STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075425	A. BUILDING _____ B. WING _____	09/09/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
VANDERMAN PLACE	595 VALLEY STREET WILLIMANTIC, CT 06226

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0600 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation and interviews, for one of three residents reviewed for neglect, (Resident#22), the facility failed to ensure repositioning and incontinent care were provided in accordance with the resident's plan of care. The findings include: Resident #22 had a [DIAGNOSES REDACTED]. A care plan dated 7/14/20 identified that the resident had the potential for alteration in skin integrity related to requiring assistance with bed mobility, and incontinence with interventions that included to provide incontinent care every two (2) hours and as needed, and to reposition every two (2) hours and as needed. A care plan dated 8/4/20 identified that the resident did not want to receive personal care from male Nurse Aides. A quarterly minimum (MDS) data set [DATE] identified that Resident #22 had moderate cognitive impairment, required extensive assistance with bed mobility, was frequently incontinent, and was at risk for developing pressure ulcers. Interview with Nurse Aide (NA) #4 on 9/2/20 at 10:30 AM identified that she had gone in to care for Resident #22 on 9/2/20 between 9:00 and 10:00 AM and noted that Resident #22's bed was soaked with urine from head to toe, and the resident stated that he/she had not received any personal care on the 11:00 PM to 7:00 AM shift. NA#4 identified that she had reported the allegation between 9:00 and 10:00 AM to the 7:00 AM to 3:00 PM supervisor, Registered Nurse (RN) #6. Interview with Resident #22 on 9/3/20 at 1:00 PM identified that although a NA came into the room and offered her juice and her neck pillow, and that the nurse had come in during the night to administer medications, she was not offered and did not receive any personal care. Interview with NA #5 on 9/4/20 at 3:00 PM identified that on 9/1/20 he had worked the 3:00 PM to 11:00 PM shift, and then had worked 11:00 PM until 3:00 AM on 9/1-9/2/20. He further identified that he was working alone on Unit 2 (Resident #22's unit), so he did not have an assignment to work off of, and he was doing his rounds on all the residents on unit 2. He stated that he had entered the Residents #22's room to provide her with a drink and a neck pillow but did not provide any repositioning or incontinent care from 11:00 PM to 3:00 AM because he was aware the resident did not want any male NA's. NA #5 further stated that he did not seek out female staff to care for Resident #22 because he was working that unit alone, and there was no female NA on the unit. NA #5 stated that he left around 3:00 AM and NA #6 had come from another unit to replace him. Interview with NA #6 on 9/3/20 at 1:30 PM identified that she had been working on Unit 3 with another NA on 9/1-9/2/20 but was asked to go to Unit 2 (Resident #22's unit) because there was only one NA (NA#5) working on that unit, and the NA was leaving at 3:00 AM. When NA #5 left for the night, he stated that all of his rounds were completed. So she started to do rounds on unit 2. NA #6 stated that she was not working from an assignment sheet because she was the only NA on the unit (providing care for 47 patients) so she was doing her best to provide repositioning or incontinent care for the residents on her unit. She further stated that she did not provide incontinent care or repositioning for Resident #22 from 3:00 AM to 7:00 AM because when Unit 2 only has one NA, unit 3 NA's usually perform rounds on the short hallway of Unit 2 (where Resident #22 resided). Interview with NA #7 on 9/3/20 at 12:30 PM identified that she worked on Unit 3 on 9/1-9/2/20. She did not provide any personal care to Resident #1, stayed in her unit all night, and did not take care of the short hallway on Unit 2. Interview with Licensed Practical Nurse (LPN) #6 on 9/3/20 at 8:30 AM identified that she was the charge nurse on Unit 2 9/1/20-9/2/20 on the 11:00 PM to 7:00 AM shift. LPN #6 was aware that NA #5 (the male Nurse Aide) was working by himself on the unit, and was also aware that Resident #22 did not want care provided by a male NA. LPN #6 further identified she did not provide any repositioning or incontinent care for Resident #22 which was required every 2 hours, but did administer medications to the resident and place his/her phone on the charger. She had assumed that once NA #6 came onto the unit around 3:00 AM that NA #3 had provided Resident #22 with incontinent care and repositioning (although she was aware that the resident required incontinent care and repositioning from the hours of 11:00 PM to 3:00 AM). Interview with the Director of Nurses on 9/8/20 at 2:44 PM identified that the conclusion to the investigation was that Resident #22 who required every 2 hour positioning and incontinent care did not receive the care on the 11:00 PM to 7:00 AM shift. The involved staff was disciplined and education was provided to all staff. The DON further identified that Unit 3 does not take the short hallway on 11:00 PM to 7:00 AM shift, and does not know why NA #6 was under that impression. The DON stated that another issue was that since the units only had 1 NA each, they were not working off of assignments, and all residents should have an assigned NA. The facility was educating staff to ensure that all NA's work off of assignments and all residents have an assigned NA. Review of the abuse policy identified that neglect is defined as any failure to provide goods and services necessary to avoid physical harm, mental anguish and/or mental illness. The policy further identified that all residents have the right to be free from abuse and the facility prohibits mistreatment, abuse and neglect.
