STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075366	A. Building B. Wing	01/19/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hamden Rehabilitation & Health Care Center	1270 Sherman Lane Hamden, CT 06514

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** 43127 Based on clinical record review, facility documentation review, facility policy review, and interviews for one of three residents (Resident #1) reviewed for a change in condition, the facility failed to ensure a physician's order for an immediate (STAT) x-ray was obtained timely. The findings include: Resident #1's diagnoses included psychotic disorder with delusions, dementia, and Parkinson's disease. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 severe cognitive impairment and required extensive assistance or was totally dependent on assistance with ADLs. The Resident Care Plan (RCP) dated 11/8/2022 identified Resident #1 required assistance with ADLs and was at risk for falls and fracture related to history of falls, weakness, impaired mobility, and impaired safety awareness. Interventions directed to transfer out of bed to a custom wheelchair with three assist with a Hoyer lift. Nurse's note dated 12/17/2022 at 4:54 AM identified Resident #1 slid from the bed to the floor during care and sustained a left outer elbow skin tear. A nurse's note by RN #2 dated 12/17/2022 at 12:00 PM identified that Resident #1 was noted with R knee swelling, APRN updated, and a telephone order received for STAT (immediate) x-ray of right knee. Supervising nurse/RN #3 note dated 12/21/2022 at 1:00 PM identified Resident #1's right knee was swollen and painful. On assessment Resident #1 had swelling, no redness, warmth or bruise was noted, and had limited range of motion (ROM) noted. The APRN was updated and a new order for a (STAT) right knee x- ray was obtained and radiology was notified. A physician's order dated 12/21/2022 directed to obtain a STAT right knee x-ray. Review of the clinical record failed to identify an x-ray was obtained on 12/21/2022. Nurse's note written by RN #3 dated 12/22/2022 at 12:35 PM (23 and a half hours after the order was obtained on 12/21/2022) identified she called radiology to obtain the right knee x-ray. Nurse's note written by RN #3 dated 12/22/2022 at 4:24 PM identified the x-ray of the right knee was completed, with results that identified an oblique (slanted) fracture of the distal femur bone (thigh bone). The APRN was updated and ordered to send Resident #1 to the hospital for further evaluation. (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	Interview with radiology/Person #1 on 1/31/2023 at 3:41 PM identified Resident #1's STAT order for an x-ray was received on 1/21/2023 and was cancelled by RN #2 on 1/21/2023. Interview with RN #2 on 1/31/2023 at 5:09 PM identified that the morning supervisor RN #3 provided an update during shift report on 1/21/2023 that Resident #1 was scheduled for an X-ray of right knee. RN #2 explained to RN #3 that Resident #1's knee had been swollen since his/her fall incident on 12/17/2022 and an X-ray had already been completed on 1/17/2023 with negative results. RN #2 indicated that she then called radiology and cancelled the order for the x-ray. RN #2 further indicated she did not call the physician or APRN to obtain a new order to cancel the x-ray that was ordered; she indicate if a physician/APRN gave an order and nursing was not going to follow through with the order, the ordering physician/APRN should be called to discuss the order. RN #2 indicated she did not call the physician/APRN because she thought the x-ray order was an error, and she should have called the practitioner who directed the x-ray. Interview with the DNS on 1/19/2023 at 2:30 PM identified RN #2 should not have cancelled the x-ray order on 12/21/2022. She indicated if an x-ray is ordered as STAT, it needs to be completed within four hours. The DNS indicated he was uncertain what may have caused RN #2 to cancel the order. Although requested, a facility policy for following physician orders was not provided.

