STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075117	A. Building B. Wing	04/24/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Nathaniel Witherell, The	70 Parsonage Rd Greenwich, CT 06830

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 - 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** 47826 Based on clinical record reviews, facility documentation, facility policies and interviews for one of three sampled residents (Resident #1) who were reviewed for a fall, a facility staff member failed to report a fall to the licensed staff when the resident had reported the unwitnessed fall so an assessment could be conducted to determine if the resident had sustained an injury or struck their head. The findings include: Resident #1's diagnoses included Alzheimer's Disease, difficulty walking, generalized muscle weakness, a history of urinary tract infections and osteoarthritis. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 rarely or never made decisions regarding tasks of daily living, required maximum assistance with toileting, moderate assistance with turning and repositioning when in bed and getting in and out of the bed and chair, supervision or touching assistance when ambulating, and utilized a walker when ambulating and wheelchair for mobility. The Resident Care Plan dated 1/29/24 identified Resident #1 had a history of urinary tract infections, a self-care deficit, and was at risk for falls. Interventions directed to monitor for signs of urinary infection, antibiotics as ordered, encourage fluids, encourage call bell use and respond promptly, physical, and occupational therapy as needed, non-skid socks when ambulating or mobilizing in wheelchair, offer bathroom use every two (2) hours, and encourage resident to remain in common areas or recreation areas for close observation by staff. A physician's order dated 4/11/24 directed to assist Resident #1 to the bathroom between 4AM and 5AM and Aspirin 81 milligrams (mg) every morning, The nurse's note dated 4/13/24 at 4:03 AM identified Resident #1 was awake all night, moving up and down the hallway in the wheelchair and making nonsensical comments, Resident #1 denied pain. The nurse's note dated 4/13/24 at 2:48 PM identified Resident #1 was awake and active throughout the shift asking staff to change his/her flight to South [NAME] and self-propelling in wheelchair up and down the hall, Resident #1 denied pain. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nurse's note dated 4/13/24 at 11:10 PM identified the nurse was called to assess Resident #1 due to noticeable left eye bruising, a large bruise to the left hip and a bump on the left side of the forehead was also noted. The note indicated there was no documentation of a recent fall in the resident's record, Resident #1 was unable to identify how the bruises occurred due to being confused, the physician was notified and directed to send Resident #1 to the Emergency Department (ED). The Facility Reported Incident form dated 4/13/24 at 8:15 PM identified a discoloration at the left eye, a bump on the left forehead and discoloration to the left hip. The investigation identified in a written statement dated 4/16/24, the 7AM-3PM nurse aide wrote when she was providing care to Resident #1 on 4/12/24, she saw a little bruise on Resident #1's forehead and hip. The statement indicated when she asked Resident #1 what happened, Resident #1 told NA #1 he/she fell the night before on 4/11/24. Review of the hospital discharge paperwork dated 4/17/24 identified Resident #1 was admitted on [DATE] and diagnosed and treated for a subarachnoid hemorrhage and a urinary tract infection. Interview with the 7AM-3PM nurse aide, Nurse Aide (NA) #1, on 4/24/24 at 11:25 AM identified she was providing morning care to Resident #1 on 4/12/24 and when she brushed his/her hair she noticed a light, quarter sized bruise on the left side of Resident #1's forehead and while dressing Resident #1 she noticed sets of four (4) clusters of light-colored dots that all together were the size of a tennis ball. NA #1 stated Resident #1 told her he/she fell the night before. NA #1 identified she did not work the day before (4/11/24) and she did not report the fall to anyone because she assumed the nursing staff were already aware. Interview with the 3-11PM Nursing Supervisor, Registered Nurse (RN) #1, on 4/24/24 at 1:15 PM identified the 3-11PM charge nurse, Licensed Practical Nurse (LPN) #1, informed her Resident #1 was more confused than baseline, a call was placed to the Advanced Practice Registered Nurse (APRN) and an order directed to get a straight catheterization for a urine test. RN #1 indicated when LPN #1 went to collect the urine specimen she noted left sided periorbital bruising and called her to assess Resident #1. RN #1 identified during the assessment, she discovered a bruise on the left hip and a bump on the left side of the head, the APRN was updated and directed to send Resident #1 to the Emergency Department. Interview with LPN #1 on 4/24/24 at 1:45 PM identified she contacted NA #1 who identified Resident #1 had told her about falling the evening of 4/11/24 and NA #1 stated she had not reported the fall to anyone. Review of the facility Falls, Management and Prevention Policy, last revised 2/7/23, identified all falls must have an incident report generated and if a fall is unwitnessed, a full physical and neuro/cognition evaluation must be completed and documented. If the facility cannot determine if the resident hit their head or if there is evidence of a head injury, the resident must be transferred to the ED.