STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075208	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village Crest Center for Health & Rehabilitation	19 Poplar Street New Milford, CT 06776

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(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** 40172 Based on review of the clinical record, facility documentation, facility policy, and interviews for one (1) of three (3) residents (Resident #3) reviewed for abuse, the facility failed to ensure a resident with known wandering behaviors was supervised to prevent an incident of sexual abuse. The findings include: Please cross reference F 657 1. Resident #2 diagnoses included Alzheimer's disease and generalized anxiety disorder. The quarterly MDS dated [DATE] identified Resident #2 had severely impaired cognition, and was independent with transfers and ambulation. The care plan dated [DATE] identified Resident #2 has the potential for negative behaviors related to coping with Alzheimer's with interventions that directed to approach and speak in calm manner, divert attention, remove from an overstimulating environment, and redirect to an alternate location as needed. Review of APRN #1's note dated [DATE] identified she was asked to see Resident #2 related to symptoms of restlessness and agitation. APRN #2 identified upon assessment Resident #2 is observed pacing, tearful, and fearful. APRN #2 identified Resident #2 required frequent redirection and reassurance. APRN #2 indicated the plan was to start Resident #2 on Remeron and Trazodone for anxiety and agitation. A physician's order dated [DATE] directed to administer mirtazapine (Remeron) 7.5 milligrams (MG) by mouth at bedtime and administer 25 MG of trazodone every 8 hours as needed for anxiety/agitation. A nurse's note dated [DATE] at 4:16 A.M. written by RN #1 (11 PM-7 AM supervisor) identified Resident #2 noted with agitation, anxiousness, and walking into other rooms. RN #1 identified Resident #2 was unable to be redirected. The nurse's note dated [DATE] at 4:42 A.M. written by RN #1 identified that Resident #2 is extremely anxious, entering other resident's rooms, and disrupting the floor. RN #1 indicated Resident #2 had an order in the past for Ativan as needed, but the order is expired. RN #1 identified she called the APRN #3 who was on-call, and a verbal order were obtained for Ativan as needed. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A physician's order dated [DATE] directed to administer lorazepam (Ativan) 0.5 MG every 8 hours as needed for anxiety. The nurse's note dated [DATE] at 8:10 P.M. written by LPN #8 identified Resident #2 noted with agitation, anxiousness, and walking into other rooms. LPN #8 indicated attempts to redirect with PRNs with little effect. LPN #8 identified Resident #2 was given a shower and it had a calming effect. Review of APRN #1's note dated [DATE] identified collaboration with the nurse and DNS regarding Resident #2 requiring near constant redirection. APRN #1 identified Resident #2 seen today for follow up evaluation after starting mirtazapine for depression, anxiety, and insomnia. APRN #2 identified Resident #2 has continued anxiety, near constant pacing on the unit, and requires much staff redirection. APRN #2 indicated Resident #2 would benefit from an increase in mirtazapine to 15 mg at bedtime. A physician's order dated [DATE] directed to administer mirtazapine 15 mg at bedtime. The nurse's note dated [DATE] at 10:18 A.M. written by LPN #2 identified this morning Resident #2 had increased anxiety, pacing in the hallway and stopping to try an open the doors. LPN #2 identified Resident #2 was unable to be redirected or distracted. LPN #2 indicated after multiple attempts Resident #2 took h/her morning medications. Review of APRN #1's note dated [DATE] identified Resident #2 has ongoing behaviors related to dementia. APRN #1 identified Resident #2 was pacing the unit and attempting to elope. APRN #1 indicated Resident #2 becomes agitated at times, verbally aggressive, and attempts to throw objects at staff. APRN #1 identified upon her assessment Resident #2 is restless and voices frustration. APRN #1 identified given Resident #2's symptoms h/she would benefit from liquid Depakote for behavioral disturbances. A physician's order dated [DATE] directed to administer valproate sodium oral solution 250 MG/5 milliliters (ML) 2.5 ml's orally two times per day related to Alzheimer's disease. The nurse's note dated [DATE] at 1:41 P.M. written by LPN #2 identified Resident #2 had increased anxiety, pacing the floor, and wandering into other resident's rooms. LPN #2 identified Resident #2 was unable to be redirected. LPN #2 indicated multiple attempts were made to administer as needed Ativan and Resident #2 initially refused stating 'you're trying to poison me'. LPN #2 identified after multiple attempts Ativan was administered to Resident #2. 