STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075309	A. BUILDING _____ B. WING _____	08/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GREENWICH WOODS REHABILITATION	1165 KING STREET GREENWICH, CT 06831

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 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the clinical record, policies, and interviews the facility failed to ensure interventions required to facilitate desired communication between the resident and his/her family members were implemented. The findings include: Resident #1 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of anonymous documentation dated 6/28/20 identified Person #1 had a discussion with facility staff on 6/28/20 to ensure staff would provide the needed assistance to Resident #1 so he/she could be able to talk on the phone to his/her family members, who requested to speak with Resident #1 daily. Facility staff indicated they could not confirm this help would be available and indicated Resident #1 was able to answer his/her phone. The documentation further identified that on 6/28/20 from 9:00 AM to 4:40 PM, Person #1 was unable to get staff to provide assistance to Resident #1 to make a phone call or provide any status updates. Person #1 was able to reach a staff member (NA #1) at the facility at 4:40 PM and was informed the unit nurse would return his/her call, however, Person #1 did not receive a call. The admission MDS dated [DATE] identified Resident #1 had severely impaired cognition, required extensive assistance with personal care and had functional limitation to one side of the upper extremity. An occupational therapy evaluation dated 7/25/20 identified Resident #1 was referred due to increased inability to perform ADL's following surgery to the left chest, decreased strength, impaired balance, endurance, pain and poor safety awareness. The evaluation noted physical/cognitive/psychosocial deficits requiring assistance with all levels of ADL's. The care plan dated 7/26/20 identified Resident #1 required assistance with ADL's due to recent surgery and cognitive loss due to dementia. Interventions included to provide extensive assistance with dressing the upper body and encourage the resident to do as much for him/herself as possible before offering assistance. An Activities Progress Note dated 7/30/20 identified recreation staff and other staff members would encourage/facilitate alternative communication with family and friends through phone calls or video calls if possible. Recreation spoke with Resident #1's representative and would contact again once out of fourteen-day quarantine to schedule an outdoor visit. Review of the Activity Log and E-Visitation (electronic) information identified Resident #1 received Face Time visits on four occasions on 7/1, 7/7, 7/9 and 7/30/20 in addition to one outdoor visit on 7/14/20. The log also noted Resident #1 was in the hospital from 7/17/20 through 7/25/20 and discharged from the facility on 7/31/20. Nursing Progress notes dated 6/26/20 through 7/31/20 identified Resident #1 received additional E-visits with family on 7/3/20 and 7/8/20 during a care plan meeting, and one documented attempt on 7/30/20 when Resident #1 was sleeping. An interview on 8/17/20 at 8:44 AM with Person #1 identified Resident #1 was admitted for short term rehabilitation and has since been discharged . From the beginning, family had informed the facility they wanted daily contact with Resident #1, who was cognitively impaired and required assistance with using devices. Person #1 described that it was difficult for the family as they were unable to see Resident #1 therefore wanted daily contact. Visits were set up through recreation and discussed with the social worker. Person #1 was informed daily visits during the week were possible and that the facility would try to accommodate the need on the weekend. Calls were made throughout the day and especially on weekends from Person #1, Person #2 and Person #3 to reach staff to assist with contacting Resident #1, however, they would not hear anything until the evening hours. This was brought to the facilities attention with an insufficient response. An interview with the Administrator and DNS on 8/17/20 9:44 AM and 10:58 AM identified visits with Resident #1's family occurred through electronic communication (E-Visits) or outside visits and were scheduled based on what the family or resident wanted, and arranged through the recreation department. Most residents required assistance with E-Visits and outdoor visits so in addition to recreational staff, other disciplinary staff would assist in facilitating visits. This would include the weekends when in addition to recreation staff, assistance would be provided from additional staff such as the Receptionist, Manager on Duty and nursing staff when available. No issues related to visitation had been reported by family members according to the Administrator and DNS. An interview and facility documentation review on 8/17/20 at 11:18 AM and 11:52 AM with the Director of Recreation identified visitation is done through electronic communications and scheduled outdoor visits. Staff assist residents using electronic communications. According to the Director of Recreation, Resident #1's family members wanted daily communication with Resident #1. It was a challenge for recreation staff to accommodate daily contact but indicated they would be able to accommodate three times weekly for electronic communication and one weekly outdoor visit after quarantine was over. Additionally, Resident #1 had his/her own personal phone and was able to contact family members daily with assistance. The Director of Recreation indicated while it was her responsibility to ensure family requests for communication are facilitated and or communicated to staff, she was unable to explain why she did not attempt to accommodate the daily visitation request by arranging through ancillary staff or communicating the need with the Administrator or DNS in an attempt to accommodate Resident# 1's family request for daily contact. A subsequent interview with the Administrator and DNS on 8/17/20 at 12:28 PM identified Resident #1 had issues with pain and limited range of motion following surgery and therefore did require some assistance to use the phone. Additionally, had they been made aware there was a problem with the family's request, every effort would be made to accommodate the request or at least try. Interview and clinical record review with the Director of Rehabilitation on 8/17/20 at 12:50 PM identified Resident #1 had full range on the right side however, required a lot of verbal cues due to forgetfulness and cognitive impairment. Resident #1 had a cell phone he/she was unable to use and could use the regular phone but required assistance. An interview with the facility Marketing Community Liaison on 8/17/20 at 12:56 PM and 1:37 PM, identified Person #1 and Person #3 shared concerns regarding the inability to contact Resident #1 and questioned why assistance was not being provided to Resident #1 to make phone calls. The Marketing Community Liaison would, at times, go to Resident #1's room where he/she was observed to have been sleeping and indicated assistance was required for Resident #1 when using electronic communication but he/she was able to pick up the phone if it rang. A policy for arranging contact between families and residents was requested, however none was provided. Although Resident #1 had severely impaired cognition and required assistance with the use of the phone, and although the facility staff was aware that Resident #1's family requested daily contact with the resident, out of 22 days at the facility, Resident #1 received only 6 documented E-visits, and one outdoor visit with his/her family.

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.