STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075322	A. BUILDING _____ B. WING _____	06/30/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ESSEX MEADOWS HEALTH CENTER	30 BOKUM RD ESSEX, CT 06426

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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 0557 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of facility documentation, review of facility policy, and interviews, for the only sampled resident, (Resident #1) reviewed for mistreatment, the facility failed to ensure staff provided treatment in a dignified manner. The findings include: Resident #1's [DIAGNOSES REDACTED]. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 was moderately cognitively impaired, required limited assistance with bed mobility, transfers, and dressing, and required supervision with walking and personal hygiene. The Resident Care Plan (RCP) dated 3/30/2020 identified Resident #1 required oversight, verbal cues, and at times physical assistance with Activities of Daily Living (ADL's). Interventions directed to provide verbal cues and monitor for increased need for physical assistance each day. The June, 2020 physician's orders [REDACTED]. The nurse's note dated 5/24/2020 at 6:37 AM identified that Resident #1 was up at approximately 4:10 AM attempting to go into the shower room to take a shower independently. Nurse Aide (NA) #1 tried to explain that it was night time when Resident #1 became verbally aggressive and was insisting it was afternoon. NA #1 went to the nursing station for assistance and Registered Nurse (RN) #2 went toward Resident #1. RN #2 was noted to be clapping his/her hands loudly and said something indiscernible. NA #2 was going toward the area of Resident #1 when RN #1 heard Resident #1 yell out and state she hit me that woman abused me and I'm going to call my (resident representative) and the authorities. RN #2 was bent over talking with Resident #1 with the shower room door handle in his/her hand and was talking to Resident #1 at eye level. Resident #1 was sitting on the seat of his/her rollator and was visibly upset. RN #1 explained it was night, showing the time to the resident and that it was dark outside and Resident #1 agreed to accept a snack and drink and go back to his/her room. After Resident #1 was calm, RN #1 called and informed the Director of Nurses (DNS) of the allegation at approximately 5:15 AM. The DNS nurse's note dated 5/24/2020 at 7:50 AM identified that Resident #1 was asking to speak with his/her representative and that he/she had been upset because a woman yelled at him/her that he/she couldn't wash his/her hair. Resident #1 stated that the woman was so rude and could have talked nicely and not loud to him her. The physician and resident representative were made aware. Review of the Reportable Event dated 5/24/2020 identified that Resident #1 was attempting to get into the shower room and NA #1 was unsuccessful at redirecting him/her and requested assistance. RN #2 observed Resident #1 hitting the ajar shower room door with his/her rollator attempting to enter. RN #2 was noted to hold the shower room door handle while holding Resident #1's back for support to prevent a fall while attempting to redirect the resident. Resident #1 continued to argue with RN #2 that he/she needed to take a shower and RN #2 clapped her hands to get the resident's attention, this lasted several minutes, and was observed by other staff. Resident #1 sat on his/her rollator, RN #2 guided the rollator over the threshold and being startled by the movement, Resident #1 yelled. RN #1 came over and RN #2 went back to his/her unit. RN #1 brought Resident #1 to his/her room and was told by Resident #1 that RN #2 had hit and abused him/her and that he/she was going to call his/her resident representative. Resident #1 was rubbing his/her left upper chest, which was noted to be slightly red. RN #2 was suspended pending the investigation. Interview and review of facility reportable event and RN #2 statement documentation with RN #2 on 6/30/2020 at 9:16 AM identified that, in part, his/her statement identified that after several minutes of holding the door against Resident #1 periodically pushing against it, Resident #1 sat on the roller walker. When Resident #1 was removed from the doorway Resident #1 screamed at the top of his/her lungs and RN #1 and NA #1 came to assist. RN #2 identified that he/she had been at the nursing station with RN #1, that NA #1 came in requesting assistance with Resident #1 and that by his/her face it was obvious he/she needed immediate help with Resident #1. RN #2 identified that he/she went to Resident #1 who was pushing on the shower door with his/her walker. RN #2 identified that he/she grabbed the door handle and explained it was not time for a shower and that they would wake people up. RN #2 identified Resident #1 stated that he/she would call his/her resident representative and that was how Resident #1 got what he/she wanted. RN #2 identified that he/she had to sometimes be firm with the resident and state we need to go back to the room now. RN #2 identified that Resident #1 got tired and sat on his/her walker. Resident #1's walker wheels were over the door threshold so RN #2 pulled Resident #1 out of the doorway, the door closed, and while doing so he/she knocked over a stool that made a loud noise and that Resident #1 screamed. RN #2 identified that RN #1 and NA #1 came over and said something