

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075163	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/24/2024
NAME OF PROVIDER OR SUPPLIER  Masonicare at Bishop Wicke Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE  584 Long Hill Ave 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)
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50094</b></p> <p>Based on the clinical record review, facility documentation review, and interviews for one of three residents (Resident #1) reviewed for accidents, the facility failed to ensure the resident was properly positioned prior to the provision of care resulting in a fall out of bed. The resident sustained a fractured ankle. The finding includes:</p> <p>Resident #1 was admitted with diagnoses that included Alzheimers disease, osteoarthritis, and abnormalities of mobility.</p> <p>The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had moderately impaired cognition, height was 67 inches, weight 181 pounds, and required maximum staff assistance with bed mobility.</p> <p>The Resident Care Plan (RCP) dated 6/28/2024 identified Resident #1 had decreased mobility and was at risk for falls. Interventions included one (1) staff assist for bed mobility.</p> <p>Facility incident report dated 6/28/2024 at 10 PM identified a NA asked the resident to turn onto his/her side so that the NA could provide care. When Resident #1 went to turn onto his/her side, the resident rolled out of bed onto the floor before the NA could reach or stop the resident. Resident #1 reported pain to the left ankle. An RN assessment was completed and identified the left ankle was swollen. The physician was notified, and the resident was transferred to the hospital for further evaluation.</p> <p>Review of the incident summary dated 7/1/2024 identified the left ankle x-ray results identified Resident #1 had oblique transverse fractures of the distal tibial and fibular metaphyses (leg bones that connect with the ankle) with posteromedial (toward the middle) displacement of the distal fragments and the bones are osteopenic. Resident #1 returned to the facility with a diagnosis of a left ankle fracture and orders for no weight bearing to left lower extremity, splint with ace wrap to left ankle at all times, follow up with the orthopedic physician in one (1) week.</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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with NA #1 on 7/24/2024 at 12:46 PM identified she was repositioning Resident #1 in the bed alone and had directed Resident #1 to turn away from her (to the opposite side of the bed). NA #1 stated there were short (1/4 or 1/2 side rails) up at the head of the bed. NA #1 further stated Resident #1's legs were close to the edge of the bed (on the side opposite where NA #1 was standing) prior to turning Resident #1 onto his/her side. The NA stated when Resident #1 turned onto his/her side, Resident #1's legs slid off the mattress to the floor and then Resident #1's upper body slid off the bed onto the floor. NA #1 states she should have moved Resident #1's legs away from the edge of the mattress to the middle of the bed or closer to where she was standing.</p> <p>Interview with MD #1 on 7/24/24 at 11 AM identified that the type of fracture that Resident #1 sustained would be caused from trauma and stated it was highly likely that this type of fracture could be caused by falling out of bed.</p> <p>Interview with the ADNS on 7/24/24 at 1:30 PM identified Resident #1 used a standard size mattress, and was positioned too close to the edge prior to being turned in bed. The ADNS stated when Resident #1 turned, his/her legs slid off the bed and his/her body then slid off the bed onto the floor. The ADNS stated she would have expected NA #1 to reposition Resident #1's legs to the center of the mattress, or closer to the NA prior to turning the resident to prevent the resident from sliding or rolling out of the bed onto the floor.</p>		