

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075047	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/01/2024
NAME OF PROVIDER OR SUPPLIER Hewitt Health & Rehabilitation Center, Inc		STREET ADDRESS, CITY, STATE, ZIP CODE 45 Maltby Street 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)
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44675</p> <p>Based on review of the clinical record, facility documentation, facility policy, and interviews for two (2) of three (3) residents reviewed for falls, (Resident #1 and Resident #2), the facility failed to ensure a safety device was utilized for transfers and ambulation in accordance with facility policy resulting in falls with injuries. The findings include:</p> <ol style="list-style-type: none"> 1. Resident #2 had diagnoses that included dementia and osteoporosis. <p>A physician's order dated 3/7/24 directed an assist of one for transfers with rolling walker.</p> <p>The quarterly MDS assessment dated [DATE] identified Resident #2 had moderately impaired cognition and required extensive assistance of one staff for transfers.</p> <p>The care plan dated 4/25/24 identified Resident #2 had multiple risk factors for falls such as deconditioning, unsteady gait, and poor safety awareness with interventions that included to transfer Resident #2 in accordance with physician's orders.</p> <p>A nurse's note written by Registered Nurse (RN) #1 dated 6/1/24 at 12:19 PM identified Resident #2 had a witnessed fall at 11:50 AM during a transfer off of the toilet. Resident #2's leg gave out and the resident was lowered to the floor. An external rotation was noted to Resident #2's left leg, the APRN was notified, and Resident #2 was transferred to the hospital.</p> <p>The accident and incident form (A & I) dated 6/1/24 identified at 11:50 AM Resident #2 had a witnessed fall in the bathroom. The fall scene investigation identified there was not a gait belt in use at the time of the fall.</p> <p>A hospital discharge summary dated 6/4/24 identified Resident #2 was found to have a displaced oblique fracture of his/her left distal femur; the fracture was to be managed with conservative treatment.</p> <p>Interview with NA #1 on 7/3/24 at 11:28 AM identified on 6/1/24 she ambulated Resident #2 to the bathroom with the walker. Resident #2 stood up for NA #1 to pull up his/her pants, and Resident #2's legs buckled under him/her and Resident #2 fell, and NA #1 heard a crack. She identified that although she is aware a gait belt must be used during transfers and ambulation, she did not use it because she had lost it.</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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with RN #1 on 7/1/24 at 12:40 PM identified she was the nurse who responded to the event on 6/1/24. She identified when she entered Resident #2's bathroom, she identified NA #1 had lowered Resident #2 to the floor and had not used the gait belt. She identified Resident #2's left thigh was noted to be rotated, so she called emergency services immediately.</p> <p>2. Resident #1 had diagnoses that included osteoarthritis and osteoporosis.</p> <p>A physician's order dated 3/2/23 directed an assist of one for transfers with a rolling walker.</p> <p>The care plan dated 8/3/23 identified Resident #1 had a fall with several fractures prior to admission and had multiple risk factors for falls such as deconditioning, unsteady gait, decreased safety awareness with interventions that included to transfer Resident #1 in accordance with physician orders.</p> <p>The annual MDS dated [DATE] identified Resident #1 had severely impaired cognition and required extensive assistance of one staff for activities of daily living (ADL's) including transfers.</p> <p>A nursing note written by RN #2 dated 9/23/23 at 9:31 AM identified Resident #1 had a witnessed fall with a head strike. Resident #1 was sent to the hospital for an evaluation due to a fall with a laceration to the back of his/her head.</p> <p>The accident and incident form (A & I) dated 9/23/23 identified at 4:20 AM Resident #1 had a witnessed fall in the bathroom. After Resident #1 used the bathroom, he/she washed and dried his/her hands. NA #2 was to Resident #1's right side when Resident #1 suddenly fell on his/her buttocks and hit his/her head on the wall. Resident #1 was sent to the emergency department and required two staples to the back of Resident #1's head. The fall scene investigation identified there was not a gait belt used at the time of the fall.</p> <p>In-service education dated 9/25/23 identified staff were in-serviced by the therapy director on the gait belt policy. The education directed to ensure the safety of the residents and staff, the use of a gait belt is mandatory by all nursing personnel and rehabilitation staff while transferring and/or ambulating residents.</p> <p>Although multiple attempts were made, an interview with NA #2 was not obtained.</p> <p>Interview with the Rehabilitation Director (RD) on 7/1/24 at 12:30 PM identified that the gait belt is used to help direct a resident if they are losing their balance, and the NA should have their hand on the gait belt during transfers and ambulation. The RD identified that any resident that requires assistance of one staff member for transfers or ambulation requires the use of a gait belt during transfers and ambulation. Resident #1 and Resident #2 both required assistance of one staff member for transfers and ambulation and therefore required the use of a gait belt.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the gait belt policy identified to ensure the safety of residents and staff, the use of a gait belt is mandatory by all nursing personnel and rehabilitation staff while transferring or ambulating a resident. It directed each NA will have a gait belt on his/her person, or readily available, gait belts will be used for transfers of residents who need the assist of 1 or 2 staff and the ambulation of residents who need an escort of 1 or 2 staff or who are unsteady with ambulation. The policy further directed staff to stand close to the resident and grasp the belt firmly to control the resident's movement using the gait belt.</p>