

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075044	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/14/2024
NAME OF PROVIDER OR SUPPLIER  Apple Rehab Farmington Valley		STREET ADDRESS, CITY, STATE, ZIP CODE  269 Farmington Ave Plainville, CT 06062	

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)
<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47826</b></p> <p>Based on clinical record reviews, facility documentation, facility policies and interviews for one (1) of three (3) sampled residents (Resident #1) who were reviewed for accidents, the facility failed to monitor the temperature of a hot water source prior to serving the resident a hot beverage resulting in the resident sustaining second degree burns after spilling the hot beverage on him/herself. The finding includes:</p> <p>Resident #1's diagnoses included dementia and type 2 diabetes mellitus.</p> <p>The quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 had a BIMS of ten (10) indicating some memory recall deficits and was independent with eating after set-up.</p> <p>The Resident Care Plan dated 10/20/24 identified Resident #1 required staff assistance with completing activities of daily living (ADL). Interventions directed, in part, for staff to set-up the meals and assist with eating as needed.</p> <p>The nurse's note dated 10/22/24 at 6:00 AM identified the Director of Nursing was called to Resident #1's room after Resident #1 had spilled hot tea on the right leg and thigh. The resident's right groin was noted to have redness, some peeling skin, and the resident was noted to be in pain. The on call Advanced Practice Registered Nurse (APRN) was notified and gave an order to send Resident #1 to the emergency room for evaluation.</p> <p>The nurse's note dated 10/22/24 at 6:55 AM identified Resident #1 was transferred to the hospital.</p> <p>The hospital discharge summary dated 10/22/24 identified Resident #1 presented to the Emergency Department with complaints of acute burns to the right leg. The summary identified Resident #1 was diagnosed with a second degree burn to the right thigh, the burn was approximately twenty-five (25) centimeters (cm) x fifteen (15) cm of skin with open areas. The summary identified Resident #1 would be discharged back to the facility with orders for wound care and pain management.</p> <p>The nurse's note dated 10/23/24 at 3:44 AM identified Resident #1 returned from the hospital. with orders to cleanse the right upper thigh burn with Normal Saline followed by bacitracin and xeroform gauze followed by a non-adherent dressing and cover with cling gauze. Change the dressing every eight (8) hours for right upper thigh burn until healed and change the right upper anterior thigh burn daily and as needed until healed.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the Facility Reported Incident form dated 10/22/24 at 6:00 AM identified Resident #1 was drinking hot tea, spilled the cup of tea on the right groin and leg, and sustained a second degree burn on 3% of the right anterolateral thigh.</p> <p>A written statement by the 11PM-7AM nurse aide, Nurse Aide (NA) #1, dated 10/22/24 identified that every morning at 6:00 AM Resident #1 asks for tea and the nurse aides use the hot water from the coffee machine in the staff break room. NA #1 explained Resident #1 was independent with eating and on 10/22/24 she set up the tea on the table and left the room. After leaving the room, NA #1 heard Resident #1 screaming saying he/she spilled the tea on his/her right leg.</p> <p>Interview with the Director of Food Service on 11/14/24 at 11:AM identified the facility does not have a policy that indicates when a liquid is too hot to serve a resident. The Director of Food Service indicated hot coffee and water are typically served from the kitchen machine which has a digital temperature screen built in and they log the temperatures daily. The Director of Food Service identified the standard of practice at the facility was to serve hot liquids between the temperature range of 150-to-160-degrees. The Director of Food Service identified that when the kitchen is closed and residents request coffee or hot water, staff obtain that from the staff break room. The Director of Food Service identified that the machine in the break room does not have a built-in temperature monitor, and the facility did not monitor the temperatures because it was not part of the meal service for residents.</p> <p>An observation was done on 11/14/24 at 11:10AM with the Director of Food Services who tested the hot water temperature from the staff break room coffee from machine which identified an initial hot water temperature of 182 degrees that cooled to 170 degrees after two (2) minutes.</p> <p>Interview with Occupational Therapist on 11/14/24 at 12:45 PM identified she conducted an initial evaluation with Resident #1 on 6/26/24 and identified Resident #1 was able to feed self with assistance for set up only and did not need adaptive equipment.</p> <p>Interview with the Director of Nursing (DON) on 11/14/24 at 1:35 PM identified staff should be getting all hot liquids from the kitchen, and she was not aware that they were getting hot liquids from the staff break room machine.</p> <p>Review of the facility policy Point of Service Dining does not address liquid hot temperature testing or acceptable temperature ranges to serve.</p> <p>Although attempted, an interview with NA #1, the former Director of Nursing, and the former Assistant Director of Nurses was not completed.</p>		