2. Resident #3's diagnoses included Alzheimer's disease and unspecified dementia. The quarterly MDS dated [DATE] identified Resident #3 had short- and long-term memory problem with severely impaired cognitive skills for daily decision making and was dependent with ADLs. The care plan dated [DATE] identified Resident #3 had a potential of psychosocial well-being problem related to incident with a female resident being sexually inappropriate with interventions that directed to monitor for any changes in psychosocial well-being, social work to follow up, and consult with psychiatric/psychological services. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nurse's note dated [DATE] at 10:05 P.M. written by RN #5 identified at 8:15 P.M. she was notified by LPN #1 that NA #2 observed Resident #2 in Resident #3's room and Resident #2 was groping Resident #3 who was in bed. RN #5 indicated the residents were immediately separated and Resident #2 was taken out of Resident #3's room. RN #5 identified Resident #2 was placed on 1:1 observation. RN #5 identified she notified the on-call MD, DON, the police were called, and the responsible parties. The nurse's note dated [DATE] at 10:09 P.M. written by LPN #1 identified Resident #2 was very aggressive this shift cursing, pacing up and down hallway, and pushing items on the floor. LPN #2 identified she was told by NA #2 that Resident #2 was seen touching Resident #3's private part in h/her room asking for sex. A review of the Facility's Reportable Event form dated [DATE] identified on [DATE] at 8:00 P.M. Resident #2 was observed groping Resident #3. The facility's investigation identified on [DATE] Resident #2 was last seen at 7:00 P.M. wandering in and out of rooms and was able to be redirected. On [DATE] at 8:00 P.M. NA #2 did not see Resident #2 walking in the hallway prompting her to look for Resident #2 and NA #2 found Resident #2 in Resident #3's room. NA #2 noted that Resident #3's first strap of the Velcro on h/her brief was undone and Resident #2's hand was under the brief. NA #2 removed Resident #2 from Resident #3's room, informed LPN #1 of the incident, and Resident #2 was placed on one-to-one observation. Interview with NA #2 on [DATE] at 10:00 A.M. identified on [DATE] she observed Resident #2 pacing the hallways per h/her usual behaviors. NA #2 identified at times Resident #2 wandered into other resident's rooms, however was always re-directable. NA #2 identified on [DATE] at approximately 7:00 P.M. she observed Resident #2 standing outside of Resident #3's room which is across the hall from Resident #2's room. NA #2 identified she re-directed Resident #2 who continued to pace the hallways and at approximately 7:30 P.M. NA #2 identified at approximately 8:00 P.M. she came out of another resident's room and did not see Resident #2 in h/her room nor pacing in the hallways. NA #2 identified she went to look for Resident #2 and found Resident #2 in Resident #3's room. NA #2 identified she observed Resident #2 standing at Resident #3's bedside with Resident #3 laying h/her bed and observed Resident #2's hand on Resident #2's private part with one side of Resident #2's brief undone. NA #2 indicated she immediately removed Resident #2 from Resident #3's room reported the incident to LPN #1. Interview with LPN #1 on [DATE] at 9:25 A.M. she identified that Resident #2 at times wanders into other resident's rooms, although easily redirected. LPN #1 identified on [DATE] she observed Resident #2 was walking the hallways and at approximately 7:00 P.M. she and NA #2 observed Resident #2 standing in the doorway of Resident #3's room. LPN #1 identified NA #2 went down the hallway and redirected Resident #2 away from Resident #3's doorway and Resident #2 went into h/her own room. LPN #1 identified NA #2 reported to her that she found Resident #3 in Resident #2's with h/her hand on Resident #3's private part. LPN #1 indicated the residents were immediately separated and Resident #2 was placed on one-to-one observation. Interview with LPN #2 on [DATE] at 10:35 A.M. she identified Resident #2 paces the hallways on the unit and wanders into other resident's rooms. LPN #2 indicated Resident #2 is able to be redirected when h/she wanders into other resident's rooms; however, requires frequent redirecting. (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 NA #3 on [DATE] at 10:50 A.M. she identified Resident #2 paces the hallways and wanders throughout the unit. NA #3 identified Resident #2 does wander into other resident's rooms and requires frequent redirection. Interview with the DNS on [DATE] at 12:00 P.M. identified prior to the incident that happened on [DATE] between Resident #2 and Resident #3 she was unaware that Resident #2 was wandering into other resident's rooms, if she had been aware she would have ensured a care plan was in place to address the wandering behaviors. The DNS indicated Resident #2 had no previous history of resident to resident