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 clinical record review, facility documentation and interviews for one of three residents reviewed for abuse, (Resident#22), the facility failed to ensure an allegation of neglect was reported and investigated in a timely manner in accordance with facility policy. The findings include: Resident #22 had a [DIAGNOSES REDACTED]. A care plan dated 7/14/20 identified that Resident #22 had the potential for alteration in skin integrity related to requiring assistance with bed mobility, and incontinence with interventions that included to provide incontinent care every two (2) hours and as needed, and to reposition every two (2) hours and as needed. A quarterly minimum (MDS) data set [DATE] identified that Resident #22 had moderate cognitive impairment, required extensive assistance with bed mobility, was frequently incontinence, and was at risk for developing pressure ulcers. Interview with Nurse Aide (NA) #4 on 9/2/20 at 10:30 AM identified that she had gone in to care for Resident #22 and noted that Resident #22's bed was soaked with urine from head to toe and Resident #22 stated that he/she had not received care on 11:00 PM to 7:00 AM. NA #4 identified that she had reported to RN #6 (the nursing supervisor) that the resident did not receive care on the 11:00 PM to 7:00 AM shift. Interview with RN #6 on 9/2/20 at 3:00 PM (5 hours after Resident #22 made the allegation) identified that she had recalled hearing the allegation about Resident #22, but could not remember who had informed her. She further stated that she did not speak with Resident #22 and had not reported the allegation to the administrator or Director of Nurses, and/or started an investigation into the allegation, because she had planned on speaking with the 11:00 PM to 7:00 AM supervisor about the allegation. Interview with RN #1 (who was covering for the DON that day) on 9/2/20 at 3:10 PM identified that she had not been informed of the allegation, and that RN #1 should have reported the allegation immediately so an investigation could have been started. Interview with Resident #22 on 9/3/20 at 1:00 PM identified that although a NA came into the room and offered her juice and

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 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) her neck pillow, and the nurse had come in during the night to administer medications, she did not receive any personal care. Interview with the Director of Nurses on 9/9/20 at 4:00 PM identified that she had spoken to RN #6, and RN #6 stated that when NA #4 reported to allegation to her she did not state that Resident #22 did not receive care. She was told the resident had a concern about care she received, but RN #6 did not inquire about what the care issue was, and she should have. Attempts were made to further interview RN #6 about her statement she gave to the DON, but were unsuccessful. Subsequent to surveyor inquiry on 9/2/20 an investigation into the allegation was initiated. Review of the abuse prohibition policy identified that allegations of abuse will be reported promptly and thoroughly investigated. The shift supervisor is responsible for immediate initiation of the reporting process, and the administrator or DON are responsible for the investigation.
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 clinical record review and facility documentation for one of three residents who were at risk for falls, (Resident #58), the facility failed to ensure proper footwear was in place in accordance with the plan of care. The findings include: Resident #58 had a [DIAGNOSES REDACTED]. A care plan dated 6/8/20 identified that Resident #58 was a fall risk related to weakness, an abnormal gait, and a history of falls with interventions that included to ensure proper footwear, and to have gripper socks or shoes on at all times. A quarterly Minimum (MDS) data set [DATE] identified that Resident #58 had severe cognitive deficits, required extensive assistance with transfers and toilet use, and had a history of [REDACTED].#58 was a high risk for falls. A nurse's note dated 9/2/20 at 1:30 AM identified that Resident #58 was found on the floor on his/her knees facing away from the bed, and not wearing his/her non-skid socks. Resident #58 stated that he/she was on the way to the bathroom. Resident #58's knees were noted to be red, but Resident #58 had no complaints of pain. Review of the September 2020 Treatment Administration Record (TAR) identified that gripper socks should be on the resident at all times, and the gripper socks were signed off for the 11:00 PM to 7:00 AM shift on 9/2/20. Review of a reportable event dated 9/2/20 at 1:00 AM identified that Resident #58 was found on his/her knees next to the bed, stating that he/she had to use the bathroom, with no injuries noted. Review of the fall scene investigation identified that Resident #58 had bare feet at the time of the fall. Interview with LPN # 6 on 9/9/20 at 10:30 AM identified that she was the nurse on the unit at the time of the fall, and although she had signed off on the TAR that Resident #58 was wearing the gripper socks, she did not actually check, as she leaves that up to the Nurse Aides (NA) to check for gripper socks. Interview with NA #5 on 9/9/20 at 3:45 PM identified that he was the only NA on the unit at the time that Resident #2 fell , and he was very busy giving care and did not have the time to check Resident #58 to ensure that the non-skid socks were in place. Interview with the Director of Nurses on 9/9/20 at 4:00 PM identified that it would be the expectation that the non-skid socks were checked for placement at the beginning of the shift, and that the should nurse only sign the TAR if she had observed the non-skid socks on Resident #58. Review of the fall policy identified that the facility will implement interventions to minimize and/or eliminate contributing factors for falls on residents at risk.