and that was when he/she left. RN #2 initially denied clapping his/her hands but then identified he/she may have but did not recall doing so. RN #2 denied hearing Resident #1 making the allegation of being hit by him/her and identified that he/she only found out about the allegation when he/she heard RN #1 talking on the telephone. RN #2 identified that the Director of Nurses (DNS) had come in early that morning to speak with him/her, but that he/she did not receive any formal training or disciplinary action. RN #2 identified that during the time between the allegation and the arrival of the DNS that he/she had gone back to his/her own unit, passed medications, and did computer work. Interview and review of facility reportable event and NA #1 statement documentation with NA #1 on 6/30/2020 at 10:00 AM identified that, in part, his/her statement identified that he/she had requested assistance because Resident #1 was becoming verbally aggressive, insisting on taking a shower. NA #1 identified that while RN #2 was with Resident #1, Resident #1 stated she hit me, was rubbing the left side of his/her chest and stated he/she was going to call his/her resident representative and not going to take this abuse. NA #1 identified that Resident #1 was noted to be very distressed over the situation. NA #1 identified that Resident #1 had been angry due to the inability to find his/her shampoo and conditioner prior to going to the shower room. When Resident #1 did find the items, he/she headed off to the shower and was standing in front of the shower room door when NA #1 left to get assistance. NA #1 identified that RN #2 went down to the shower, not far from the nursing station, and that when RN #2 clapped his/her hands it scared Resident #1 because it was so loud and it was quiet at night. NA #1 identified that he/she and RN #1 had heard the clap and then a bang which, NA #1 assumed was a metal stool that was located in the area that had fallen over. NA #1 went running down to Resident #1 and RN #1 followed behind after hearing the bang and the yell. NA #1 identified that RN #2 had stated Hey yo, (Resident name) and questioned out loud who does that to an elderly (person) at 4:00 AM? NA #1 identified that when he/she arrived on the scene, Resident #1 was seated and struggling with RN #2 over the door handle. NA #1 identified that when RN #1 arrived he/she asked RN #2 to leave, bent down, and asked what happened. Resident #1 identified repeatedly that RN #2 had hit him/her and was rubbing his/her left chest and stated that he/she shouldn't have had this abuse. Resident #1 then pulled his/her top over and said you see, you see and showed us a red mark. Interview and review of facility reportable event with the DNS on 6/30/2020 at 11:05 AM identified that after the allegation had been reported to him/her, he/she had told RN #1 that RN #2 was not to go down there and that he/she needed statements. The DNS could not recall if he/she had directed RN #1 to tell RN #2 not to go back to his/her unit. The DNS identified that he/she had arrived at the facility at approximately 6:00 AM and that when he/she arrived RN #2 had been cleaning his/her medication cart on the unit and that the DNS went to see Resident #1 and he/she had been sleeping. The DNS identified that

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 0557 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) the facility abuse policy directs that staff who have an allegation of abuse should not work with patients. Interview and review of facility reportable event and RN #1 statement documentation with RN #1 on 6/30/2020 at 11:20 AM identified that, in part, his/her statement identified Resident #1 stated she hit me, that woman abused me and I'm going to call my (resident representative) and the authorities. RN #1 identified that he/she had heard RN #2 loudly clapping and say something that he/she could not make out. RN #1 identified that Resident #1 yelled and he/she stated to NA #1, I can't let him/her fall. When he/she arrived to Resident #1, RN #2 was bent over the rollator Resident #1 was seated upon his/her walker and Resident #1 stated honey, honey she hit me. Resident #1 identified that he/she wanted to call the authorities and his/her resident representative and that Resident #1 was really upset. RN #1 identified that RN #2 was present when Resident #1 made the allegation. RN #1 identified that after settling Resident #1 back in his/her room he/she telephoned the DNS to report the allegation. RN #1 identified that he/she was told to obtain statements from all staff, that RN #2 was to stay away from Resident #1, but he/she was never instructed to have RN #2 leave the unit or the facility. Re-interview with the DNS on 6/30/2020 at 12:45 PM identified that he/she was unable to substantiate the allegation because the red area on Resident #1's chest looked more like a rubbed area and nothing was seen on the skin audit, the time was short, and that there was nothing there. Additionally, the resident representative, when interviewed, identified that this was what Resident #1 did when he/she was mad and didn't get what he/she wanted. While unable to substantiate abuse the facility failed to ensure a staff member spoke to a resident in a dignified manner. Review of facility Resident Rights policy identified, in part, that a resident has the right to be treated with consideration, respect and full recognition of their dignity and individuality.