incidents nor any history of inappropriate sexual behaviors. The DNS identified following the incident on [DATE] Resident #2 was placed on one-to-one monitoring until h/she was cleared by psych on [DATE]. Interview with APRN #1 on [DATE] at 1:25 P.M. she identified prior to the incident on [DATE] Resident #2 had no inappropriate sexual behaviors nor any other resident to resident incidents. APRN #1 identified Resident #2 has end stage dementia which can provoke inappropriate sexual behaviors and APRN #1 has adjusted Resident #2's Depakote dose to aid in impulsive behaviors. Review of facility abuse resident to resident policy identified, in part, the policy is to prevent residents residing in the facility from inflicting harm (physical/mental) on other residents. To ensure that any incident of inappropriate resident to resident contact is thoroughly investigated and managed to prevent reoccurrence.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40172 Based on review of the clinical record, facility documentation, facility policy, and interviews for one (1) of three (3) residents (Resident #4) reviewed for pressure injury, the facility failed to develop a comprehensive care plan with interventions to prevent skin breakdown when the resident was identified at high risk for developing pressure injuries. The findings include: Resident #4 had diagnoses that included multiple sclerosis, Guillan-Barre syndrome, and generalized muscle weakness. The nursing admission assessment dated [DATE] identified Resident #4 was alert to person, place, and situation, continent of bowel and bladder, required the assistance of one with bed mobility, assistance of 2 to ambulate, and Resident #4's skin was intact. Review of the Resident #4's Braden Scale for predicting pressure sores dated 6/22/24 identified Resident #4 was at high risk. The admission MDS dated [DATE] identified Resident #4's skin was intact, a formal clinical assessment was conducted, and determined Resident #4 was at risk for developing pressure ulcers/injuries. The nurse's note dated 7/24/24 at 12:37 P.M. written by RN #4 identified during weekly skin check Resident #4 was noted to have an intact fluid blister to the back of h/her left heel. RN #4 indicated skin prep was applied and APRN #2 was notified. RN #4 indicated she provided education to Resident #4 on offloading pressure to heels, frequent repositioning, maintain adequate nutrition, and wear proper fitting shoes. RN #4 identified she updated Resident #4's wife on the new blister on Resident #4's left heel and Resident #4's wife will bring in a larger pair of sneakers. The care plan dated 7/24/24 identified Resident #4 had the potential for skin breakdown due to decreased mobility with interventions that directed weekly skin evaluations, skin checks with care and report any changes to nurse and provide a pressure redistribution mattress. A physician's order dated 7/24/24 directed to apply skin prep to the blister on left heel every day and evening shift. Review of Resident #4's care plan dated 7/24/24 identified Resident #4 has a blister to left heel with interventions that directed heel boots on except for transfers and ambulation, sneakers on only when ambulating, and off load heels with heels boots when in bed and/or at all times. Review of MD #3's (wound doctor) note dated 7/26/24 identified Resident #4 is being seen for an initial wound assessment. MD #3 identified Resident #4's left heel has a deep tissue injury with non-blanchable deep red, maroon, or purple discoloration. MD #3 directed to off load Resident #4's heels per facility protocol. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and clinical record review with DNS on 9/19/24 at 12:30 P.M. she was unable to provide documentation to reflect that Resident #4 had a comprehensive care plan developed and implemented on 6/22/24 when Resident #4 was identified at high risk for developing pressure injuries. The DNS identified her expectation is when any resident is identified at risk for skin breakdown a comprehensive care plan is implemented with appropriate interventions. The DNS indicated on 7/24/24 after Resident #4 developed a deep tissue injury to h/her left heel a comprehensive care plan was developed and interventions were implemented. The DNS identified that off loading heels and turning every two hours is standard of practice, and although not documented prior to 7/24/24, both were in place. Review of the facility Baseline/Comprehensive Person-Centered Care Plan policy; in part, identified the interdisciplinary team will utilize the Comprehensive Person-Centered Care Planning process to address residents' strengths, needs, and/or problems identified on the admission discharge summary, as well as other professional assessments. The interdisciplinary team will identify functional disabilities and high-risk factors requiring interventions for potential improvement or prevention.