F 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, facility documentation, interviews, and review of staffing levels, the facility failed to ensure adequate staffing levels to meet the needs of the residents, and for one of three residents reviewed for neglect, (Resident#22), the facility failed to ensure that staffing was adequately distributed throughout the facility to meet the needs of the resident. The findings include: a) Review of staffing levels on 8/27/20 into 8/28/20 on the 11:00 PM to 7:00 AM shift identified that from 11:00 PM to 4:00 AM there were 2 Nurse Aides in the facility to care for a census of 84 residents. This staffing ratio was 6.2 hours lower than the minimum requirements of the State Agency for the time period of 11:00 PM until 4:00 AM. Interview with the Director of Nurses on 9/3/20 at 1:30 PM identified that on 8/27-8/28/20 there were 3 nurse aides scheduled to work, but there was a no-call no-show and they were unable to replace the NA for the shift. The DON identified that the facility was able to get staff to come in early to help starting at 4:00 AM, but it still left 2 NA's to care for 84 residents from 11:00 PM until 4:00 AM, which would not be optimal staffing to care for the residents. The DON stated that they have had difficulties with staffing on the 11:00 PM to 7:00 AM shift for the past month because they had terminated 2 Nurse Aides (NA) and one NA had changed to per diem status. The facility was not previously using agency staff, but has contracted with several staffing agencies and have submitted staffing needs for the month of September 2020. b) Resident #1 had a [DIAGNOSES REDACTED]. A care plan dated 7/14/20 identified that Resident #22 had the potential for alteration in skin integrity related to requiring assistance with bed mobility, and incontinence with interventions that included to provide incontinent care every two (2) hours and as needed, and to reposition every 2 hours and as needed. A care plan dated 8/4/20 identified that the resident #22 did not want personal care from male Nurse Aides. A quarterly minimum (MDS) data set [DATE] identified that Resident #22 had moderate cognitive impairment, required extensive assistance with bed mobility, was frequently incontinence, and was at risk for developing pressure ulcers. Interview with Nurse Aide (NA) #4 on 9/2/20 at 10:30 AM identified that she had gone into care for the Resident #22 on 9/2/20 between 9:00 and 10:00 AM and noted that the residents bed was soaked with urine from head to toe and Resident #1 stated that he/she had not received any personal care on the 11:00 PM to 7:00 AM shift. NA#4 reported the allegation to the 7:00 AM to 3:00 PM supervisor, Registered Nurse (RN) #6. NA #4 further identified that she had come in on 9/2/20 for the 7:00 AM to 3:00 PM shift on Unit 2 and found at least four (4) residents soaked in urine. The urine appeared to have been there for quite some time as the urine had made rings on the sheets. Interview with Resident #22 on 9/3/20 at 1:00 PM identified that although a NA came into the room and offered him/her juice and his/her neck pillow, and the nurse had come in during the night to administer medications, she was not offered and did not receive any personal care. Interview with NA #5 on 9/4/20 at 3:00 PM identified that on 9/1/20 he had worked the 3:00 PM to 11:00 PM shift, and then had worked 11:00 PM until 3:00 AM on 9/1-9/2/20. He further identified that he was working alone on Unit 2 (Resident #22's unit), so he did not have an assignment to work off of, and was doing his rounds on all the residents on Unit 2. He stated that he had entered the Residents #22's room to provide a drink and a neck pillow but did not provide any repositioning or incontinent care, because he was aware that Resident #22 did not want any male NA's. NA #5 further stated that he did not seek out female staff to care for Resident #22, there was not a female NA assigned to the unit and furthermore all of the staff were aware that he was working that unit alone, and were also aware that Resident #22 did not want male NA's caring for him/her. NA #5 stated that he left around 3:00 AM and NA #6 had come from another unit to replace him. Interview with NA #6 on 9/3/20 at 1:30 PM identified that she had been working on Unit 3 with another NA but was asked to go to Unit 2 (Resident #22's unit) because there was only one NA (NA#5) working on that unit, and the NA was leaving at 3:00 AM. When NA #6 left for the night, he stated that all of his rounds were completed, so she started to do rounds on Unit 2. NA #6 stated that she was not working from an assignment sheet because she was the only NA on the unit (she stated that she was providing care for 47 patients) so she was doing her best to provide repositioning or incontinent care for the residents on her unit. She further stated that she did not provide incontinent care or repositioning for Resident #22 