STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075258	A. Building B. Wing	07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Douglas Manor	103 North Road Windham, CT 06280

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** 48879 Based on review of the clinical record, facility documentation, facility policy and interviews for one (1) of three (3) residents, (Resident #1), reviewed for falls, the facility failed to complete an assessment on a resident who had a fall with a subsequent injuries. The findings include: Resident #1's diagnoses included dementia without behavioral disturbances, anxiety, syncope and collapse, transient cerebral ischemic attack (stroke), atrial fibrillation (irregular heart rate) and unsteadiness in the feet. The 5-day Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 was severely cognitively impaired and required supervision for bed mobility, moderate assistance for transfers and was dependent with toileting. Additionally, it identified that the resident had a history of falls prior to admission to the facility. The Resident Care Plan dated 12/12/23 identified that Resident #1 was a fall/safety risk with interventions that included keeping the call bell within reach, encouraging the use of the call bell, ensuring that appropriate footwear is worn, keeping the bed in the lowest position, observing for alterations in gait and maintaining a clutter free environment. A nurse's transfer form dated 12/13/23 at 2:56 PM identified that Resident #1 was transferred to the hospital due to a fall. Review of nurses' notes dated 12/13/23 failed to identify any documentation regarding a fall or a completed assessment post fall. Review of the post-fall evaluation dated 12/13/23 identified the form to be blank with no documentation. Review of the facility reportable event documentation dated 12/13/23 identified that the resident had a fall at 3:00 PM that day and was complaining of head and left hip pain. Statements were obtained from LPN #3, NA #3, NA #4, NA #5 and NA #6. A statement from RN #3 (Nursing Supervisor) were not available. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of statement from NA #5 identified that the family requested that Resident #1 be put to bed towards the end of the 7:00 AM to 3:00 PM shift. She identified that she toileted the resident at 2:33 PM and he/she had a bowel movement, and then put him/her back to bed. Resident #1 then requested ice cream and she provided it to him/her with assistance. She stated that shortly after, she was charting, and NA #4 called her requesting assistance because Resident #1 was on the floor. She indicated that RN #3 came into the room and ordered them to get the resident off the floor and cleaned up and then put back to bed before emergency services arrived. She identified that it took 3 NA's to transfer the resident and that he/she was complaining of pain in his/her left hip. Interview with NA #4 on 7/30/24 at 2:06 PM identified that she was present in Resident #1's room after he/she fell and reported that when RN #3 came in, she chit chatted with him/her for only a minute or so and did not assess the resident for injuries, but told the staff (NA #3, NA #4, NA #5 and NA #6) to get the resident up to the toilet and cleaned up, stating that he had a bowel movement. She indicated that RN #3 then left the room to call the provider. She reported that they listened to RN #3 because she was in charge, but that the resident was very difficult to get off the floor and it took 3 or 4 people to get him up and into the wheelchair. She then identified that they put him on the toilet and when they went to get him off he wouldn't stand at all and was yelling in pain. Per the direction of RN #3, they then put the resident in bed to wait for emergency services to arrive. Interview with NA #3 on 7/30/24 at 2:08 PM identified that RN #3 did not assess Resident #1 after the fall on 12/13/23. She indicated that RN #3 came in the room and talked to the resident briefly and then told them (NA #3, NA #4, NA #5 and NA #6) to get him/her up off the floor and toileted. She indicated that when they first put the resident in the wheelchair it was difficult, but the resident seemed okay. When they got him/her on and off the toilet, he/she started yelling out and appeared to be in pain also