ready to eat or until staff was able to assist him/her and she did not know why that was not done. Observation of the food warmer identified it was located in the hall outside the dining room and was not plugged in. Review of the daily census report dated 6/14/20 identified the total number of residents was 99 out of 130 available beds in the facilty. Review of the daily nursing attendance report dated 6/14/20 identified 7 CNA's were staffed for the day shift, 10 CNA's for the second shift and 4 CNA's for the night shift. Review of the facilty assessment staffing to census form identified when the facilty census was 99 the facilty should staff 11 CNA's on the day shift, 10 CNA's on second shift and 6 CNA's on the night shift. Interview with the DON on 6/14/20 at 3:30 PM identified the facilty was absent 4 nurse aides on 6/14/20 from 7:00 AM to 3:00 PM. One CNA called out and the scheduler was unable to staff the 3 other openings. The DON indicated the nurse aides should not have been assigned more than 9 residents each per the facilty assessment and staffing to census ratios on the day shift and this did not occur. The DON indicated 3 nurses were placed on call, however, could not be used to cover the nurse aide call outs as they were used to replace the licensed staff who called in sick and/or had holes in the schedule. Furthermore, the DON identified the facilty had 20 open nurse aide positions and was not authorized by administration to use an outside staffing agency and indicated it was difficult to hire

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.

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F 0725 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) staff and/or find staff to cover from the internal pool due to the facilities location. Review of the amended contingency staffing plan dated 6/14/20, subsequent to discussions with administrative staff regarding low staffing levels, identified the staffing plan moving forward would allow the CNA's to care for 7-9 residents on the day shift and 10-11 residents on the 3-11 shift. Additionally, the plan indicated an on-call list of nurses would be created and used as back up support and the facilty would advertise for the temporary nurse aide position and offer bonuses for all nursing positions. Review of the Facilty Interim Contingency plan identified the corporation would provide adequate staffing per federal and state guidelines in a pandemic and would use an in-house agency pool to meet staffing needs. Additionally, the plan identified the facilty would use ancillary staff to assist with non-care items, use therapy staff to assist with activities of daily living as needed, administrative staff would assist with dining, department heads would be scheduled on off shifts and weekends to provide additional support, temporary nurse aides would be hired and trained to care for non covid residents, and an employee referral bonus would be offered.