STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075438	A. BUILDING _____ B. WING _____	06/18/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ORCHARD GROVE SPECIALTY CARE CENTER, LLC	5 RICHARD BROWN DRIVE UNCASVILLE, CT 06382

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 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a clinical record review, facilty documentation and staff interviews for 1 of 2 residents reviewed for abuse (Resident #2), the facilty failed to report an injury of unknown origin to the state agency. The findings include: Resident (R) #2 was admitted to the facilty on 10/4/17 with [DIAGNOSES REDACTED]. The quarterly Minimum Data Set ((MDS) dated [DATE] identified severe cognitive impairment, extensive assistance of one person for dressing, eating and transfers, extensive assistance of 2 for toileting and ambulated in his/her room and corridor with limited assistance of one person. Additionally, R #2 had wandering behavior and rejected care. physician's orders [REDACTED]. The care plan dated 11/13/20 identified R #2 had a bruise on his/her left cheek and the intervention included to monitor the area. The reportable event form dated 11/13/20 identified R #2 had a bruise on her left facial cheek and the internal investigation form indicated R #2 had increased wandering, intrusive behavior and appeared to have bumped her face on the wall. Additionally, the corrective measures included to monitor the bruise, redirect R #2 if he/she exhibits wandering and intrusive behaviors, and continue behavioral health services. Review of the facilty licensing and investigations reportable event site identified the bruise of unknown etiology was not reported to the state agency. Interview with RN #2 on 6/22/20 at 9:45AM identified R #2 had a bruise on his/her face that was very noticeable, and he/she was not sure what caused the bruise. Interview with the Director of Nursing (DNS) on 6/18/20 at 9:29 AM identified the bruise of R #2's left cheek was not reported to the state agency because the exact cause was not witnessed. The facilty concluded R #2 had bumped his/her cheek on an object when wandering in and out residents rooms. Additionally, the DNS would only have reported the injury to the state agency, if an allegation abuse was reported and/or suspected. The DNS identified the facility staff did not report an allegation of abuse for Resident #2. Review of the facilty policy for accident incidents and reportable events directed in part that any injury of unknown origin would be investigated. All staff that cared for the resident 24 hours prior to the observation of the injury would be interviewed, ensuring all statements were documented. If unable to determine a cause through the investigation, the investigation would be documented as inconclusive. The policy failed to direct that an injury of unknown origin would be reported to the state agency immediately, but not later than two hours after the injury was identified.
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, a clinical record review, staff interviews, and a review of the facility documentation for 1 of 2 residents (Resident #1), reviewed for abuse, the facilty failed to follow the plan of care. The findings include: Resident (R) #1 was admitted to the facilty on 9/22/18 with [DIAGNOSES REDACTED]. The quarterly Minimum Data Set ((MDS) dated [DATE] identified severe cognitive impairment, extensive assistance of 2 staff members for bed mobility, personal hygiene, bathing and toileting, total dependent for transfers and dressing, and the resident did not ambulate. The physical therapy discharge summary dated 10/27/18 identified R #1 met the therapy goal for bed mobility to safely transition from lying to sitting and with minimal assistance and required moderate to maximum assistance of two persons for bed mobility upon discharge from therapy. Additionally, the discharge summary indicated R #1 was confused, agitated and had behaviors that prevented R#1 from achieving established goals. The individualized resident assessment dated [DATE] identified R #1 required a mechanical lift for transfer and may need assistance of two for bed mobility. The Occupational Therapy discharge summary dated 11/12/19 identified R #1 was dependent and required assistance of 2 helpers for bathing, toilet hygiene, upper and lower body dressing upon discharge from therapy. The behavior care plan dated 6/1/20 identified R #1 could exhibit increased agitation, frustration, restlessness, and complaints of care when touched, and was resistive to care. Interventions included to offer items in attempt to distract the resident and speak calmly. The behavior care plan was revised on 6/10/20 and included an intervention to re-approach the resident for care if agitated and resistive, and to provide care and bed mobility with assistance of two persons. Additionally, the care plan identified a problem of a self-care deficit secondary to weakness, pain, and immobility with interventions that included to provide R#1 with assistance when washing, dressing and complete management of R #1's incontinent care needs. physician's orders [REDACTED].#1 with assistance of two persons utilizing a mechanical lift. Review of the behavior intervention record for June 2020, identified R #1 had an episode of yelling and was combative with care on 6/10/20 on the evening shift and failed to document an intervention. The reportable event form dated 6/10/20 at 8:15 PM identified RN #1 was called to R#1's room by LPN #1 as R#1 said NA #1 hurt him/her. Additionally, the report identified R#1's right hand was swollen and bruised without deformities or pain and could move all fingers. NA #1 was sent home and the physician was notified. Imaging was conducted on 6/10/20 that identified [MEDICAL CONDITION] change and no acute fracture. Observation of R #1's right hand on 6/18/20 identified a faded yellow discoloration, no swelling or pain and full range of motion. Interview with R #1 identified he/she got the bruise by rushing when he/she was shopping. Interview with the Director of Nursing (DNS) on 6/18/20 at 1:30 PM identified she concluded the injury was not intentional and R #1 likely bumped his/her hand on the bed rail when NA #1 provided care. Additionally, the DNS indicated R #1 was agitated and combative prior to NA #1 going in the room to provide evening care to R #1 and NA #1 continued to provide care by him/herself while the resident was agitated. The DNS indicated NA #1 should have stopped care and reproached the resident at a later time. Additionally, the DNS would have expected NA #1 to provide care with the assistance of another nurse aide as the care card and MDS identified R#1 required the assistance of two people. Interview with NA #1 on 6/18/20 at 1:38 PM identified R #1 was screaming and agitated when he came into his/her room to provide care on 6/10/20 at approximately 7:00 PM. NA #1 indicated he washed R #1's upper body and then turned R#1 in bed by himself while he/she was swinging and agitated while providing incontinent care. Additionally, NA #1 indicated he continued to provide care because R #1's brief was soiled, and he could not leave him/her in a soiled brief. Further, NA #1 identified he did not bend R #1's hand backwards and stated he provided care for R #1 by himself because there were only two aides on that wing and the and the other aide was busy. NA #1 indicated he did not know R#1 required assistance of two persons. Interview with OT#1 on 6/18/20 at 12:30 PM identified R #1 was last evaluated by physical therapy in November of 2019 and required assistance of two staff for all care because it was not safe to have one caregiver wash, dress, and move R#1 in bed due to behaviors, poor cognition and difficulty following directions. Interview with LPN #1 on 6/18/20 at 2:45 PM identified R #1 was agitated prior to the time NA #1 provided care. LPN #1 indicated R #1 told her NA #1 bent his/her wrist backwards. LPN #1 identified R #1 had a bruise and swelling to the right hand that was not present when LPN #1 fed R#1 supper. Additionally, LPN #1 indicated she was not sure what level of

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.

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F 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) assistance R#1 required for evening care and did not witness NA #1 bend R#1's hand. Review of the investigation summary dated 6/19/20 identified the facilty did not substantiate resident abuse and corrective actions included to provide assistance of 2 staff members for care and educate NA #1 on how to care for a dementia resident with behaviors. Although the plan of care identified R #1 required the assistance of two persons for bed mobility, bathing and dressing, NA#1 provided evening care by himself and continued to provide care to R #1 while he/she was agitated and combative.