STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075231	A. BUILDING _____ B. WING _____	**08/04/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
APPLE REHAB COLCHESTER	**36 BROADWAY STREET COLCHESTER, CT 06415**

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 0689 **Level of harm -** Actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on a clinical record review, staff interviews, a review of the facilty documentation and a review of the facility policy for one of three residents reviewed for accidents (Resident#1), the facilty failed to follow the plan of care to prevent an accident that resulted in a significant injury. The findings include: Resident (R) #1 was admitted to the facilty on 1/11/12 with [DIAGNOSES REDACTED]. The individualized resident assignment dated 1/5/18 identified R#1 required the assistance of two persons for care when combative. The behavioral health note dated 4/15/20 identified R#1 with combative and resistive behaviors which occur randomly during the day and with care. Trazadone 25 milligrams (mg) was ordered every 6 hours as needed. Review of the Occupational Therapy discharge summary dated 4/24/20 identified R#1 required total assistance of staff for hygiene, dressing, and toileting. The behavioral health note dated 5/14/20 identified R#1 continued to be resistive and combative with care and directed to continue the administration of trazadone as needed. The note dated 6/11/20 identified trazadone was used intermittently for combative and aggressive behaviors. The quarterly Miminimum Data Set ((MDS) dated [DATE] identified severe cognitive impairment, extensive assistance of 2 staff members for bed mobility, dependence on 2 staff members for transfers, and did not ambulate. Additionally, R#1 required extensive assistance of one person for dressing and was dependent on one staff for toilet use, personal hygiene and bathing. The care plan dated 6/11/20 identified behaviors that included agitation, restlessness, combativeness such as yelling, spitting and punching staff during care with interventions that included the provision of two care givers when combative and to re-approach R #1 if reassurance during care was ineffective. Physician's orders dated 7/2/20 directed to transfer R #1 via a mechanical lift with the assistance of two staff members. The nursing note written by RN #1 dated 7/18/20 at 5:30 AM identified R#1 was in bed during morning care and R#1's femur appeared dislocated or fractured. R#1 showed nonverbal signs of pain and was administered [MEDICATION NAME]. The physician and family were notified, and R#1 was transferred to the hospital via ambulance at 5:45 PM. Review of the reportable event form dated 7/18/20 identified R#1 was admitted to the hospital with [REDACTED].#1 rolled R#1 in bed. R#1 attempted to kick NA#1 in the chest. R#1 rolled close to the edge of the bed, and to keep R#1 from falling on the floor, NA#1 grabbed R#1 left leg and then heard a pop. The state reportable event form dated 7/18/20 identified R#1 was confused. R #1 could be cooperative and within one minute could become verbally abusive, combative, and spitting requiring 2 to 3 persons to make sure R#1 was positioned properly to prevent an injury to him/herself and staff. The emailed statement written by NA #1 on 7/20/20 identified at approximately 5:00 AM NA #1 asked R#1 if he/she could get R#1 dressed for breakfast and R#1 was hesitant but not resistive. NA #1 proceeded to wash R#1's face and torso and when she went to put on R#1's shirt R#1 became combative. NA #1 then informed R#1 she just had to change the brief and turned R #1 to the left side to remove and replace the brief. Upon turning R#1 to the right-side R#1 attempted to kick NA #1 and R#1 started to fall off the edge of the bed. NA #1 grabbed R#1's left leg near his/her ankle and anchored R#1's bottom with his/her knee to push R#1 back into bed. As NA #1 lifted R#1's left leg back onto the bed she heard a popping sound and R#1's leg went limp. NA #1 immediately notified the nurse. Review of the hospital discharge summary dated 7/24/20 identified R#1 presented to the emergency room from the skilled nursing facilty on 7/18/20 with a left leg deformity after a fall or near fall and imaging revealed a displaced [MEDICATION NAME] femur. Orthopedic surgery was consulted. R#1 underwent a femoral nail insertion on 7/19/20. Review of the physical therapy (PT) evaluation dated 7/27/20 identified prior to the incident R#1 was dependent on staff to complete toileting hygiene, bathing, upper and lower