

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075198	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/08/2024
NAME OF PROVIDER OR SUPPLIER  Bristol Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 23 Fair Street Forestville, CT 06010	

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 0805</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41682</b></p> <p>Based on clinical record review, facility documentation review, facility policy review, and interviews for one of three residents (Resident #1) reviewed accidents, the facility failed to ensure a resident with dysphagia was provided the correct liquid consistency in accordance with physician orders, resulting in respiratory distress and hospitalization . The findings include:</p> <p>Resident #1's diagnoses included cerebrovascular infarction with hemiplegia and hemiparesis, dysphagia (difficulty swallowing) and vascular dementia. The RCP dated 5/12/2024 identified Resident #1 was at risk for impaired swallowing related to cerebrovascular accident and dementia. Interventions directed assistance of one staff for all meals, do not leave any liquids unsupervised with resident, and mechanically altered diet as ordered. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 as alert and oriented, was dependent for all ADL's, and required a mechanically altered diet.</p> <p>A physician's order dated 5/18/2024 directed to provide a dysphagia puree texture diet and thick liquids - nectar consistency diet.</p> <p>A facility reportable event form and investigation dated 6/8/2024 at 12:45 PM identified Resident #1 started to choke and became cyanotic with dyspnea. The Heimlich maneuver was performed, Resident #1 was suctioned, and the respiratory team placed Resident #1 on a non-rebreather oxygen mask at 15 liters/minute. Resident #1 was transferred to the hospital for evaluation.</p> <p>Review of NA #1's written statement dated 6/8/2024 identified as NA #1 was feeding Resident #1, NA #1 proceeded to give Resident #1 his/her milk when NA #1 noticed the milk was not thickened and Resident #1 started coughing. NA #1 identified it was his error in judgement to not check the milk prior to Resident #1 drinking it, but NA #1 presumed it was already thickened and did not usually have to thicken it himself. The statement indicated NA #1 made an error to not check the beverage before feeding Resident #1.</p> <p>Although attempted, an interview with NA #1 was not able to be obtained during the survey.</p> <p>Nursing note dated 6/10/2024 at 8:45 AM identified a call was placed to the hospital for an update and was informed Resident #1 was admitted for acute hypoxic respiratory failure/acidosis secondary to aspiration. The hospital further indicated Resident #1 aspirated Keppra during the hospital stay.</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 0805</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Hospital Discharge Summary dated 6/10/2024 identified Resident #1 was admitted to the hospital with suspected aspiration pneumonia. Initially, Resident #1 was placed on intravenous antibiotics (Vancomycin and Levaquin) however they were discontinued after a negative chest X-Ray result. Resident #1 continued to have low oxygen levels (hypoxic), a CT scan of the chest was obtained, and the results identified bilateral lower lobe infiltrate, consistent with pneumonia. Resident #1 was discharged back to the facility with orders for oral Vantin (antibiotic) for seven (7), three (3) days of oral azithromycin (antibiotic), DuoNeb (bronchodilator - used to treat inflammation by opening airways) and antitussives (prevent/relieve cough) as needed. Further, the Summary directed to wean off the oxygen. Hospital speech therapy evaluation recommended to continue a puree diet with thick liquids.</p> <p>Interview with ADON on 7/8/2024 at 8:45 AM identified on 6/8/2024, the facility investigation concluded Resident #1 had an incident related to aspiration of milk. The ADON indicated the lunch tray from the kitchen had a packet of thick-it for the milk and the food was puree as ordered, but NA #1 did not thicken the milk in accordance with physician orders. After the event, the facility educated kitchen staff to update nursing when pre-thickened liquids are not available to send with the meals.</p> <p>Interview with Interim FSD on 7/8/2024 at 10:10 AM identified although he was not working at the facility at the time of this event, Interim FSD stated the facility normally sends liquids to the unit pre-thickened. The Interim FSD stated on 6/8/2024, the facility did not have the pre-thickened milk available for the residents and instead sent the meal with regular milk and a thick-it packet on the tray. The Interim FSD identified although there was no direct line of communication between nursing and the dietary staff, his assumption would be that the nursing staff would check the dietary ticket for all special meal directions, and check to ensure all food and liquids items match the resident's meal, including any thickened liquids.</p> <p>Interview with LPN #1 on 7/8/2024 at 11:25 AM identified he was working during the 7:00 AM to 3:00 PM shift on 6/8/2024, when he responded to Resident #1's room for the incident. Upon entering Resident #1's room, nursing and respiratory teams were at the bedside, and Resident #1 was cyanotic and had his/her hands across the chest/neck area (displaying the universal choking sign). LPN #1 and RN #1 performed the Heimlich maneuver, as well as back blows, while respiratory attempted to suction and placed oxygen on Resident #1. EMS was called and Resident #1 was transferred to the hospital for evaluation. After the resident left, LPN #1 observed Resident #1's room and saw his/her lunch tray at the bedside. LPN #1 identified the milk was thin/regular consistency, with an unopened thick-it packet on the tray. LPN #1 stated he spoke with NA #1, who indicated he knew Resident #1 required nectar-thick liquids, but believed the kitchen had already pre-thickened it, and it was ready for consumption by Resident #1.</p> <p>Interview and record review with RN #1 on 7/8/2024 at 12:40 PM identified 911 was called immediately. Staffed performed the Heimlich maneuver and back blows, suctioned Resident #1, oxygen was applied, and Resident #1 was transferred to the hospital.</p> <p>Interview with SPT #1 on 7/8/2024 at 12:25 PM identified Resident #1 required nectar-thick liquids with the use of a straw. SPT #1 indicated that milk or any liquid for Resident #1 must be thickened for safe swallowing. SPT #1 indicated Resident #1 was evaluated after the incident on 6/8/2024, and there was no change to his/her diet at this time.</p> <p>(continued on next page)</p>		

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F 0805  Level of Harm - Actual harm  Residents Affected - Few	<p>Interview with Administrator on 7/8/2024 at 1:45 PM identified the facility had ordered the pre-thickened milk, but unfortunately, the item was on backorder from their vendor at that time (the supply out of stock for approximately the first week of June and restock has since been received).</p> <p>The DON was unavailable for interview during the survey.</p> <p>Although requested, the facility did not have a policy regarding following physician orders. Interview with the Administrator identified it was the facility practice to follow physician orders accordingly.</p> <p>Facility documentation review identified staff education was initiated on 6/11/2024 regarding education for all licensed and NA staff to ensure proper consistency of liquids and meals, ensure all meals served are corrected, check diet slips and liquid for correct texture/consistency, and the charge nurses to sign off on all resident meals that have an altered diet. Audits were initiated on 6/11/2024, and a QAPI meeting was held on 6/12/2024. Based on review of facility documentation, past non-compliance was identified.</p>		