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40172 Based on review of the clinical record, facility documentation, facility policy, and interviews for one (1) of three (3) residents (Resident #2) reviewed for behaviors, the facility failed to review and revise a resident's care plan when the resident was identified as wandering in and out of other resident's rooms. The findings include: Resident #2 diagnoses included Alzheimer's disease and generalized anxiety disorder. A nurse's note dated 7/21/24 at 8:37 P.M. written by LPN #8 identified Resident #2 pacing the unit, visibly upset, entering other resident's rooms. The care plan dated 8/15/24 identified Resident #2 has the potential for negative behaviors related to coping with Alzheimer's with interventions that directed to approach and speak in calm manner, divert attention, remove from an overstimulating environment, and redirect to an alternate location as needed. The quarterly MDS dated [DATE] identified Resident #2 had severely impaired cognition, and was independent with transfers and ambulation. A nurse's note dated 8/21/24 at 4:16 A.M. written by RN #1 (11 PM-7 AM supervisor) identified Resident #2 noted with agitation, anxiousness, and walking into other rooms. A nurse's note dated 8/21/24 at 4:42 A.M. written by RN #1 identified that Resident #2 is extremely anxious, entering other resident's rooms. A nurse's note dated 8/21/24 at 8:10 P.M. written by LPN #8 identified Resident #2 noted with agitation, anxiousness, and walking into other rooms. LPN #8 indicated attempts to redirect with PRNs with little effect. LPN #8 identified Resident #2 was given a shower and it had a calming effect. A nurse's note dated 8/31/234 at 1:41 P.M. written by LPN #2 identified Resident #2 had increased anxiety, pacing the floor, and wandering into other resident's rooms. LPN #2 identified Resident #2 was unable to be redirected. LPN #2 indicated multiple attempts were made to administer as needed Ativan and Resident #2 initially refused stating 'you're trying to poison me'. LPN #2 identified after multiple attempts Ativan was administered to Resident #2. A nurse's note dated 8/31/24 at 10:05 P.M. written by RN #5 identified at 8:15 P.M. she was notified by LPN #1 that NA #2 observed Resident #2 in Resident #3's room and Resident #2 was groping Resident #3 who was in bed. RN #5 indicated the residents were immediately separated and Resident #2 was taken out of Resident #3's room. RN #5 identified Resident #2 was placed on 1:1 observation. Interview with LPN #1 on 9/18/24 at 9:25 A.M. she identified that Resident #2 is always pacing the hallways on the unit and at times Resident #2 wanders into other resident's rooms, and usually can be redirected out of other resident's rooms. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with NA #2 on 9/18/24 at 10:00 A.M. she identified Resident #2's baseline behaviors include pacing the hallways on the unit and wandering into other resident's rooms. Interview with LPN #2 on 9/18/24 at 10:35 A.M. she identified Resident #2 paces the hallways on the unit and wanders into other resident's rooms. LPN #2 indicated Resident #2 is able to be redirected when h/she wanders into other resident's rooms; however, requires frequent redirecting. Interview with NA #3 on 9/18/24 at 10:50 A.M. she identified Resident #2 paces the hallways and wanders throughout the unit. NA #3 identified Resident #2 does wander into other resident's rooms and requires frequent redirection. Interview and clinical record review with the DNS on 9/18/24 at 12:00 P.M. indicated prior to 8/31/24 she was unaware that Resident #2 had been wandering into other resident's room. The DNS identified she became aware of Resident #2's history of wandering while investigating the incident that happened on 8/31/24 when Resident #2 wandered into Resident #3's room and was observed inappropriately touching Resident #3. The DNS identified that she would expect to be notified when a resident is wandering into the other resident's rooms and the care plan should be reflective of the resident wandering into other resident's rooms. Subsequent to surveyor inquiry Resident #2's care plan was revised. Review of Resident #2's care plan dated 9/19/24 identified Resident #2 wanders on the unit and into other's rooms and demonstrated inappropriate sexual behavior toward a male resident with interventions directed to redirect, offer snacks/fluids, offer activity to patient when wandering into other's rooms. Review of the facility Baseline/Comprehensive Person-Centered Care Plan policy; directed in part, the interdisciplinary team will utilize the Comprehensive Person-Centered Care Planning process to address residents' strengths, needs, and/or problems identified on the admission discharge summary, as well as other professional assessments. The Comprehensive Person-Centered Care Plan will be periodically reviewed and revised by a team of qualified persons.

