STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075368	A. BUILDING _____ B. WING _____	**06/03/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GARDNER HEIGHTS HEALTH CARE CENTER, INC	**172 ROCKY REST ROAD SHELTON, CT 06484**

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 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, interviews, and review of facility documentation, for one sampled resident reviewed for a change in condition, (Resident #4), the facility failed to ensure a Registered Nurse (RN) assessment and physician notification for a change in condition were completed in a timely manner. The findings include: Resident #4's [DIAGNOSES REDACTED]. The quarterly Minimum Data Set ((MDS) dated [DATE] identified Resident #4 had severe cognitive impairment and was totally dependent on two staff for toilet use. The care plan dated 5/11/20 identified Resident #4 was at an increased risk for decreased nutritional status, history of frequent ileus. Interventions included dietician follow-up as needed. A nurse's note written by Licensed Practical Nurse (LPN) #3, dated 5/30/20 at 5:26 AM identified Resident #4 had emesis (vomited) once, small, digested food, brown color, no nausea or diarrhea, abdomen slightly distended, non- tender, denies upset stomach, bowel sounds all quadrants positive, bowel movements times one, formed/soft/brown, positive oral intake, resting quietly at this time. physician's orders [REDACTED]. physician's orders [REDACTED]. Nurse's note dated 6/1/20 at 4:16 PM identified Resident #4 had complained of stomach pain this morning, Advanced Practice Registered Nurse (APRN) ordered stat abdominal x-ray which revealed ileus, new orders for clear liquid diet x 24 hours, [MEDICATION NAME] twice a day for two days, [MEDICATION NAME] 10 mg suppository x 1, and repeat abdominal x-ray in the morning. physician's orders [REDACTED]. Interview with APRN #1 on 6/3/20 at 9:12 AM identified that no nursing staff had notified him/her, nor was he/she aware of any other physician or APRN being notified that Resident #4 had vomited on 5/30/20. The APRN further identified that had he/she been informed that the resident had vomited on 5/30/20, he/she would have ordered the abdominal x-ray at that time, as the resident had a history of [REDACTED].#$ having emesis on 5/30/20, nor did the record reflect an assessment at the time by the RN. The DNS further identified that nursing is responsible to report changes in condition to the physician, the RN should have completed an assessment, and the DNS could not explain why this was not done. The facility policy for Change in Condition identified that all significant changes in a resident's condition will be reported to the physician and the family. A policy for RN assessment was not provided.
F 0689 **Level of harm** - Minimal harm or potential for 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 review of the clinical record, interviews, observation, and review of facility documentation, for one resident reviewed for elopement, (Resident #1), the facility failed to ensure interventions to prevent elopement by a resident at risk for elopement were implemented in a timely manner. The findings include: Resident #1 was admitted on [DATE] with [DIAGNOSES REDACTED].#1 had been hospitalized after being found wandering by Emergency Personnel. Nursing admission assessment dated [DATE], completed by Licensed Practical Nurse (LPN) #1 and reviewed by Registered Nurse (RN) #1, identified Resident #1 did not have any history of elopement or any other elopement risk factors. physician's orders [REDACTED]. The care plan dated 4/30/20 did not reflect risk for wandering/elopement. A nurse's note dated 5/1/20 identified Resident #1 was ambulating without assistance and verbalizing desire to leave and looking for exit, supervisor updated. Review of the clinical record failed to reflect interventions were implemented following these behaviors. A nurse's note dated 5/3/20 identified that upon coming out of a resident's room, a nurse aide noted the resident's empty chair by the nurse's station and noted Resident #1 outside walking in the driveway in back. Resident #1 was assisted back into the building, vital signs were taken and elopement assessment was done. Resident #1 was placed on fifteen-minute checks due to poor safety awareness. The admission Minimum Data Set ((MDS) dated [DATE] identified Resident #1 had severe cognitive impairment, required limited assistance of one staff to walk in the room and corridor, and had wandered on one to three days. Interview with Registered Nurse (RN) #1 on 6/3/20 at 11:45 AM identified that he/she had reviewed the admissions documentation completed by the LPN and did review the hospital discharge documents, and he/she should have identified a history of wandering. He/She further identified that the RN is responsible for all assessments. Interview with LPN #1 on 6/3/20 at 11:55 identified that he/she did see the discharge paperwork identifying that the resident had been found wandering, and in error noted no history of elopement in the admission elopement assessment. LPN #1 further identified that he/she was responsible to fill out documents accurately, and identified that RN #1 did review the documents. Interview, review of the clinical record, review of facility documentation including the Reportable Event Form dated 5/3/20, and observation, with the Director of Nurses (DNS) on 6/3/20 at 11:25 AM identified that the facility investigation identified that Resident #1 had followed dietary staff out of the facility into the parking lot and driveway, where Resident #1 was seen by dietary staff who were outside of the building, and nursing staff who were inside the building. The area the resident was found in was on facility property and visible from multiple facility windows. The DNS identified that the Dietary staff should have ensured that no resident followed them out of the facility. The DNS identified that both LPN #1 and RN #1 should have noted the history of elopement and the RN should have ensured interventions were put into place to prevent elopement. The DNS further identified that when wandering or exit seeking was noted, nursing was responsible for reviewing and revising the care plan, and notifications as needed. The DNS could not explain why this was not done.

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.