STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075355	A. BUILDING _____ B. WING _____	**10/06/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
NEWTOWN REHABILITATION & HEALTH CARE CENTER	**139 TODDY HILL ROAD NEWTOWN, CT 06470**

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, review of facility documentation and facility policies, and interviews for one sampled resident (Resident #1) who had behavioral symptoms, the facility failed to ensure the resident was treated with dignity and respect when a medication was administered. The findings include: Resident #1's [DIAGNOSES REDACTED]. The 5-day Minimum Data Set assessment dated [DATE] identified Resident #1 made poor decisions and required supervision with tasks of daily living, had difficulty focusing attention, was easily distracted, had disorganized thinking, physical and verbal behavioral symptoms, rejection of care, was independent with eating after set-up of the meal and received antipsychotic and antidepressant medications. The Resident Care Plan initiated on 4/21/20, reviewed with readmission and in place on 7/22/20, identified Resident #1 had impaired cognition related to short term memory loss, resisted care, and episodes of anxiety. Interventions directed to identify self, speak slowly, explain all procedures, use simple/direct communication, present one thought, command or question at a time and administer anti-anxiety medications per the physician's orders [REDACTED]. The nursing progress note dated 7/22/20 at 8:22 AM identified around 3:00 AM, the 11PM-7AM Nursing Supervisor, Registered Nurse (RN) #1, was called by an 11PM-7AM charge nurse, Licensed Practical Nurse (LPN) #2 to assist with redirecting Resident #1, as Resident #1 was confused, restless and agitated. The note indicated RN #1 attempted to redirect Resident #1 without success and called the on-call Advanced Practice Registered Nurse (APRN) for a one (1) time order for [MEDICATION NAME] 25 milligrams (mg) by mouth for the agitation. The nursing progress note dated 7/22/20 at 8:29 AM identified around 2:40 AM, LPN #1 observed Resident #1 in the hallway yelling and screaming, Resident #1 was alert, confused and agitated. The note indicated LPN #1 with the assistance of LPN #2 attempted to redirect Resident #1 without success, LPN #2 called the Nursing Supervisor, RN #1, to assist with redirecting Resident #1. The note identified RN #1 attempted to redirect Resident #1 without success and Resident #1 became more combative and aggressive. The note identified RN #1 called the APRN for a Trazadone 25 mg one (1) time dose, RN #1 administered the medication, the nurse aide assisted Resident #1 back to bed and there were no further episodes of yelling and screaming. The Reportable Event Form dated 7/22/20 at 9:00 AM identified a complaint was received that the agency 11PM-7AM Nursing Supervisor, RN #1, was seen holding Resident #1's nose to administer an as needed (prn) medication. The investigation identified LPN #1 and LPN #2 witnessed RN #1 to have held Resident #1's nose during two (2) separate attempts to administer the as needed medication, Trazadone, for agitation around 2:40 AM on 7/22/20. The investigational summary identified the DON (Director of Nursing) removed RN #1 from the schedule, RN #1 was no longer allowed to work at the facility, the police and family were notified, and Resident #1 was seen by the Social Worker and the APRN on 7/22/20. The social service note dated 7/22/20 at 1:37 PM identified Resident #1 apparently had a screaming fit last night and Resident #1 did not remember the event, Resident #1 had no ill-effects from the incident. Interview with LPN #2 on 10/6/20 at 12:15 PM, she heard Resident #1 yelling and went to assist LPN #1 around 2:40 AM on 7/22/20 and she and LPN #1 attempted to redirect Resident #1 without success. LPN #2 identified she called RN #1 to assist with redirecting Resident #1 without success, at which time RN #1 called an APRN and obtained an order for [REDACTED].#2 identified she observed RN #1 crush the medication, mix it in pudding, rub Resident #1's throat, pinch Resident #1's nose, wait for Resident #1 to take a breath, force the spoon into Resident #1's mouth causing Resident #1 to cough, gag and spit out the medication mixed in the pudding. LPN #2 indicated she directed RN #1 to stop administering the medication as it caused Resident #1 to cough and call the APRN back to obtain an order for [REDACTED].#1 to cough, gag and soil the resident's clothing. Interview with LPN #1 on 10/6/20 at 12:45 PM, identified she observed Resident #1 spitting, yelling, and screaming in the hallway around 2:40 AM on 7/22/20, and she and LPN #2 attempted to redirect Resident #1 without success. LPN #1 indicated she directed LPN #2 to call the Nursing Supervisor, RN #1, to assist with redirecting Resident #1. LPN #1 identified RN #1 had attempted to redirect Resident #1 without success and obtained an order for [REDACTED].#1 identified she observed RN #1 crush the medication, mix it in pudding, pinch Resident #1's nose, wait for Resident #1 to take a breath, force the spoon into Resident #1's mouth which caused Resident #1 to cough, gag and spit the medication mixed in the pudding out. LPN #1 identified LPN #2 had directed RN #1 to stop administering the medication as it caused Resident #1 to choke. LPN #1 indicated she then observed RN #1 proceed to crush another Trazadone tablet, mix it in juice, again pinch Resident #1's nose and pour the juice into Resident #1's mouth which caused Resident #1 to cough and gag. LPN #1 indicated that she was unaware RN #1 had planned to hold Resident #1's nose during the medication administration. Interview with Assistant Director of Nursing (ADON) on 10/6/20 at 1:50 PM identified LPN #1 and LPN #2 reported the incident the morning of 7/22/20, an investigation was started, RN #1 was removed from the schedule and was not allowed back into the facility. The ADON identified residents should not have medications administered in an undignified manner. Review of facility Resident Rights policy directed in part, that Residents have the right to be treated with respect, full recognition of dignity, receive quality care and services with reasonable accommodation of individual needs and preferences.

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.