STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075084	A. Building B. Wing	01/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Villa Maria Nursing and Rehabilitation Community	20 Babcock Avenue Plainfield, CT 06374

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 0689 Level of Harm - 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** 47826 Based on clinical record reviews, facility documentation, facility policies and interviews for one (1) of three (3) sampled residents (Resident #1) who was status post fracture of the right lower leg and required a knee brace and an assistive device for standing, the facility failed to apply the hinged knee brace to the right leg prior to standing the resident which caused the resident's leg to buckle resulting in a fall and the resident sustained an acute fracture of the proximal tibia. The findings include: Resident #1's diagnoses included dementia, fracture lower end of right femur, osteoarthritis of the right knee, and generalized weakness. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of four (4) indicating short and long-term memory recall deficits and was dependent on staff for dressing, showers, and transfers. The Resident Care Plan dated 10/31/24 identified Resident #1 had a self-care deficit and was at risk for falls due to weakness and deconditioning related to traumatic brain injury and history of a distal femur fracture. Interventions directed assistance of two (2) with transfers, weight bearing as tolerated (WBAT), and the application of a hinged knee brace to the right knee which may be removed for showers and skin checks. A physician's order dated 11/26/24 for Resident #1 directed a right knee hinged brace in place at all times, may be unlocked for mobility and may be removed for showers and skin checks. A physician's order dated 12/3/24 directed to transfer assistance of two (2) with the [NAME] Hall [NAME] (SHT) assistive device (this device is a safe and practical standing and turning aid), and WBAT with the right knee brace. (continued on next page)

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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F 0689 Level of Harm - Actual harm Residents Affected - Few	The nurse's note dated 12/8/24 at 9:55 PM identified the 3-11PM charge nurse, Licensed Practical Nurse (LPN) #1, was called into the shower room at 4:00 PM by a 3-11PM nurse aide, Nurse Aide (NA) #1. The note indicated when NA #1 and another nurse aide, NA #2 attempted to transfer Resident #1 from the shower bench back to the wheelchair, once Resident #1 was in the standing position, Resident #1's knees buckled two (2) times so NA #1 and NA #2 lowered Resident #1 to the floor, Resident #1 did not have the hinged knee brace on. The note identified the 3-11PM Nursing Supervisor, Registered Nurse (RN) #1 and a Physical Therapist (PT) #1 were called to the room, the resident was transferred back to bed with the mechanical lift, the physician was notified, and x-rays were ordered. Resident #1 was subsequently transferred to the Emergency Department for further evaluation and treatment. The hospital record dated 12/9/24 identified Resident #1 sustained an acute fracture of the proximal tibia. The record identified Resident #1 was discharged back to the facility with a long posterior splint and non-weight bearing status until follow up with orthopedics. The nurse's note dated 12/9/24 at 11:02 PM identified Resident #1 returned from the hospital at 10:45 PM with a diagnosis of an acute fracture of the proximal tibia and old fractures of the distal tibia and proximal tibia. A right lower leg splint was in place, secured with an ace wrap, and a physician's order directed non weight bearing (NWB) status until an orthopedic follow-up. The physician's progress note dated 12/10/24 at 3:45 PM identified Resident #1 was diagnosed with an unspecified fracture of the upper end of the right tibia and the physician's order directed Resident #1 remain non weight bearing, to wear the splint and ace wrap and a follow up with orthopedics. Review of the facility's summary report dated 12/12/24 indicated Resident #1 was being transferred from the shower chair to the wheelchair when Resident #1's knees buckled, and he/she was lowered to the floor by two (2) nurse aides. According to staff interviews, NA #1 and NA #2 identified that after the shower, they assisted Resident #1 to hold onto the grab bar as they assisted him/her to rise, and the resident's knees buckled. The nurse aides indicated they were unable to pull the wheelchair closer to allow Resident #1 to sit so they lowered Resident #1 to the floor. The report identified Resident #1's hinged knee brace was not on at the time of the event. Interview with Physical Therapist, (PT) #1, on 1/2/25 at 11:40 AM identified the purpose of the right hinged knee brace was to prevent the knee from buckling and to promote healing of a femur fracture sustained in August 2024. PT #1 explained she assessed Resident #1 immediately after the fall and identified NA #1 and NA #2 did not use the SHT device for the stand pivot transfer and they attempted to stand Resident #1 without the knee brace on. Interview with NA #1 on 1/2/25 at 12:10 PM identified on 12/8/24 she assisted NA #2 with Resident #1's transfer into the shower. NA #1 identified she and NA #2 transferred Resident #1 from the wheelchair to the shower chair with the knee brace on and the resident had no difficulty with the transfer. NA #1 indicted they removed the knee brace and NA #2 proceeded to shower Resident #1. After the shower was completed, she and NA #2 assisted Resident #1 to stand to dry his/her bottom, Resident #1's leg buckled, and they attempted to sit Resident #1 back down when Resident #1's leg buckled again. NA #1 identified they slowly lowered Resident #1 to a seated position on the floor. NA #1 identified she and NA #2 had not applied the knee brace prior to standing Resident #1. NA #1 identified she did not review Resident #1's nurse aide Kardex and was not aware of the orders for the knee brace on when weight bearing and to utilize the SHT device. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Interview with the Director of Nursing (DON) on 1/2/25 at 2:50 PM identified the nurse aides were responsible to review the nurse aide Kardex for all transfer requirements for a resident or take directions from a nurse. The DON indicated the knee brace should have been applied prior to Resident #1 being assisted to a standing position and at the point a transfer was to occur, the SHT device should have been used. The DON identified the facility's investigation determined the cause of the fall was when the Resident #1's knees buckled due to not wearing the knee brace, the nurse aides failed to follow the plan of care. The facility policy, Care Plans, Comprehensive Person-Centered identified the Interdisciplinary Team (IDT) in conjunction with the resident and his/her legal representative, develops and implements a comprehensive, person-centered care plan for each resident. The policy further states, in part, that the care plan will aid in preventing or reducing decline in the resident's functional status and/or functional levels and enhance the optimal function of the resident by focusing on a rehabilitative program. The facility policy Activities of Daily Living (ADL) identified, in part, that appropriate care and services would be provided for residents who were unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care. Attempts to interview LPN #1 and NA #2 were unsuccessful.