grabbing their left side. She reported that as they were standing him/her, their body limped out and they struggled to get him/her back into the wheelchair and then in the bed, as it took 3 people to stand and transfer him/her. Interview with NA #6 on 7/30/24 at 2:16 PM identified that he was just coming on to his shift when the staff requested his assistance in Resident #1's room. He identified that Resident #1 was lying on the floor and RN #3 came in the room but was just there briefly and then they were told to just get him up and on the toilet. He identified that the resident had stooled all over and that he/she was dead weight and it required 3 people to get him/her up and transfer them to the wheelchair, then to the toilet, then back to the wheelchair, and then into bed. He stated he remembered the resident yelling and he/she appeared to be in excruciating pain every time they moved him, favoring one side. Interview with RN #3 on 7/30/24 at 1:18 PM identified that she directed the NA's to clean up Resident #1 post fall on 12/13/23 because he was soiled, but could not recall if she had directly told them to keep him/her on the floor or get them up. She reported that when she first walked in the resident's room, he/she was on their left side, and she remembered he/she had complained of back pain but that his/her cognition was off and could not remember if she had done a complete assessment. She indicated that the assessment should have been documented in the post fall assessment and a progress note and she was unsure why it was not done. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and clinical record review with the DNS on 7/30/23 at 12:56 PM identified that the clinical record failed to reflect documentation indicating that an assessment was completed on Resident #1 after the fall occurred on 12/13/23. She identified that after a fall, the RN is responsible for assessing the resident for any injuries or abnormalities and reporting off to the provider of their findings. She indicated that the resident should not be moved until the resident is assessed. If the resident is complaining of pain or any has any abnormalities, they should stay in that position until the provider gives direction and/or emergency services arrives. She identified that they are responsible for documenting their assessment in the post fall evaluation, which then triggers a progress note to be written. She identified that recently due to system changes, nurses can sign the evaluations without them being completed so they need to come up with a process to check the evaluations for completeness. She indicated that they currently review their Accident and Investigations (A & I) at the At-Risk meetings that are held weekly on Thursday ' s, as well as in morning report, but was unsure why the documentation and assessment on the 12/13/23 A & I for Resident #1 was incomplete. Although attempted, LPN #3 and NA #5 could not be reached for interview. Review of hospital documentation dated 12/13/23 identified that Resident #1 had sustained a left hip intertrochanteric fracture. Review of the Prehospital Care Report (ambulance run sheet) dated 12/22/23 identified that Resident #1 was found to have an intertrochanteric fracture of the left femur and underwent an Open Reduction and Internal Fixation (ORIF) surgery. It also reported that he/she has had a significant decline over the duration of the hospital admission and was discharged home with hospice services. Review of the Change in a Resident's Condition or Status policy dated 8/2017 directed, in part, that prior to notifying the Physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provide, including information prompted by the Interact SBAR Communication Form. The Charting and Documentation policy dated 3/2023 directed, in part, that documentation of procedures and treatments will include care-specific details, including: The date and time the procedure/treatment was provided, the name and title of the individual who provided the care, the assessment data and/or any unusual findings obtained during the procedure/treatment, how the resident tolerated the procedure/treatment, whether the resident refused the procedure/treatment, notification of family, physician or other staff, and the signature and title of the individual documenting.

