

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075138	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/11/2025
NAME OF PROVIDER OR SUPPLIER  Bloomfield Center for Nursing & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 355 Park Avenue Bloomfield, CT 06002	

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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49021</p> <p>Based on clinical record reviews, review of facility policies and procedures, and interviews for one (1) of three (3) sampled residents (Resident #1) who were reviewed for an allegation of staff to resident abuse, the facility failed to ensure a staff member would not retaliate towards the resident. The findings include:</p> <p>Resident #1's diagnoses included bipolar disorder and vascular dementia with behavioral disturbance.</p> <p>The quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of 15 indicating Resident #1 was alert and oriented to person, place and time, was independent with most Activities of Daily Living and utilized a walker as an assistive device.</p> <p>The nurse's note dated 1/23/25 at 1:14 PM identified Resident #1 reported an incident had occurred with a nurse aide and the nurse aide stated, if Resident #1 hits her, she was going to hit Resident #1 back.</p> <p>The Facility Reported Incident report dated 1/23/25 at 12:00 PM identified Resident #1 alleged a few weeks ago during an altercation with a nurse aide related to a spilled lunch tray, the nurse aide said, if Resident #1 hits me, I'm going to hit back.</p> <p>The investigation determined Resident #1 had an incident with a nurse aide, Nurse Aide (NA) #1, over a spilled lunch tray and NA #1 did state if Resident #1 hits her, she would retaliate and hit Resident #1 back, and another staff member witnessed NA #1 make the comment.</p> <p>The social services note dated 1/24/25 at 9:45 AM identified during the visit Resident #1 reported an alleged incident with staff from almost two (2) weeks prior and Resident #1 reported feeling good and appeared to be doing well.</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 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview and review of the Facility Reported Incident report dated 1/23/25 with the Director of Nursing (DON) on 2/11/25 at 10:44 AM identified Resident #1 reported the incident to social services on 1/23/25, which was when he was informed of the incident. The DON indicated although no specific date and time of the incident was identified during the investigation, it was determined the Administrative Assistant heard NA #1 state if Resident #1 hits her, she was going to hit Resident #1 back. The DON identified the statement made by NA #1 upset Resident #1 at which time Resident #1 called NA #1 names and yelled at NA #1 and that was when NA #1 made the comment. The DON indicated facility policy prohibited abuse of any kind and NA #1 was no longer employed at the facility.</p> <p>Interview with the Administrative Assistant on 2/11/25 at 11:04 AM indicated that although she was unable to recall the exact time and date of the incident, she witnessed an incident two (2) weeks prior to 1/23/25 involving Resident #1 and NA #1. The Administrative Assistant identified she was at her desk in the front of the building, heard a commotion on the B wing, went down the hall, saw food scattered on the floor, and heard Resident #1 yelling it's not true, I don't always spill my food, stop lying and saw it was directed at NA #1. The Administrative Assistant indicated she then saw Resident #1, who was very upset, rush up to NA #1 in the hallway yelling stop lying. The Administrative Assistant identified she went up to Resident #1, tried to get Resident #1 to calm down, and then NA #1 said, I will be losing my job today, if he/she hits me, I am going to hit him/her back. The Administrative Assistant indicated she told NA #1 you cannot say that to Resident #1, NA #1 then left the area, and she stayed with Resident #1 until Resident #1 calmed down.</p> <p>Interview with Resident #1 at 2/11/25 11:20 AM identified although he/she was unable to recall specific details related to the incident, Resident #1 explained the incident occurred several weeks ago and recalled feeling upset when NA #1 told him/her that he/she always spilled the meal trays on the ground.</p> <p>Review of the facility Abuse Policy &amp; Procedure dated 1/2023 defined abuse, in part, as the willful infliction of injury, intimidation, or punishment with resulting physical harm, pain or mental anguish, and directed that abuse was prohibited.</p> <p>Review of the facility Resident's [NAME] of Rights policy dated 2/2024 directed residents had the right to be free from abuse.