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	05/06/2025

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	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** 50249 51183 Based on interviews, review of the clinical record, facility documentation, and facility policy for 1 of 5 residents (Resident #24) reviewed for falls, the facility failed to provide a transfer according to physician orders which resulted in a fall with injury and failed ensure all appropriate doors were secured on the locked memory care unit. The findings include: 1. Resident #24's diagnoses included transient cerebral ischemic attack, morbid obesity, and difficulty in walking. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #24 was moderately cognitively impaired, had no falls since the previous assessment (5/18/23), had received physical therapy services from 6/2/23 through 7/4/23, required setup or clean-up assistance with eating, substantial/maximal assistance with bed mobility, and was dependent for transfers. A physician order dated 8/23/23 directed to provide extensive assistance of 1 staff member for bed mobility, Resident #24 required the use of a Sarita lift for transfers, was non-ambulatory, required limited assistance for upper extremity dressing, required extensive assistance with lower body dressing, and was independent with eating. The Resident Care Plan (RCP) dated 8/28/23 identified Resident #24 was at risk for falls related to deconditioning, gait/balance problems, psychoactive drug use, and a prior fall without injury on 5/29/23. Interventions included every shift must ensure Resident #24 was wearing non-skid socks while in bed and physical therapy to evaluate as ordered or as needed. Additionally, the RCP dated 8/28/23 identified Resident #24 had an activities of daily living (ADL) deficit related to generalized weakness especially to the lower extremities. Interventions included Resident #24 required extensive assistance by 1 staff member to turn and reposition in bed and required the use of a Sarita (mechanical lift) with assistance by 2 staff members for transfers. (continued on next page)

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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F 0689 Level of Harm - Actual harm Residents Affected - Few	The Nurse Aide (NA) care card for Resident #24 dated 9/1/23 identified to transfer Resident #24 assist out of bed (OOB) to the chair/wheelchair as tolerated with assistance of 1 staff member (a discrepancy with physician orders and RCP in effect at that time directing to utilize a Sarita lift for transfers) and Resident #24 was to be transferred using the Sarita with the assistance of 2 staff members. A nursing note written by Registered Nurse (RN) #3 on 9/8/23 at 10:26 AM identified she had been requested to assess Resident #24 following a fall. The note identified that upon RN #3 entering the room, Resident #24 was observed sitting on the floor next the bed with his/her legs outstretched. The note identified Resident #24 verbalized pain to the right ankle with and without manipulation of the ankle. Additionally, the nursing note identified NA #1 reported Resident #24's leg appeared to twist as NA #1 lowered Resident #24 to the floor during a transfer. The note identified no bruising or swelling was observed to the right ankle, Resident #24 was assisted back to bed using a mechanical lift, and the Advanced Practice Registered Nurse (APRN) #1 and Resident #24's responsible party were updated. The note further identified an x-ray was ordered to rule out injury to the right ankle. A facility Reportable Event form identified on 9/8/23 at 10:00 AM Resident #24 was lowered to the floor by NA #1 during a transfer after which Resident #24 verbalized pain to the right ankle. The report identified x-rays were performed and identified 2 fractures: the base of the medial malleolus (inner side of the ankle) and distal fibular (end of leg bone near the ankle) fracture. The report identified Resident #24 was sent to the hospital ED for evaluation and treatment. The RE identified Resident #24's physical status before the event was to transfer with extensive assistance of 1 staff member (a discrepancy with the physician order dated 8/23/23 which directed Resident #24 required extensive assistance of 1 staff member for bed mobility, required use of a Sarita for transfers and was non-ambulatory), and Resident #24's physical status after the event was transfer with mechanical lift and assistance of 2 staff members. A nursing note written by Licensed Practical Nurse (LPN) #8 and dated 9/9/23 at 2:33 AM identified x-rays of the right ankle were completed at 12:30 AM. A radiology report dated 9/9/23 at 4:40 AM identified 3-view right ankle x-rays had been completed for Resident #24 on 9/8/23 with findings of an acute nondisplaced fracture at the base of the medial malleolus (inner side of the ankle) with an acute comminuted nondisplaced distal fibular (end of leg bone near the ankle) fracture. Diffuse osteopenia (decreased bone density) was seen. A nursing note written by RN #8 on 9/9/23 at 6:48 AM identified Resident #24 was status post a fall with complaints of pain to the right ankle, the x-ray results were positive for fractures to the medial malleolus and distal fibula, and the on-call Advanced Practice Registered Nurse was updated and directed to send Resident #24 to the hospital emergency department (ED). A nursing note written by LPN #8 on 9/9/23 at 7:44 AM identified Resident #24 was transferred to the hospital ED at 7:40 AM with all required paperwork. The note identified Resident #24's right leg and ankle were swollen with no bruising noted, Resident #24 complained of knee pain and Tramadol (pain medication) was administered at 7:00 AM. