| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 075047 | A. Building<br>B. Wing | 11/08/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Hewitt Health & Rehabilitation Center, Inc | 45 Maltby Street<br>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 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Respond appropriately to all alleged violations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50059<br><br>Based on clinical record reviews, facility documentation, facility policy and interviews for one (1) of three (3) sampled residents (Resident #1) who were reviewed for an allegation of abuse and neglect, the facility failed to ensure resident safety by removing a staff member from resident care after an allegation of abuse was reported in accordance with the facility's policy. The findings include:<br><br>Resident #1's diagnoses included vascular dementia, anxiety, and depression.<br><br>The admission Minimum Data Set assessment dated [DATE] identified Resident #1 was alert and oriented to person, place and time and required substantial/maximal assistance with transfers, personal care, and dressing.<br><br>The Resident Care Plan dated 10/21/24 identified mood disorder related to anxiety, depression, and dementia. Interventions directed to follow with psych, medication, and assist with care.<br><br>The nurse's note dated 10/19/24 at 7:00 AM identified the 11PM-7AM charge nurse was informed by the 11PM-7AM Nursing Supervisor that Resident #1 had called 911 and the Emergency Medical Services (EMS) was enroute to the facility. The note indicated although he could not recall the time earlier in the shift when he entered Resident #1's room, the charge nurse observed the nurse aide providing care to the resident. The note identified Resident #1 reported a nurse aide had treated him/her badly, the nurse aide pulled the phone from Resident #1's hand, hurting his/her fingers, and hit Resident #1 on the right shoulder. The note indicated Resident #1 was mumbling and confused, there was no physical injury, and the charge nurse let the nurse aide continue to provide care.<br><br>The nurse's note dated 10/19/24 at 11:00 AM identified the Nursing Supervisor received a call from EMS dispatch at 6:14 AM indicating they received a call from a resident. The note indicated Resident #1 stated a nurse aide was mean, pulled the phone from his/her hand hurting his/her fingers, and hit Resident #1's right shoulder.<br><br>Review of facility documentation including a video timeline dated 10/19/24 from 5:58 AM until 7:00 AM identified the 11PM-7AM nurse aide, Nurse Aide (NA) #1, had entered and exited Resident #1's room during the time after the facility received a call at 6:14 AM from the 911 dispatcher stating Resident #1 had placed a call to EMS.<br><br>(continued on next page) |

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| F 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | In an interview with Resident #1 on 11/8/24 at 10:55 AM he/she identified he/she reported to the 11PM-7AM charge nurse, Licensed Practical Nurse (LPN) #1, that NA #1 had treated him/her badly, pulling the phone cord out of his/her hand hurting their fingers, and hit his/her right shoulder.<br><br>In an interview with the Director of Nursing (DON) on 11/8/24 at 11:35 AM identified on 10/19/24 Resident #1 stated NA #1 had treated him/her badly, hurting his/her fingers, and hitting their right shoulder. The DON stated Resident #1 reported he/she notified LPN #1 earlier in the shift, before the resident called 911. The DON identified when LPN #1 was told by Resident #1 NA #1 was hurting him/ her, LPN #1 should have removed the NA #1 from resident care and reported the allegation immediately to the Nursing Supervisor.<br><br>In an interview with the 11PM-7AM Nursing Supervisor, Registered Nurse (RN) 1, on 11/8/24 at 3:05 PM identified she was not made aware by LPN #1 that Resident #1 reported an allegation of abuse. RN #1 stated had she been told she would have removed the nurse aide from resident care, assessed Resident #1 and started an investigation. RN #1 identified once she was made aware of the allegation, NA#1 had already left the building, and she reported the alleged incident to the DON.<br><br>Although attempted, an interview with NA#1 was not obtained.<br><br>Review of the Abuse/Resident policy identified: Abuse or mistreatment of any kind toward a resident is strictly prohibited. Allegations of abuse, by any individual (staff, family, visitor, resident) toward a resident must be reported immediately to a facility supervisor. All allegations will be thoroughly investigated and acted upon according to the steps of the policy. |