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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** 43127 Based on clinical record review, facility documentation review, and interviews for one of three residents (Resident #1) reviewed for accidents, the facility failed to ensure care was provided in accordance with the plan of care to prevent an injury. The findings include: Resident #1's diagnoses included psychotic disorder with delusions, dementia, and Parkinson's disease. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had severe cognitive impairment, required extensive assistance with ADLs, had highly impaired hearing, unclear speech, and had hallucinations and delusions. The Resident Care Plan (RCP) dated [DATE] identified Resident #1 required assistance with ADLs and was at risk for falls and fracture related to history of falls, weakness, impaired mobility, and impaired safety awareness. Interventions directed to provide assist of two persons for ADLs and to assist Resident with ADLs such as personal hygiene and incontinent care. A physician order dated [DATE] directed to provide Resident #1 with assistance of two staff when performing activities of daily life (ADL) such as personal hygiene and bathing, and to transfer Resident #1 using a Hoyer lift with an assist of two per facility policy. Review of Resident #1's Care Profile (a record that give guidance for Resident's care needs and preferences) identified Resident #1 required assistance of two persons during care. Nurse's note dated [DATE] at 4:54 AM identified Resident #1 slid from the bed to the floor during care and sustained a left outer elbow skin tear. RN #1 observed the bed in the low position and Resident #1 on the floor to the left side of the bed. Resident #1 was confused and unable to explain what happened. NA #1 indicated when she turned Resident #1 in the bed to provide care, Resident #1 slid off the bed and onto the floor. The note further indicated Resident #1's left elbow hit a small table to the left side of the bed, and a skin tear measuring 6 centimeters (cm) by 3 cm was observed on the outer left elbow. The note further indicated NA #1 failed to follow the physicians order to provide assistance with two persons resulting in Resident #1 falling out of bed. Review of the clinical record and facility documentation failed to identify a second staff member assisted NA #1 with Resident #1's care on [DATE]. A nurse's note by RN #2 dated [DATE] at 12:00 PM identified that Resident #1 was noted with R knee swelling, APRN updated, and a telephone order received for STAT (immediate) x-ray of right knee. Review of the clinical record identified no right knee edema or complaints of discomfort from ,d+[DATE] through [DATE]. Supervising nurse/RN #3 note dated [DATE] at 1:00 PM identified Resident #1's right knee was swollen and painful. On assessment Resident #1 had swelling, had limited range of motion (ROM) noted, and no redness, warmth or bruise was noted. The APRN was updated and a new order for a STAT right knee x- ray was obtained and radiology was notified. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician's order dated [DATE] directed to obtain a STAT right knee x-ray. Review of the x-ray report dated [DATE] identified an acute minimally displaced fracture of the right distal femur. Facility incident report dated [DATE] at 4:30 PM identified Resident #1 had a fall with a fracture on [DATE] while being assisted with incontinent care. An x-ray of the right knee on [DATE] was negative for a fracture and revealed osteoporosis. Right knee swelling persisted, and a second x-ray was ordered and obtained on [DATE] which identified a distal femur fracture to the right lower extremity with severe osteoporosis. Facility investigation identified there was no additional fall that occurred after the [DATE] incident. Resident #1 underwent a surgical Open Reduction and Internal Fixation (ORIF) on [DATE] and remained hospitalized . The report further indicated Resident #1 developed pneumonia and post-operative complications, and was made Comfort Care at the hospital, and subsequently expired at the hospital. The supervising RN nurse's note dated [DATE] at 4:24 PM identified an x-ray of the right knee was completed and indicated an oblique (slanted) fracture of the distal femur bone (thigh bone). The APRN was updated and ordered to send Resident #1 to the hospital for evaluation. Interview with NA #1 on [DATE] at 10:25 AM identified she was the NA that provided Resident #1's care on [DATE] when the fall occurred. NA #1 indicated she was providing care for Resident #1 about 5 AM without another staff member and had raised the bed to a high position to facilitate the care. NA #1 indicated Resident #1 became combative when she asked Resident #1 to roll over so she could finish making the bed; Resident #1 was fighting, spitting and more combative trying to get off the bed. NA #1 did not indicate she called for help or notified the nurse. NA #1 indicated she held onto Resident #1, lowered the bed, and tried to change the sheets under Resident #1, when Resident #1 slid off the bed on the side opposite where she was standing and landed on the floor. Although Resident #1's Care Profile directed two (2) staff for care, NA #1 indicated she provided the care alone; she indicated she did not know she should have another staff with her. Further, NA #1 further indicated she knew that she should have made sure Resident #1 was safe and left him/her when Resident #1 became combative. NA #1 failed to ensure care was provided in accordance with the resident's plan of care. NA #1 failed to ensure two (2) staff provided care, and failed to ensure Resident #1 was safe and leave him/her when the resident became combative. Interview with RN #1 (supervisor during the [DATE] incident) on [DATE] at 2:02 PM identified when she arrived in Resident #1's room after the incident, NA #1 indicated she was providing care for Resident #1 alone/by herself without the assistance of another staff member. RN #1 indicated Resident #1 required than one staff person to perform his/her care. Interview with the DNS on [DATE] at 2:30 PM identified the NAs are expected to check the Resident Profile for residents before administering care. The DNS further indicated it was the expectation that NA #1 should have had the assistance of another staff person as per physician's order to perform personal care, and if Resident #1 was combative, NA #1 should have made sure he/she was safe, leave and go back later with help. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Although requested, a facility policy regarding following the plan was care was not provided for surveyor review.