STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075359	A. Building B. Wing	08/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fresh River Healthcare	96 Prospect Hill Rd East Windsor, CT 06088

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. (continued on next page)

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical records, interviews, and review of facility documentation and policy for one (1) of three (3) residents (Resident #4) reviewed for discharge, the facility failed to ensure the resident had home nursing services established upon discharge from the facility. The findings included:Resident #4 was admitted to the facility [DATE] with diagnoses of infection following a procedure, disruption or dehiscence of closure of other specified surgical wound, Alzheimer's, and anxiety disorder.Review of the admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #4 had a Brief Mental Interview for Mental Status (BIMS) score of fifteen (15) and indicated Resident #4 was cognitively intact. The MDS further identified Resident #4 required partial assistance with bathing, dressing, chair/bed and toileting transfers, and when walking ten (10) feet. Review of Resident #4's Care Plan dated [DATE] identified an activity of daily living self-care performance deficit and mobility deficit related to post surgical intervention and impaired/decline in cognitive function or impaired thought processes related to a condition other than delirium: dementia (other than Alzheimer's disease). Interventions directed to encourage the resident to use the call bell for assistance and to monitor medications, especially new/changed/discontinued for side effects and the resident's response contributing to cognitive loss/dementia.Review of Recapitulation of Stay documentation dated [DATE] identified Resident #4 was discharged from the skilled nursing facility on [DATE], was now independent with activities of daily living, and that the resident had home health care to deliver his/her medications and provide wound care.Review of SW#2 note dated [DATE] at 11:51 AM identified Resident #4 was discharged home, that the visiting nurse agency and home care would visit the resident today for his/her re-open, and that Resident #4 was very knowledgeable regarding his/her discharge services, medications, and two upcoming appointments. Interview with Person #1 (clinical team leader at the home health care agency) on [DATE] at 11:40 AM identified Resident #4 received care from the agency prior to his/her admission to the skilled nursing facility (SNF), which entailed behavioral health services twice daily for medication administration and home health aide services five (5) times per week for showering, activities of daily living assistance, and physical therapy. Person #1 identified Resident #4's certification for services expired on [DATE] (following admission to the SNF) without plans for renewal as the resident's medical needs had risen to a level above what the agency could provide. Person #1 further identified the home care agency was informed either on [DATE] or [DATE] by Resident #4 that he/she had been discharged from the SNF and needed services. Person #1 indicated that prior to re-opening his/her case with the home care agency, Resident #4 needed to be evaluated by a physician for wound care as this was now the primary component (medical versus behavioral) of the nursing services needed. Interview with SW #1 on [DATE] at 3:23 PM identified the facility would make referrals to home care agencies, send the paperwork over via fax, and then receive confirmation via phone call if the resident was accepted for the services requested. However, SW #1 was unable to provide a fax confirmation indicating Resident #4's discharge packet was sent to the home care agency regarding his/her medical needs (which included medication management, wound care, physical therapy, and patient care assistance) and/or that he/she was accepted back for services. SW #1 further identified her contact at the home care agency was Person #2.Interview with Person #2 (Intake Manager for Behavioral Services at the home care agency) on [DATE] at 9:20 AM identified he/she did not receive any discharge paperwork (fax) requesting services for Resident #4 and was not aware a request for services was made prior to or upon his/her discharge from the SNF. Person #2 further indicated he/she communicated with the SNF, within a week following Resident #4's admission to the SNF, that the resident would not be accepted back for services as the agency was unable to provide the increased level of care Resident #4 required. However, Person #2 did indicate the case could be reviewed closer to the date of discharge if Resident #4's service needs had changed. Following notification that Resident #4's was discharged from the SNF without medical services/support in place, the agency made an allowance to accept the resident back and took appropriate steps to recertify the resident for services.Review of the Discharge Planning policy directed the facility social work staff to assist, as needed or requested, with referrals to community-based agencies for coordination of as needed post-discharge services.