F 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, review of facility documentation, review of facility policy, and interviews, for the only sampled resident, (Resident #1) reviewed for mistreatment, the facility failed to follow the abuse prevention policy during the COVID-19 pandemic. The findings include: Resident #1's [DIAGNOSES REDACTED]. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 was moderately cognitively impaired and required limited assistance with bed mobility, transfers and dressing, and required supervision with walking and personal hygiene. The Resident Care Plan (RCP) dated 3/30/2020 identified Resident #1 required oversight, verbal cues and at times physical assistance with Activities of Daily Living (ADL's). Interventions directed to provide verbal cues and monitor for increased need for physical assistance each day. The June, 2020 physician's orders [REDACTED]. The nurse's note dated 5/24/2020 at 6:37 AM identified that Resident #1 was up at approximately 4:10 AM attempting to go into the shower room to take a shower independently. NA #1 tried to explain that it was night time when Resident #1 became verbally aggressive and was insisting it was afternoon. NA #1 went to the nursing station for assistance and Registered Nurse (RN) #2 went toward Resident #1. RN #2 was noted to be clapping his/her hands loudly and said something indiscernible. NA #1 was going toward the area of Resident #1 when RN #1 heard Resident #1 yell out and state she hit me that woman abused me and I'm going to call my (resident representative) and the authorities. RN #2 was bent over Resident #1 with the shower room door handle in his/her hand and was talking to Resident #1 at eye level. Resident #1 was sitting on the seat of his/her rollator and was visibly upset. RN #1 explained it was night, showing the time to the resident and that it was dark outside and Resident #1 agreed to accept a snack and drink and go back to his/her room. After Resident #1 was calm, RN #1 called and informed the DNS of the allegation at approximately 5:15 AM. The DNS nurse's note dated 5/24/2020 at 7:50 AM identified that Resident #1 was asking to speak with his/her representative and that he/she had been upset because a woman yelled at him/her that he/she couldn't wash his/her hair. Resident #1 stated that the woman was so rude and could have talked nicely and not loud to him/her. The MD and resident representative were made aware. Review of the Reportable Event dated 5/24/2020 identified that Resident #1 was attempting to get into the shower room and NA #1 was unsuccessful at redirecting him/her and requested assistance. RN #2 observed Resident #1 hitting the ajar shower room door with his/her rollator attempting to enter. RN #2 was noted to hold the shower room door handle while holding Resident #1's back for support to prevent a fall while attempting to redirect the resident. Resident #1 continued to argue with RN #2 that he/she needed to take a shower and RN #2 clapped her hands to get the resident's attention, this lasted several minutes, and was observed by other staff. Resident #1 sat on his/her rollator, RN #2 guided the rollator over the threshold and being started by the movement, Resident #1 yelled. RN#1 came over and RN #2 went back to her his/unit. RN #1 brought Resident #1 to his/her room and was told by Resident #1 that RN #2 had hit and abused him/her and that he/she was going to call his/her resident representative. Resident #1 was rubbing his/her left upper chest, which was noted to be slightly red. RN #2 was suspended pending the investigation. Review of the Director of Nurses (DNS) statement dated 5/24/2020 identified that Resident #1 was banging on the shower room door with his/her walker and insisting it was time to shower. RN #2 was holding the shower room door handle and supporting the resident's back. When another nurse intervened and showed the resident the time, Resident #1 agreed to return to bed. RN #2 identified that she could have let the resident go into the shower room to avoid upsetting Resident #1. Interview and review of facility reportable event and RN #2 statement documentation with RN #2 on 6/30/2020 at 9:16 AM identified that, in part, her statement identified that after several minutes of holding the door against Resident #1 periodically pushing against it, Resident #1 sat on the roller walker. When Resident #1 was removed from the doorway Resident #1 screamed at the top of his/her lungs and RN #1 and NA #1 came to assist. RN #1 identified that he/she had been at the nursing station with RN #1, that NA #1 came in requesting assistance with Resident #1, and that by the look on his/her face it was obvious he/she needed immediate help with Resident #1. RN #2 identified that he/she went to Resident #1 who was pushing on the shower door with his/her walker. RN #2 identified that he/she grabbed the door handle and explained it