

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER 075096	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/27/2020
NAME OF PROVIDER OF SUPPLIER GROVE MANOR NURSING HOME, INC		STREET ADDRESS, CITY, STATE, ZIP 145 GROVE ST WATERBURY, CT 06710	
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 F 0886	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		
<p>Level of harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Based on interviews, and review of facility documentation the facility failed to ensure that facility staff had been tested for COVID 19 in accordance with The Center for Medicare and Medicaid services (CMS) Guidelines of Center for Disease Control (CDC) recommendations. The finding includes: Interview with the infection control nurse on 8/19/20 at 10:35 AM identified the facility only tested each employee twice between 7/9/2020 through 8/5/2020. The infection control nurse identified the facility's understanding of the algorithm provided to them by DPH. The infection control nurse identified it was not the facilities understanding that every employee to test weekly for over a 14 day period. Review of the facility schedules and facility COVID 19 testing documentation with the Infection Control Nurse on 8/27/2020 at 11:00 AM identified for the testing period 7/9/20-7/15/20 nine employees were not tested , for the testing period 7/16/20-7/22/20 five employees were not tested , for the testing period 7/23/20-7/29/20 thirty four employees were not tested , and for the testing period 7/30/20-8/4/20 forty employees were not tested . The facility paused testing on 8/5/2020.</p>		

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.