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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 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** 48879 Based on review of the clinical record, facility documentation and interviews for one (1) of three (3) residents reviewed for falls (Resident #2), the facility failed to supervise a resident in the bathroom who was cognitively impaired and required assistance, resulting in a fall with injury. The findings include: Resident #2's diagnoses included dementia without behavioral disturbances, a history of transient ischemic attack and cerebral infarction (stroke), muscle weakness and unsteadiness on feet. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 was moderately cognitively impaired and required extensive assistance of two (2) for bed mobility, transfers, toileting and personal hygiene. Additionally, it indicated that the resident had a history of falls, one of which resulted in a major injury in the facility. The Resident Care Plan dated 5/3/21 identified that Resident #2 was at risk for falls due to impaired mobility, incontinence and impaired safety awareness with interventions that included ensuring that appropriate footwear was worn, reminding and encouraging the use of the call bell, keeping frequently used items within reach, and a physical therapy screen as indicated. A physician's order dated 6/7/21 directed that Resident #2 was an assist of 1 with the grab bar or bed rail for all transfers. Review of the Resident Care Card (RCC) dated 4/19/21 identified that Resident #2 was a fall risk, had a low bed, and required a 1 person assist for transfers, ambulation, bathing, dressing, grooming and eating. Additionally, it identified that the resident had poor safety awareness. Review of the Fall Risk assessment dated [DATE] identified that Resident #2 was a high fall risk, indicating that the resident had intermittent confusion, had one (1) to two (2) falls in the past three (3) months, was chair bound and required assistance with elimination and required the use of an assistive device. A post fall evaluation note dated 6/19/21 at 2:07 AM identified that the nursing shift supervisor conducted a post fall assessment, that indicated that the resident continued to exhibit poor safety awareness. The Nurse Aide on duty left the resident in the bathroom and instructed the resident to use the call light or yell out for assistance when h/she was done. The NA heard a thump and found the resident on the bathroom floor. The resident sustained a laceration to the left side of his/her occipital lobe (the back of the head) and the resident was sent to the hospital by ambulance. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A post fall progress note dated 6/19/21 at 2:53 PM identified that on 6/18/21 at 9:40 PM Resident #2 was observed by facility staff on his/her right side on the bathroom floor, the resident had self-transferred off the toilet resulting in the fall. Subsequent to the fall, the resident sustained a 2-centimeter laceration to the right occipital lobe, and the RN along with 3 other staff transferred the resident off of the floor with a gait belt. The note identified that the provider was notified, and staff received an order to transfer the resident to the hospital, where it was determined that the resident sustained an acute L1 fracture (first vertebra of the lumbar spine). Review of the facility reportable event documentation dated 6/18/21 identified that Resident #2 had a fall in his/her bathroom at approximately 9:40 PM. NA #1 toileted the resident and then proceeded to wait outside the resident's bathroom providing privacy. NA #2 heard a thump and then found the resident on the floor. Interventions tput into place after the fall included reminding the resident to call for assistance and staff education was provided on requiring a female NA to always be present within the bathroom when the resident is toileting. Review of the hospital discharge paperwork dated 6/19/21 identified that Resident #2 sustained an acute compression fracture of L1 and was transferred back to the nursing facility. Review of the facility schedule for 6/18/21 on the 3:00 PM to 11:00 PM shift when the fall occurred identified RN #2 was the nursing supervisor and the staff on the first floor (Resident #2's unit) included LPN #1, LPN #2, NA's #1, NA #2 and NA #7. Interview with NA #1 on 7/20/24 at 10:30 AM identified that he had brought Resident #2 to the bathroom and he/she had requested privacy so he stepped out into the bedroom leaving the bathroom door slightly ajar. He indicated that even though the resident required assistance with toileting, he/she had the right to privacy so he directed the resident to pull the bathroom alarm or call out when he/she was ready to get up and that he would stand outside and come assist. He identified that he checks the care card in the room prior to giving care but could not recall the details of this resident and if he/she had impaired cognition. He indicated that when the resident asked him to step out, he thought it was okay to do so because he was right outside the door. He reported that after the resident fell , he stayed with the resident and called out for help and the nurse came and then sent the supervisor and the other NA's for assistance. Interview with NA #2 on 7/30/24 at 11:13 AM identified that NA #1 had not requested any assistance with Resident #2 prior to the fall that she could recall. She indicated that if a resident is an assist of 1 she does not leave the resident alone in the bathroom. Although attempted RN #2, LPN #1, and LPN #2 could not be reached for an interview. Interview with the DNS on 7/30/24 at 11:27 AM identified that she was not the DNS at the time of the incident, but that NA #1 should have looked at the care card for the resident prior to providing any care on him/her. She indicated that if the resident requested privacy and he knew that he/she was an assist of 1, he should have called the nurse for assistance and notified her prior to leaving the resident in the bathroom unattended. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with COTA #1 (Rehab Director) on 7/30/24 at 1:14 PM identified that any resident requiring any level assistance should not be left attended and should be within arm's reach. She indicated that it was not appropriate for NA #1 to be outside of the bathroom door when Resident #2 was on the toilet.