STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075183	A. BUILDING _____ B. WING _____	**04/20/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FOX HILL CENTER	**1253 HARTFORD TNPK ROCKVILLE, CT 06066**

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 0580 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, observations, review of facility documentation and interviews for one sampled resident (Resident #1) who was reviewed for change in condition, the facility failed to ensure that responsible party was updated when a change in condition was identified. The findings include: Resident #1's [DIAGNOSES REDACTED]. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 was alert to person place and time. The admission record identified that Resident #1 was not responsible for self and there was a care conference person to notify when Resident #1 was ill or in the case of death. The nurse's note dated 4/19/20 at 5:18 PM identified Resident #1 had a change in condition which included nausea and vomiting, and the note failed to reflect documentation the responsible party had been notified at that time. Review of the nurse's notes from 4/19/20 at 5:18 PMM through 4/20/20 at 1:25 PM identified Resident #1 continued to have episodes of vomiting and was subsequently transferred to an acute care hospital at which time the responsible party was updated. In an interview with the Director of Nursing (DON) on 4/20/20 at 11:20 AM indicated that on 4/19/20 Resident #1 had a change of condition during the second shift and it was the responsibility of the charge nurse to ensure that the responsible party was updated at the time of the change. The DON identified the charge nurse reported that change occurred late in the shift and she did not inform the family of the change in condition. Review of the facility notification of change in condition policy indicated that the facility must immediately inform the patient, consult with the patient's physician, and notify, consistent with his/her authority, the patient's health care decision maker when a significant change in the patient's physical mental or psychosocial status.

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.