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 _____	**06/04/2020**

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 0550 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation, and interviews for two of four residents reviewed for resident rights (Resident #1 and Resident #4), the facility failed to ensure that the resident's rights were maintained, and for Resident #4 the facility failed to ensure the resident was treated in a dignified manner. The findings include: a) Resident #4 had a [DIAGNOSES REDACTED]. Review of a care plan dated 2/24/20 identified that the resident had anxiety and dementia with an impaired thought process with interventions that included to break down tasks, allow time for expression of feelings, provide empathy, encouragement and reassurance, and to evaluate behavioral symptoms. Review of nurse's notes from 5/1/20 to 6/3/20 identified that on several occasions the resident was very restless, and anxious, was pacing on the unit and in and out of his room, and was medicated with as needed [MEDICATION NAME]. Interview with NA #2 on 6/1/20 at 8:45 AM identified that one night on the 3:00 PM to 11:00 PM shift, Resident #4 was confused and walking around in the hallway, pacing, and needed a lot of redirection. Licensed Practical Nurse (LPN) #1 told the resident that he didn't need to be in the hallway, and then stated to Resident #4 I don't have time for this. Interview with LPN #1 on 6/3/20 at 5:30 PM identified that Resident #4 needed constant redirection, because he/she was constantly pacing back and forth on the unit. LPN #1 further identified that the resident would be redirected and a few seconds later would forget he has been re-directed. One evening recently (he could not recall the date) the resident was constantly pacing and trying to leave the unit, he had already redirected the resident several times, and felt very stressed out and said to Resident #4 I'm not dealing with this tonight out of frustration. LPN#1 stated that he felt badly about what he had said to the resident, and later apologized. LPN#1 further identified that when he felt frustrated with the resident, he could have called the supervisor and told him/her that the resident was difficult to direct and he/she needed some assistance. Interview with the Director of Nurses on 6/4/20 at 9:30 AM identified that if LPN #1 was feeling stressed out by the resident's behavior, he/she should have taken a break off of the unit, or called the supervisor. The DON further identified that LPN #1 should not have spoken to the resident in that manner. Review of the resident rights policy identified that all staff must treat every resident with respect and dignity. b) Resident #1 had a [DIAGNOSES REDACTED]. Review of a care plan dated 10/11/19 identified that identified that while in the facility it was important that he/she had the opportunity to engage in daily routines that were meaningful and relative to his/her preferences with interventions that included the importance of watching sports on television. An admission Minimum (MDS) data set [DATE] identified that the resident had moderate cognitive impairment, and required extensive assistance with activities of daily living. Review of a grievance form dated 10/24/19 identified that Resident #1's family filed a grievance because the resident informed him/her that the nurse wanted the television and lights off. The grievance further stated that the nurse thought there was a policy that lights were off by 11:00 PM. The nurse was educated that there was no such policy and the lights and television can stay on per the resident's choice. The grievance form further identified that the grievance/concern was confirmed. Resident #1 had been discharged from the facility and was unavailable for an interview. Interview with Nurse Aide #1 on 6/1/20 at 2:06 PM identified that the nurse requested that she turn Resident #1's television off. When she entered the room the resident was watching a baseball game and wanted to continue watching the game, so she lowered the volume and closed the door. She further identified that it was the nurse (RN#1) who had turned the resident's television off. Attempts to contact RN #1 were unsuccessful. Interview with the administrator on 6/1/20 at 12:14 PM identified that she had addressed the grievance and interviewed the resident who stated that he/she was upset because he/she was watching a baseball game, and RN#1 came in and told him/her that the television and lights had to be off. The administrator identified that RN #1 was educated that the resident had the right to watch television and keep the lights on, and that there was no policy on what time the television had to be turned off. Review of the resident rights policy identified that the resident has the right to make choices about the aspects of his/her life in the facility that are significant to the resident.
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.** Based on clinical record review, facility documentation, and interviews, for 1 of 6 residents reviewed for abuse (Resident #2), the facility failed to ensure incidents of potential mistreatment were reported timely. The findings include: A) Interview with Registered Nurse (RN) #2 on 6/1/20 at 1:45 PM identified that at the beginning of May 2020 on the 11:00 PM to 7:00 AM shift there was an incident with a resident (she could not recall the resident's name) who had the television at a loud volume. RN #2 asked the resident to turn the volume down, and the resident did so. RN #1 was on the unit and explained to RN #2 that the resident knows the rules and he/she is not supposed to have the television on. RN#1 went into the room and told the resident that he/she had to turn the television off, but the resdient did not want to turn the television off. RN #1 was then heard telling the resident in a rude and aggressive tone that he/she knew the rules, and needed to turn the television off. The resident was trying to explain to the nurse that he/she wanted the television to stay on, but RN# 1 turned the television off. RN #2 identified that although she knew that the incident should be reported, she was afraid of retaliation, and did not report the incident. B) Interview with Nurse Aide (NA) #2 on 6/1/20 at 2:00 PM identified that a few weeks ago on the 11:00 PM to 7:00 AM shift RN #1 told NA #2 that Resident #2's television needed to be turned off. NA #2 went into Resident #2's room and the resident wanted the television to stay on, so NA#2 left the television on. NA#2 stated that RN #1 then went into Resident #2's room and shut off the television. NA #2 stated that RN #1 is very stern when speaking to the residents, and she had not reported her concerns because she was afraid of retaliation and she had quit shortly after the incident. C) Interview with NA #3 on 6/1/20 at 12:30 PM identified that although she could not recall the resident's name, sometime in mid May 2020 h/she was working the 3:00 PM to 11:00 PM shift and a resident asked h/her to shut the television off, because she didn't want the nurse (RN#1) come in and yell at h/her for having the television on. NA#3 identified that h/she did not report what the resident said because she did not want to get the resident in trouble. NA#3 identified another incident occurred last week on the 11:00 PM to 7:00 PM shift with a different resident where RN#1 told NA#3 that all televisions had to be turned off at 11:30 PM. NA #3 went into the resident's room and the resident did not want the television turned off, so h/she turned it down. RN#1 then told NA#3 that the television needed to be off, then proceeded to go into the residents room and take the television remote, turn the television off, and placed the remote on top of the television (out of reach of the resident). NA#3 identified that she did not report the incident because she was afraid that RN #1 would retaliate against h/her. Interview with RN #1 on 6/1/20 at

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.

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 _____	**06/04/2020**

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 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) 8:00 AM identified that she had never turned a television off if the resident wanted it to remain on. She further identified that if the television was too loud for the roommate the facility provides ear plugs. She further identified that she has never spoken to a resident in a disrespectful manner, but her loud voice could be misinterpreted as intimidating. Interview with the Director of Nurses on 6/1/20 at 3:00 PM identified that although there had been a grievance filed for RN #1 for turning a resident's television off in October of 2019 which was addressed, she had not heard of any recent incidents, and no one had ever reported to her that RN #1 had yelled or was rude to the residents. She further identified the allegations should have been reported at the time of the incident and she would have started an investigation. The DON identified that she would be initiating an investigation to look into the allegations. Review of the abuse policy identified that mistreatment is defined as the inappropriate treatment on a resident and should be reported to a supervisor immediately.