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A nursing note written by RN #7 on 9/9/23 at 5:08 PM identified Resident #24 returned to the facility from the hospital emergency department at 3:30 PM with a diagnosis of a right ankle fracture, a soft cast in place to the right lower extremity and the on-call medical doctor was updated on Resident #24's return. Interview with NA #1 on 5/5/25 at 2:15 PM identified she was the NA caring for Resident #24 on 9/8/23 and indicated the NA care card in the computer was confusing and directed that Resident #24 could either be transferred by a stand/pivot transfer and the assistance of 2 staff members or by a Sarita lift. NA #1 identified she was unable to locate another staff member to assist her with the transfer and thought she would be fine to complete the transfer by herself. NA #1 identified as she was transferring Resident #24 from the bed to the wheelchair by herself when Resident #24's legs buckled and as NA #1 lowered Resident #24 to the floor, Resident #24's ankle went backwards and twisted. NA #1 identified that the instructions on the NA care card were confusing and she did not ask a staff member for clarification regarding if Resident #24 transfer status. NA #1 further noted if Resident #24 needed to be transferred by the Sarita lift, she still should have had a second staff member with her for Resident #24's transfer. Interview with the DNS on 5/5/25 at 2:30 PM identified the policy for any mechanical lift including the Sarita was that 2 staff members were required for the transfer with the mechanical lift without exception. The DNS identified NA #1 should have completed the transfer using a Sarita lift, should have had a second staff member with her for the transfer and did not follow facility policy for use of the Sarita lift. Review of the Mechanical Lift policy directed, in part, 2 staff members must be involved in the transfer of a resident with a mechanical lift, when lifting a resident from the floor, two staff members including a licensed nurse must be present while operating the mechanical lift, and documentation of need for a mechanical lift was in the care plan and NA care card. 2. Review of the Resident Listing Report dated 4/28/25 indicated there were 30 residents living on the facility's secured/locked memory care unit. An observation on the secured /locked memory care unit with the Director of Maintenance on 4/28/25 at 12:45 PM identified the shower room contained a metal nail clipper and a bottle with a white liquid in it (soap). Additionally, the door to the room labeled dentist office was propped open with a garbage can, and the door to the room labeled soiled utility, which was equipped with a key pad locking mechanism (the mechanism had been bypassed), was not locked/secured. The soiled utility room contained two bottles of cleaning solution with liquid in them. Interview with the Maintenance Director on 4/28/25 at 12:49 PM while on the secured locked memory care unit identified he was not aware the dentist office and soiled utility room doors were not locked/secured. The Maintenance Director indicated the soiled utility room should have been locked/secured and staff should have only used the keypad code to gain access to the room. He demonstrated how the keypad code could be bypassed, resecured the keypad lock and stated he would plan to install a different lock on the door that could no longer be bypassed. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Observation and interview with LPN #2 on 4/28/25 at 1:05 PM identified the door to the room labeled dentist office was found propped open and not locked/secured as it should have been. LPN #2 indicated she was not sure why the door was not locked/secured but sometimes nursing staff used the room for charting. LPN #2 identified the nursing station was also equipped with a retractable plastic barrier that could be pulled to deter access to the area behind the nurse's station (where the dentist office was located) but that it was not pulled/secured and should have been. Subsequent to surveyor inquiry, on 4/28/25 at 1:08 PM the retractable barrier was pulled/secured by LPN #2. Interview with the Administrator on 4/28/25 at 1:20 PM identified all doors on the secured locked memory care unit should have been locked/secured for the safety of the residents. The Administrator indicated he would have expected the soiled utility and dentist office doors to always be locked/secured. The Administrator identified he would speak to the nursing supervisor about providing staff further education and oversight on keeping all doors locked/secured on the unit. Subsequent to surveyor inquiry, on 4/29/25 at 10:00 AM the door to the shower room on the secured locked memory care unit was now equipped with a keypad locking mechanism. Review of the facility policy, Living Legacy Memory Care Unit, undated, directed the unit provided a secure environment where the safety and well-being of residents is maintained. The policy further directed the unit was a safe, secured physical environment which allowed maximum freedom, safety, and a sense of security for residents and families.