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F 0689 Level of Harm - 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** 40172 Based on a review of clinical records, facility documentation, facility policy, and interviews for one (1) of three (3) residents (Resident #1) reviewed for accidents, the facility failed to provide adequate assistance during a bed linen change and as a result, the resident rolled out of bed onto the floor sustaining a left hip fracture. The finding includes: Resident #1 had diagnoses that included Alzheimer's disease, generalized muscle weakness, and difficulty walking. Review of Resident #1's side rail evaluation dated 6/14/24 identified the indication and use of the side rails is per the request of Resident #1 and h/her responsible party. The side rail evaluation identified Resident #1 has a self-care deficit with interventions that directed the use of quarter (1/4) side rails for assistance/enablers with bed mobility. The side rail evaluation identified for use of the side rails are not to exceed 28 inches in length from the head of bed. The quarterly MDS assessment dated [DATE] identified Resident #1 had severely impaired cognition, was always incontinent of bowel and bladder, required maximal assistance with bed mobility, and dependent with transfers, Activities of Daily Living (ADLs), and was non-ambulatory. The care plan dated 6/21/24 identified Resident #1 has an ADL self-care performance deficit with interventions that included to provide total care with the assist of one for incontinent care and bed mobility, and two (2) upper 1/4 side rails for bed mobility. Review of the Facility reportable event form dated 8/27/24 at 10:00 P.M. identified Resident #1 rolled onto right side and fell out of bed with no signs of injury. The reportable event identified Resident #1 was assessed by the Registered Nurse (RN #2) and Resident #1 had no bruises and no signs of injuries. The treatment directed to monitor Resident #1's vital signs per protocol, observe and report any changes. The reportable event did not indicate if Resident #1's quarter side rails were up or in use when Resident #1 fell out of bed. Review of the change in condition assessment dated [DATE] at 10:00 P.M. completed by Registered Nurse (RN) #4 identified Resident #1 had an unwitnessed fall with no apparent injuries. RN #4 identified evaluation of Resident #1's neurological status identified no changes and Resident #1 had no complaints of pain. The pain tool assessment dated [DATE] at 10:00 P.M. conducted by RN #4 identified Resident #1 has no evidence of pain. The nurse's note dated 8/27/24 at 10:22 P.M. written by RN #2 identified Resident #1 rolled on to his/her right side in bed and then rolled onto the floor. RN #2 indicated Resident #1 had no injuries, vital signs stable, the on-call Advanced Practice Registered Nurse (APRN), and Resident #1's family were notified. The nurse's note dated 8/27/24 at 10:28 P.M. written by Licensed Practical Nurse (LPN) #3 identified while Resident #1 was in bed receiving a bed change Resident #1 rolled onto the floor. LPN #3 indicated Resident #1 had no injury and Resident #1's vital signs were stable. (continued on next page)

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(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 - Actual harm Residents Affected - Few	The change in condition follow-up note dated 8/28/24 at 2:00 A.M. written by the DNS identified the note as a follow-up note for Resident #1's fall. The DNS identified Resident #1 is now complaining of left hip pain and guarding was noted. The nurse's note dated 8/28/24 at 3:04 A.M. written by RN #1 identified Resident #1 was status post fall from the last shift. RN #1 identified Resident #1 is complaining of pain and was seen guarding left hip while being changed. RN #1 indicated Resident #1's left hip is aligned with no deformity or swelling noted. RN #1 identified she