was not time for a shower and that they would wake people up. RN #2 identified Resident #1 stated that he/she would call his/her resident representative and that was how Resident #1 got what he/she wanted. RN #2 identified that he/she had to sometimes be firm with the resident and stated we need to go back to the room now. RN #2 identified that Resident #1 got tired and sat on his/her walker. Resident #1's walker wheels were over the door threshold when he/she sat, so she pulled Resident #1 out of the doorway, the door closed, and while doing so RN #2 knocked over a stool that made a loud noise and that Resident #1 screamed. RN #2 identified that RN #1 and NA #1 came over and said something and that was when she left. RN #2 initially denied clapping her hands but then identified she may have but did not recall doing so. RN #2 denied hearing Resident #1 making the allegation of being hit by her and identified that she only found out about the allegation when she heard RN #1 talking on the telephone. RN #2 identified that the DNS had come in early that morning to speak with him, but that he/she did not receive any formal training or disciplinary action. RN #2 identified that the DNS inferred he/she could have done what NA #2 had done in the past and let Resident #1 go in the shower room to look around. RN #2 identified that during the time between the allegation and the arrival of the DNS that he/she had gone back to her own unit, passed medications, and did computer work and was never told to stay off her unit. Interview and review of facility reportable event with the DNS on 6/30/2020 at 11:05 AM identified that that after the allegation had been reported to him/her, he/she had told RN #1 that RN #2 was not to go down there and that he/she needed statements. The DNS could not recall if he/she had directed RN #1 to tell RN #2 not to go back to her unit. The DNS identified that he/she had arrived at the facility at approximately 6:00 AM and that when he/she arrived RN #2 had been cleaning his/her medication cart on the unit and that he/she went to see Resident #1 and he/she had been sleeping. The DNS identified that the facility abuse policy directs that staff who have an allegation of abuse should not work with patients. Interview and review of facility reportable event and RN #1 statement documentation with RN #1 on 6/30/2020 at 11:20 AM identified that, in part, his/her statement identified Resident #1 stated she hit me, that woman abused me and I'm going to call my (resident representative) and the authorities. RN #1 identified that he/she had heard RN #2 loudly clapping and say something that he/she could not make out. RN #1 identified that Resident #1 yelled and he/she stated to NA #1, I can't let him/her fall. When he/she arrived to Resident #1, RN #2 was bent over the rollator, Resident #1 was seated upon his/her walker and Resident #1 stated honey, honey she hit me. Resident #1 identified that he/she wanted to call the authorities and his/her resident representative and that Resident #1 was really upset. RN #1 identified that RN #2 was present when Resident #1 made the allegation. RN #1 identified that after settling Resident #1 back in his/her room he/she telephoned the DNS to report the allegation. RN #1 identified that she was told to obtain statements from all staff, that RN #2 was to stay away from Resident #1 but he/she was never instructed to have RN #2 leave the unit or the facility. Re-interview with the DNS on 6/30/2020 at 12:45 PM identified that he/she was unable to substantiate the allegation because the red area on Resident #1's chest looked more like a rubbed area and nothing was seen on the skin audit, the time was short and that there was nothing there. Additionally, the resident representative, when interviewed, identified that this was what Resident #1 did when he/she was mad and didn't get what he/she wanted. The DNS

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F 0607 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) identified that after a review of the medication kardex, RN #2 had given one medication to a resident that was due at 6:00 AM. The DNS identified that when he/she went to RN #2's unit he/she asked where RN #2 was and was told that he/she had just gone into a room. The DNS identified that she opened the door to the room, stood there, observed RN #2 explain the resident's medication to the resident, administer the medication and then told RN #2 that he/she was not supposed to be with residents. Additionally, the DNS identified that he/she knew that nothing happened (to the resident receiving the medication) because he/she was there. Review of facility Abuse Policy identified, in part, that an employee of the community who has been accused of abuse, neglect, or mistreatment will be immediately suspended until the results of the investigation have been reviewed by the administrator or designee.