from 3:00 AM to 7:00 AM because when Unit 2 only has one NA, Unit 3 NA's usually perform rounds on the short hallway of unit 2 (where Resident #22 resided). Interview with Licensed Practical Nurse (LPN) #6 on 9/3/20 at 8:30 AM identified that she was the charge nurse on Unit 2 on 9/1/20-9/2/20 on the 11:00 PM to 7:00 AM shift. LPN #6 was aware that NA #5 (the male Nurse Aide) was working by himself on the unit, and was also aware that Resident #22 did not want care provided by a male NA. LPN #6 further identified she did not provide any repositioning or incontinent care for the resident, but did administer medications to Resident #22 and place his/her phone on the charger. She had assumed that once NA #6 came onto the unit around 3:00 AM that she had provided Resident #22 with incontinent care and repositioning. Interview with the NA #7 who worked on Unit 3 on 9/3/20 at 12:00 PM identified that she did not provide any personal care to Resident #22, and stayed on her unit all night, and did not take care of the short hallway on Unit 2. Interview with NA #8 on 9/3/20 at 1:45 PM identified that she had come in at about 5:00 AM and went to Unit 3 to help with rounds. Review of the 11:00 PM to 7:00 AM schedule had NA#5 scheduled to work Unit 2, but she went to Unit 3 because she was scheduled there for the 7:00 AM to 3:00 PM shift. Interview with NA #9 on 9/3/20

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F 0725 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) at 1:25 PM identified that she had come to work at 6:00 AM to help the 11:00 PM to 7:00 AM shift with rounds, and although she was scheduled to work on Unit 2, she reported to Unit 3 because that is where she was scheduled to work on the 7:00 AM to 3:00 PM shift. Review of the staffing for 9/1/20 into 9/2/20 for the 11:00 PM to 7:00 AM shift identified that Unit 3 had two NA's from 11:00 PM until 3:00 AM, one nurse aide from 3:00 AM to 5:00 AM, two NA's from 5:00 AM until 6:00 AM and three NA's from 6:00 AM to 7:00 AM with a census of 24. Unit 2 had one NA from 11:00 PM to 3:00 AM and when that NA went home, another NA worked from 3:00 AM until 6:45 AM with a census of 47. Interview with the nursing supervisor (RN #7) on 9/3/20 at 7:30 AM identified that he/she worked on 9/1-9/2/20 on the 11:00 PM to 7:00 AM shift and that there was one NA on Unit 1 with 6 patients, but it was the COVID-19 observation unit, she had already started her assignment and could not help the other units for fear of cross contamination of the residents. She further identified that NA #6 had come to her on that night crying, and stated that she felt she could not handle the patient load. RN #7 stated that she tried to calm NA #6 down, and told her that they would get through this. RN #7 identified that she did not call management, or make adjustments to NA#6's workload, because there was no one to call in to help, and that the staffing situation was not adequate in the facility on many occasions. Interview with the Director of Nurses (DON) on 9/3/20 at 1:00 PM identified that one NA on Unit 2 would not be optimal to care for the residents, and that NA's #8 and #9 should have checked the 11:00 PM to 7:00 AM schedule and reported to Unit 2 to help NA #6 with rounds. Furthermore, she was not contacted or told that NA #6 felt she could not handle the workload on Unit 2 that night. The DON stated that because there was only one NA on each unit they were not using assignments, but that every resident should have a NA assigned to them to ensure they receive care. Also, the facility will be doing education in regards to all residents having an assigned NA. The DON identified that the staffing that was usually scheduled on the 11:00 PM to 7:00 AM shift was one NA on Unit 1, two NA's on Unit 2, and 2 NA's on Unit 3. The DON further identified that although there was enough staff scheduled on the 11:00 PM to 7:00 AM shift, the staffing was not organized in the way that it should have been, and the staff should have been more evenly distributed to meet the needs of the residents.
F 0732 **Level of harm -** Potential for minimal harm **Residents Affected -** Some	**Post nurse staffing information every day.** Based on observation, facility documentation and interviews, the facility failed to post daily staffing levels. The findings include: Observation on 9/2/20 at 12:41 PM identified that the staffing information was located on the front desk and was dated 9/1/20 (the previous day). Interview with RN #1 on 9/2/20 at 2:00 PM identified that the staffing should be posted for the current day, it was the responsibility of the 11:00 PM to 7:00 AM shift, and she did not know why it was not posted for the current day. Review of the nurse staffing information policy identified that the facility will post the current date, total number of registered nursing, licensed practical nursing, and nurse aide hours, and include the current resident census daily.