body dressing and activities and may need 2 or more helpers. Additionally, the evaluation identified R#1's prior level of function, required maximum assistance of two persons to move from side to side in bed. Interview with PT#1 on 8/4/20 at 10:00 AM identified R#1 was non ambulatory, required a Hoyer lift for transfers and was dependent on staff to reposition him/herself in bed prior to the incident. PT #1 indicated he/she would expect two staff to provide care to R#1 when R#1 had combative behaviors. Interview with RN #1 (Nursing Supervisor) on 8/4/20 at 11:14 AM identified she was called to assess R#1 after NA #1 had provided morning care. RN#1 indicated R#1's leg was deformed upon assessment and NA#1 informed her R#1 was combative during incontinent care. NA #1 indicated R #1 almost fell off the bed and she attempted to get R#1 back into the bed and heard a pop noise. Additionally, RN#1 indicated NA #1 should not have provided care to R#1 by herself and she would have expected 2 staff to care for R#1 as R#1 could become combative and aggressive at any minute, even if R#1 was calm at the start of care. Furthermore, RN#1 educated the staff that R#1 required assistance of two staff for care to protect both the resident and the staff from injury. Interview with the DNS on 8/4/20 at 11:45 AM identified NA #1 should not have provided care by herself. NA #1 should have also notified the nurse when R#1 became combative during care and re-approached at an alternate time. Additionally, the DNS indicated R#1's behavior was unpredictable and the plan of care was updated to reflect assistance of two staff for all care regardless of the resident's behavior. Interview with NA #1 on 8/5/20 at 5:30 PM identified NA #1 went into R#1's room at approximately 5:00 AM to provide morning care. NA #1 indicated she pulled R#1 up in the bed using both sides of the draw sheet from the top of the bed by herself. NA #1 washed R#1's face and upper body and when she went to put on his/her shirt, R#1 became combative and ripped the mask off NA #1's face. Although, R#1 was combative and agitated, NA#1 proceeded to turn R#1 onto the left side to provide incontinent care and change his/her brief. Once on his/her left side NA #1 used the draw sheet to move R#1 closer to NA#1. NA #1 began to turn R#1 to the right side and R#1 attempted to kick NA #1 and upon lifting his her legs, R#1's legs and buttocks started to fall off the edge of the bed. NA #1 indicated she repositioned R#1 too close to the edge of the bed. NA # 1 identified she grabbed R#1's left leg with her right hand near the ankle and anchored R#1 buttocks on the bed with her knee and pushed R#1's body back into the bed so he/she would not fall on the floor. NA #1 indicated when she moved R#1's left leg onto the bed she heard a pop and immediately notified the nurse. Additionally, NA #1 indicated she did not inform the charge nurse that R#1 became combative during care and should have. NA #1 identified he/she did not know where LPN #1 was as there were other issues on the unit at that time. Additionally, NA #1 felt she had a good rapport with R#1 and although R#1 had unpredictable behavior, she usually did not have problems caring for R#1 by herself. Additionally, NA #1 indicated at night it was hard to rely on extra people for assistance to provide care. NA #1 indicated she should have had someone help her, and she should have re-approached R#1 as he/she was combative and did not. Interview with LPN #1 on 8/5/20 at 9:02 AM identified she was notified by NA #1 that during morning care, R#1 became combative and was about to fall off the bed, and NA #1 grabbed R#1's left leg and heard a pop. LPN #1 notified the nursing supervisor. Additionally, LPN #1 indicated NA #1 did not notified her that R#1 was combative during care and would have expected to be notified so she could assist NA #1. Additionally, LPN #1 indicated R#1 cannot reposition him/herself and required the assistance of two staff members for care when R#1 was combative. Review of the policy entitled Falls: Minimizing the risk of injury directed in part that residents who are at risk for falls would have a care plan that addressed interdisciplinary measures to prevent falls and any

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 0689 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) environmental or equipment recommendations to prevent injuries. Additionally, an individualized care plan would be developed and updated as needed to identify interventions to prevent falls and minimize injuries.