STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075332	A. BUILDING _____ B. WING _____	**05/29/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
VALERIE MANOR	**1360 TORRINGFORD ST TORRINGTON, CT 06790**

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 0677 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, review of facility documentation, facility policy review and interviews for one sampled resident (Resident #1) who was required staff assistance with grooming and personal hygiene, the facility failed to provide care in accordance with the plan of care. The findings include: Resident #1's [DIAGNOSES REDACTED]. A physician's order dated 4/14/20 directed to complete a weekly body audit on Resident #1's shower day which was Tuesday. The Resident Care Plan dated 4/16/20 identified Resident #1 required supervision with self-care tasks due to the dementia. Interventions directed to provide assist of one as needed for self-care tasks and to encourage the resident's maximum participation in self-care tasks. The care plan failed to identify Resident #1's activities of daily living preferences, needs, goals or interventions. The admission Minimum Data Set assessment dated [DATE] identified Resident #1 had short and long term memory deficits, was not able to make decisions regarding tasks of daily life, had preferences for customary routines and activities that it was important for Resident #1 to have the option to choose between a tub bath, bed bath, shower and a sponge bath, required supervision and one (1) person assistance with repositioning while in the bed, transfers, ambulating and toileting, extensive one (1) person assistance with personal hygiene, grooming and the resident was totally dependent on staff for bathing. Review of the April and May 2020 Treatment Administration Records identified weekly body audits were conducted on 4/21/20, 4/28/20 and 5/4/20 when Resident #1 would have received a shower. Upon further review, the clinical record failed to reflect documentation Resident #1 had received showers, was shaven, had the fingernails trimmed and cleaned or indicate Resident #1 preferred showers, bed baths or sponge baths. The nursing progress notes dated 5/2/20 and 5/7/20 identified Resident #1 was alert and cooperative with hands on care. Review of the electronic clinical record failed to reflect documentation that a Resident Care Card was developed. Although requested, the Director of Nursing was unable to locate Resident #1's care card to provide to the surveyor. Interview with Person #1 on 5/29/20 at 10:40 AM identified that he/she spoke with the Administrator when Resident #1 was admitted to the facility and had requested Resident #1 was to be cleanly shaven, mustache trimmed and Resident #1's preference was a weekly shower in the afternoon or evening. Person #1 identified that during a window visit with Resident #1 on 4/26/20, Resident #1 had appeared unkempt with a beard, the fingernails were long with a dirt like substance, the hair appeared unwashed and stains were present on the resident's shirt. Person #1 identified his/her concern for Resident #1's appearance was brought to the attention of the Administrator. Person #1 indicated that when Resident #1 arrived at the hospital emergency department on 5/7/20 he/she observed the resident had a beard, untrimmed mustache, unwashed hair, a dirt like substance under his/her fingernails and stains on his/her clothing. Person #1 identified Resident #1 remained in the hospital after testing positive for COVID-19 until the resident passed away. Person #1 identified when he/she obtained Resident #1's personal belongings from the facility, he/she observed the Resident's personal hygiene items such as soap and lotion appeared full and unused. Person #1 indicated he/she received Resident #1's dentures in a cup filled with cloudy water which had mold and food like particles floating on the surface of the water. Interview with the Administrator on 5/29/20 at 12:10 PM identified Resident #1's family member had identified to her a concern that Resident#1 was not cleanly shaven and had an unkempt appearance during a window visit that occurred on 4/26/20. The Administrator identified upon Resident #1's admission to the facility, the family members did not specify or request that the resident be cleanly shaven. Interview with the Director of Nursing (DON) on 5/29/20 at 12:30 PM identified Resident #1 at times was resistive to personal care and needed encouragement. Based on Resident #1's clinical record, the DON was able to identify weekly body audits were conducted but was unable to identify if Resident #1 had received showers. The DON identified he would except a resident's dentures would be clean and dry before they were returned to a family member to ensure infection control measures and the integrity of the dentures maintained. Interview with NA #1 on 5/29/20 at 12:38 PM identified that he/she was unable to recall if Resident #1 had received showers during the resident's stay at the facility. NA #1 identified that he/she provided Resident #1 with bed baths and had not been resistive to care. Review of the facility policy for activities of daily living identify a program of activities of daily living (ADL) is provided to residents to maintain or restore maximum functional independence. A program of assistance and instruction in ADL skills is developed and implemented based on the individual evaluation to encourage the highest level of functioning.

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.