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 49021</p> <p>Based on clinical record review, review of facility documentation, review of facility policy, and interviews for one (1) of three (3) sampled residents (Resident #1) who were reviewed for an allegation of staff to resident abuse, the facility failed to ensure a witnessed allegation of verbal abuse was reported within two (2) hours to the Administrator or designee. The findings include:</p> <p>Resident #1's diagnoses included bipolar disorder and vascular dementia with behavioral disturbance.</p> <p>The quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of 15 indicating Resident #1 was alert and oriented to person, place and time, was independent with most Activities of Daily Living and utilized a walker as an assistive device.</p> <p>The nurse's note dated 1/23/25 at 1:14 PM identified Resident #1 reported an incident had occurred with a nurse aide and the nurse aide stated, if Resident #1 hits her, she was going to hit Resident #1 back.</p> <p>The Facility Reported Incident report dated 1/23/25 at 12:00 PM identified Resident #1 alleged a few weeks ago during an altercation with a nurse aide related to a spilled lunch tray, the nurse aide said, if Resident #1 hits me, I'm going to hit back.</p> <p>The investigation determined Resident #1 had an incident with a nurse aide, Nurse Aide (NA) #1, over a spilled lunch tray and NA #1 did state if Resident #1 hits her, she would retaliate and hit Resident #1 back, and another staff member witnessed NA #1 make the comment.</p> <p>The social services note dated 1/24/25 at 9:45 AM identified during the visit Resident #1 reported an alleged incident with staff from almost two (2) weeks prior, all parties were notified and Resident #1 reported feeling good and appeared to be doing well.</p> <p>Interview and review of the Facility Reported Incident report dated 1/23/25 with the Director of Nursing (DON) on 2/11/25 at 10:44 AM identified Resident #1 reported the incident to social services on 1/23/25, which was when he was informed of the incident. The DON indicated although no specific date and time of the incident was identified during the investigation, it was determined the Administrative Assistant heard NA #1 state if Resident #1 hits her, she was going to hit Resident #1 back. The DON identified although he was aware of the incident related to the spilled tray, he was not made aware of the statement NA #1 made directed toward Resident #1 until 1/23/25 when Resident #1 reported it to social services, which was not considered a timely notification and in accordance with facility policy since the incident of abuse was witnessed by the Administrative Assistant. The DON indicated the expectation was for all staff to notify him of any abuse or allegations of abuse immediately.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with the Administrative Assistant on 2/11/25 at 11:04 AM indicated that although she was unable to recall the exact time and date of the incident, she witnessed an incident two (2) weeks prior to 1/23/25 (during the week of 1/8/25) involving Resident #1 and NA #1. The Administrative Assistant identified she was at her desk in the front of the building, heard a commotion on the B wing, went down the hall, saw food scattered on the floor, and heard Resident #1 yelling it's not true, I don't always spill my food, stop lying and saw it was directed at NA #1. The Administrative Assistant indicated she then saw Resident #1, who was very upset, rush up to NA #1 in the hallway yelling stop lying. The Administrative Assistant identified she went up to Resident #1, tried to get Resident #1 to calm down, and then NA #1 said, I will be losing my job today, if he/she hits me, I am going to hit him/her back. The Administrative Assistant indicated she told NA #1 you cannot say that to Resident #1, NA #1 then left the area, and she stayed with Resident #1 until Resident #1 calmed down.</p> <p>The Administrative Assistant identified facility policy was to report allegations of abuse to the DON right away and identified the reason she did not do so was because she was so focused on helping Resident #1 calm down and she did not report to the DON what she witnessed NA #1 say to Resident #1.</p> <p>Review of the facility Abuse Policy &amp; Procedure dated 1/2023 defined abuse, in part, as the willful infliction of injury, intimidation, or punishment with resulting physical harm, pain or mental anguish, and directed for staff members to immediately notify the administrator or nursing supervisor on duty of an allegation of abuse.</p>		