notified on-call physician MD #4 on 8/28/24 at 1:55 A.M., and a new order was obtained for a STAT x-ray of Resident #1's left hip. The nurse's note dated 8/28/24 at 3:59 A.M. written by LPN # 9 identified Resident #1 was medicated with Tylenol (a pain reliever) for left hip pain. LPN #9 identified she conducted passive range of motion to Resident #1's legs without complaints, but when Resident #1 was turned he/she was guarding the left hip and pelvic area. The nurse's note dated 8/28/24 at 6:51 A.M. written by LPN #9 identified that the administration of Tylenol was effective and Resident #1's pain scale was 0/10. Review of Resident #1's radiology results report dated 8/28/24 at 8:50 A.M. identified an acute-appearing fracture of the left femur with mild displacement. The nurse's note dated 8/28/24 at 12:15 P.M. written by LPN #2 identified Resident #1's X-ray results were reviewed with APRN #2 and a new order was obtained to transfer Resident #1 to the hospital for evaluation. Review of the Facility's Reportable Event Report dated 8/28/24 at 8:45 A.M. identified on 8/27/24 at 10:00 P.M., Nurse Aide (NA) #1 witnessed Resident #1 roll out of bed onto his/her back during care with no initial evidence of pain and no change in Range of Motion. On 8/28/24 at 3:00 A.M. Resident #1 complained of pain with noted guarding of left pelvic and hip region, the on-call physician was notified, an order was obtained for an X-ray which demonstrated an acute appearing fracture and Resident #1 was transferred to the hospital. Review of the facility's summary dated 8/30/24 at 2:16 P.M. on 8/27/24 Resident #1 fell out of bed during a bed linen change, sustaining a fracture of the left intertrochanteric (upper part) femur. Resident #1 was transferred to the hospital for evaluation and returned to the facility without surgical intervention. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075208	A. Building B. Wing	09/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village Crest Center for Health & Rehabilitation	19 Poplar Street New Milford, CT 06776

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 - Actual harm Residents Affected - Few	Interview with NA #1 on 9/19/24 at 10:30 A.M. identified Resident #1 was dependent with bed mobility with the assistance of one (1) staff. NA #1 identified on 8/27/24 at approximately 10:00 P.M. NA #1 was providing incontinent care and a complete bed change for Resident #1. NA #1 indicated Resident #1's bed was in a high position when he was changing the sheets, he was standing on the left side of the bed behind Resident #1 who was lying on his/her right-side center of the bed with his/her hands on the side rail as enablers. NA #1 identified he had one hand on Resident #1's waist when NA #1 pulled the soiled bed sheets out from under Resident #1. NA #1 identified he then had to release his hand from Resident #1's waist so he could tuck and secure the sheets to the mattress. NA #1 identified as he pulled on the sheets to tuck them Resident #1 rolled out of bed onto the floor. NA #1 identified that Resident #1's two (2) upper 1/4 side rails were both up when he pulled on the sheets and Resident #1's had h/her hands on the 1/4 side rails. NA #1 identified prior to Resident #1 falling out of bed he thought Resident #1 was able to grip the upper quarter side rails. NA #1 indicated he believes the reason Resident #1 fell out bed on to the floor was because when he pulled on the sheets to tuck them in, the weight of Resident #1's left leg pulled h/her off the bed. Interview with the DNS on 9/19/24 at 10:45 A.M. identified on 8/27/24 at 10:00 P.M. NA #1 had Resident #1 lying on his/her right-side when NA #1 moved to the left side of the bed to tuck the new sheet under the mattress when Resident #1 rolled out of the bed. The DNS identified Resident #1's care plan was updated with a new intervention that directed to provide the assistance of two with bed mobility.