STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075196	A. Building B. Wing	06/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harbor Village North Health and Rehabilitation Cen	78 Viets St Extension New London, CT 06320

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41223 Based on clinical record review, facility documentation review, facility policy review, and interviews for two of four residents (Resident #1 and Resident #2) reviewed for abuse, the facility failed ensure the resident was free from mistreatment. The findings include: 1. Resident #1 was admitted with diagnoses that included dementia, attention-deficit hyperactivity disorder, and depression with anxiety. An admission MDS assessment dated [DATE] identified Resident #1 had severely impaired cognition with behaviors that included significant intrusion on the privacy of others disrupting care or living environment. Resident #1 was independent with bed mobility, transfers and walking, and had unclear speech with occasionally understanding others. A resident care plan (RCP) dated 4/19/2024 identified Resident #1 was an elopement risk, had a mood/behavioral disorder that included behaviors that were combative with care, pacing, restlessness, intrusive, difficult to redirect, wandering and had actual resident to resident altercations on 4/29, 5/20 and 5/21/2024. The RCP directed to cue, reorient, supervise as needed, do not corner if agitated, provide space and remain calm, call for assistance, learn to recognize/help resident to identify stressors that may be early signs of problem behavior intervene and remove stressors when possible. 2. Resident #2 was admitted with diagnoses that included dementia, schizophrenia and generalized muscle weakness. A quarterly MDS assessment dated [DATE] identified Resident #2 had moderate cognitive impairment and was independent for bed mobility, transfer and walking. The RCP dated 4/8/2024 identified Resident #2 had a potential for mood disorder with behaviors of delusions, hallucinations, combative, resistive to care, swearing and angry mood. The RCP directed to face the resident when speaking and make eye contact, when possible, speak softly and clearly when communicating, and allowing opportunity to communicate feelings. Social services note dated 5/28/2024 at 10:04 AM identified on 5/22/2024, loud screaming was heard from Resident #2's room and upon arrival, Resident #1 was found next to Resident #2's bed causing Resident #2 to yell for Resident #1 to get out of his/her room. A facility accident and investigation report dated 6/3/2024 at 10:50 AM identified a resident-to-resident incident without injury. Resident #1 walked into Resident #2's room and was near his/her bedside. LPN 32 observed both residents swinging their fists and were separated with no injuries identified. Both residents were immediately placed on one-to-one (1:1) supervision until psychiatric evaluation was completed, and Resident #1 was transferred to the hospital for evaluation. (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record reviews identified both residents were evaluated by psychiatry. The psychiatry note identified Resident #1 had wandered into Resident #2's room and was touching Resident #2's belongings, triggering the interaction. Both residents were deemed to not be a risk of injury to self or others, and the 1:1 supervision was discontinued. Record review identified Resident #1 returned from the hospital on 6/8/2024. Interview with LPN #1 on 6/11/2024 at 1:45 PM identified that she was the regular charge nurse for Residents #1 and #2 and worked on 5/22/2024 when the incident occurred. LPN #1 stated Resident #1 had entered Resident #2's room and Resident #2 yelled at Resident #1 to leave the room and she redirected Resident #1 out of the room. LPN #1 stated it was the first time she was aware of any incident between Residents #1 and #2. LPN #1 further stated she placed a Velcro cloth stop sign across Resident #2's doorway to prevent Resident #1 from entering the room. Interview with SW #1/Dementia Program director on 6/11/2024 at 12:40 PM identified on 5/22/2024 at approximately 2:45 PM he responded to Resident #2's room after hearing loud yelling. He observed Resident #1 next to Resident #2's bed, leaning over Resident #2. Resident #2 was yelling for Resident #1 to get out of her/his room and staff redirected Resident #1 out of Resident #2's room. After the incident, the nursing staff placed a white Velcro cloth sign across Resident #2's room door as an intervention to deter Resident #1 from entering as Resident #1 was known to wander into any area where the door was open (it had stopped Resident #1 previously from entering other resident rooms). SW #1 placed a note in the psych APRN's communication book requesting follow up for Resident #1's behavior. a. A facility incident report dated 6/3/2024 at 10:50 AM, and investigation summary dated 6/7/2024 identified LPN #2 witnessed Resident #1 standing over Resident #2's bed and hitting Resident #2. LPN #2 immediately separated the residents and placed them on placed on 1:1 observation. Assessments identified no injuries, and Resident #2 was unable to recall the incident. Residents #1 and #2 were evaluated by psychiatry; psychiatry directed Resident #1 to be transferred to the hospital for evaluation due to continued pacing the hallway with clenched fists at his/her side and was not redirectable. Clinical record review and facility documentation identified although there was an incident on 5/22/2024 between Resident #1 and #2 and LPN #1 placed a stop sign across the doorway, the stop sign was not documented as in place on 6/7/2024. Interview with LPN #2 on 6/11/2024 at 1:50 PM identified that she responded to Resident #2's room on 6/3/2024 when she heard loud yelling from Resident #2's room and observed Resident #1 standing over Resident #2. She observed both residents punch each other on the face with closes fists before she was able to intervene. Resident #2 was telling Resident #1 to get the f---- out of the room and she separated the residents. Both residents had red marks on the face and no other injuries. LPN #2 stated Resident #1 wanders into any area where there is an open door and that there was not a Velcro cloth stop sign affixed to the door as she entered the room. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DON 6/12/2024 at 12:35 PM identified a Velcro cloth stop sign had been placed on Resident #2's door after the incident on 5/22/2024 to prevent Resident #1 from entering Resident #2's room. Although the DON stated the Velcro stop sign should have been in place as it had been effective to prevent Resident #1's entry into resident rooms, he was unable to explain why it was not in place to prevent Resident #1 from entering the room on 6/3/2024. The facility Abuse Prohibition Policy dated 10/26/2022, directed in part, the facility had a zero tolerance for any form of abuse of a resident. Abuse is defined as the willful (acted deliberately) infliction of injury, intimidation or punishment resulting in physical harm, pain, or mental anguish, including verbal abuse, physical abuse, and mental abuse. Mental abuse is the infliction of mental pain or emotional suffering and includes humiliation, harassment and intimidation. Physical abuse was the infliction of physical pain or injury to a resident and includes hitting, slapping, pinching and kicking.