STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075085	A. Building B. Wing	09/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saint Mary Home	2021 Albany Ave West Hartford, CT 06117

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47460 Based on clinical record review, facility documentation review, facility policy review, and interviews for one of three residents (Resident #2) reviewed for accidents, the facility failed to ensure care was provided in accordance with the plan of care. The findings include: Resident #2's diagnoses included cerebral infarction, and hemiplegia (weakness) of left nondominant side. The admission MDS assessment dated [DATE] identified Resident #2 required extensive two (2) persons physical assist for bed mobility/support. Review of Physical Therapy evaluation note dated 5/4/2024 indicated that Resident #2 was instructed on rolling side to side with max assist of two (2), noted Resident #2 listed towards the right side with noted left hemiplegia neglect, attempted to sit at edge of bed with assist of two (2), and unable to sit fully upright at edge of bed. The Resident Care Plan (RCP) dated 5/6/2024 identified Resident #2 required assistance with ADLS. Interventions directed assist of two (2) with ADLs as needed. Physician's note dated 5/6/2024 indicated Resident #2 was oriented to person, place and time, had dense left hemiplegia and could not feel his/her left side, weakness. The nurse aide care card (Resident Summary) directed Resident #2 required the assist of two (2) at all times. Facility accident/incident report dated 5/8/2024 at 5:40 AM identified Resident #2 rolled out of bed onto floor during AM care. The facility investigation identified Resident #2 required total assistance with care, and Resident #2 stated he/she lost his/her grip on the bedrail during incontinent care. No injuries were identified. Review of NA #1's written signed statement after the fall identified Resident #2 was holding onto the railing when she provided care and Resident #2 let go of the bedrail and slipped onto the floor. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of nursing note dated 5/8/2024 (written by LPN #1) identified that while Resident #2 was provided care, staff rolled Resident #2 onto his/her left side and Resident #2 tried to hold onto the bedrail. Resident #2 was too weak to hold onto the rail, let go of the rail and rolled out of bed onto the floor. The supervisor was notified at 5:40 AM, resident was assessed by supervisor, assisted back off floor with Hoyer lift, the family and APRN were notified. Interview, clinical record and facility documentation review with LPN #1 on 9/5/2024 at 12:31 PM identified NA #1 was a float staff and had provided care to Resident #2 by herself prior to the fall out of bed on 5/8/2024 at 5:40 AM. LPN #1 further indicated that a resident with a stroke should have a two person assist for care if the resident's care plan indicated two (2) person assist. On 9/5/2024 at 1:59 PM interview, clinical record review and facility documentation review with the DNS identified that Resident #2 could not use his/her left side, and that NA #1 should have had another staff member with her to provide care, as the Resident Care Plan directed assist of two (2) staff. The DNS was unable to explain why NA #1 did not have a second staff, and indicated that NA #1 was given a written warning regarding not having a second person to assist when providing ADL care to the resident. Interview, clinical record and facility documentation review with RN #2 on 9/9/2024 at 7:58 AM indicated that on 5/8/2024 when Resident #2 fell /slipped out of bed. RN #2 stated she provided education to NA #1 that a second NA was required for Resident #2's care and NA #1 needed to read the facility Resident Summary (NA care card). On 9/10/2024 at 12:51 PM interview, review of facility documentation with NA #1 identified she was aware Resident #2 required two (2) staff for care, but she provided the care alone because the other NA working was busy assisting another resident. NA #1 stated she was changing Resident #2 while Resident #2 was holding onto the railing, and then let go. Resident #2 slipped to the floor, and stated she could not hold Resident #2 to prevent the fall. NA #2 stated she had read the resident's care card and she should have had another staff with her to provide the care.

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NAME OF PROVIDER OR SUPPLIER Saint Mary Home		STREET ADDRESS, CITY, STATE, ZIP CODE 2021 Albany Ave West Hartford, CT 06117	

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(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 - 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** 47460 Based on clinical record review, facility documentation review, facility policy review, and interviews for one of three residents (Resident #2) reviewed for accidents, the facility failed to ensure resident care was provided in accordance with the plan of care to prevent a fall. The findings include: Resident #2's diagnoses included cerebral infarction, and hemiplegia (weakness) of left nondominant side. The admission MDS assessment dated [DATE] identified Resident #2 required extensive two (2) persons physical assist for bed mobility/support. Review of Physical Therapy evaluation note dated 5/4/2024 indicated that Resident #2 was instructed on rolling side to side with max assist of two (2), noted Resident #2 listed towards the right side with noted left hemiplegia neglect, attempted to sit at edge of bed with assist of two (2), and unable to sit fully upright at edge of bed. The Resident Care Plan (RCP) dated 5/6/2024 identified Resident #2 required assistance with ADLS. Interventions directed assist of two (2) with ADLs as needed. Physician's note dated 5/6/2024 indicated Resident #2 was oriented to person, place and time, had dense left hemiplegia and could not feel his/her left side, weakness. The nurse aide care card (Resident Summary) directed Resident #2 required the assist of two (2) at all times. Facility accident/incident report dated 5/8/2024 at 5:40 AM identified Resident #2 rolled out of bed onto floor during AM care. The facility investigation identified Resident #2 required total assistance with care, and Resident #2 stated he/she lost his/her grip on the bedrail during incontinent care. No injuries were identified. Review of NA #1's written signed statement after the fall identified Resident #2 was holding onto the railing when she provided care and Resident #2 let go of the bedrail and slipped onto the floor. Review of nursing note dated 5/8/2024 (written by LPN #1) identified that while Resident #2 was provided care, staff rolled Resident #2 onto his/her left side and Resident #2 tried to hold onto the bedrail. Resident #2 was too weak to hold onto the rail, let go of the rail and rolled out of bed onto the floor. The supervisor was notified at 5:40 AM, resident was assessed by supervisor, assisted back off floor with Hoyer lift, the family and APRN were notified. Interview, clinical record and facility documentation review with LPN #1 on 9/5/2024 at 12:31 PM identified NA #1 was a float staff and had provided care to Resident #2 by herself prior to the fall out of bed on 5/8/2024 at 5:40 AM. LPN #1 further indicated that a resident with a stroke should have a two person assist for care if the resident's care plan indicated two (2) person assist. (continued on next page)

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(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 - Minimal harm or potential for actual harm Residents Affected - Few	On 9/5/2024 at 1:59 PM interview, clinical record review and facility documentation review with the DNS identified that Resident #2 could not use his/her left side, and that NA #1 should have had another staff member with her to provide care to prevent the fall. The DNS was unable to explain why NA #1 did not have a second staff, and indicated that NA #1 was given a written warning regarding not having a second person to assist when providing ADL care to the resident. Interview, clinical record and facility documentation review with RN #2 on 9/9/2024 at 7:58 AM indicated that on 5/8/2024 when Resident #2 fell /slipped out of bed. RN #2 stated she provided education to NA #1 that a second NA was required for Resident #2's care and NA #1 needed to read the facility Resident Summary (NA care card). On 9/10/2024 at 12:51 PM interview, review of facility documentation with NA #1 identified she was aware Resident #2 required two (2) staff for care, but she provided the care alone because the other NA working was busy assisting another resident. NA #1 stated she was changing Resident #2 while Resident #2 was holding onto the railing, and then let go. Resident #2 slipped to the floor, and stated she could not hold Resident #2 to prevent the fall. NA #2 stated she had read the resident's care card and she should have had another staff with her to provide the care to prevent the fall.