STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075230	A. Building B. Wing	06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ledgecrest Health Care Center	154 Kensington Rd Kensington, CT 06037

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation, facility policy, and interviews for one of three residents (Resident #1) reviewed for accidents, the facility failed to ensure staff did not move a resident with visible head injuries after an unwitnessed fall with major injuries (closed head injuries and multiple fractures). The findings include: Resident #1's diagnoses included heart failure, anxiety and chronic pain. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had moderate cognitive impairment (Brief Interview for Mental Status (BIMS) score of 10). The Resident Care Plan (RCP) dated [DATE] identified a risk for falls. Interventions directed to transfer with an assist of one (1) and rolling walker, ensure call bell was within reach and encourage use of a call bell for assistance. A Physician order dated [DATE] directed siderails: two (2) half up for bed mobility, elevate head of bed to prevent hypoxia while lying flat, assist of one for transfers with rolling walker, and Aspirin 81 mg (milligrams) one tablet at bedtime for heart health. A psychotherapy note dated [DATE] identified Resident #1 was alert, oriented to person, place, time and situation, forgetful, goal directed with good to fair attention, judgment and insight. Review of the Reportable Event dated [DATE] at 4:30 AM indicated Resident #1 had an unwitnessed fall. Resident #1 was observed lying face down next to his/her bed with his/her head under the overbed table on the side of bed closest to bedroom door. Resident #1 was noted to have a large lump to the back of the head and to the left forehead, a cut to the outer corner of the left eye, an abrasion to the left neck and complained of discomfort to the left wrist. The APRN was notified, Resident #1 sent to the Emergency Department (ED) for evaluation, and an investigation was initiated. Review of the Situation Background Assessment Request (SBAR) and nurse progress note dated [DATE] identified Resident #1 had a fall with a change in condition. Resident #1 fell from bed and was found lying face down on the floor with a large lump to the left forehead, back of head, a cut on outer corner of the left eye, abrasion to the left neck and complained of pain to the left wrist. Resident #1's description of the event, I was going to the bathroom. The call light was within reach. Resident #1 was on an anticoagulant and was transferred to the hospital. (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Emergency Medical Services (EMS) run sheet dated [DATE] identified EMS was called at 4:28 AM. The run sheet identified Resident #1 had been assisted back to bed via mechanical left after an unwitnessed fall out of bed, facial injuries, and injuries to the neck and left wrist. Resident #1 was placed in a cervical collar and moved to a stretcher, edema and ecchymosis (bruising) was noted to the right femur, and Resident #1 had complaints of nausea en-route to the hospital. Hospital documents dated [DATE] identified Resident #1 was diagnosed with traumatic subdural hematoma, subarachnoid hemorrhage, left maxillary sinus fracture, left distal radius and ulnar fracture, scattered contusions, hematoma inferior to platysma (platysma muscle is a thin, sheet-like muscle located in the neck, primary functions of lowering the lower lip and mouth corner, and assisting in facial expressions like frowning, smiling, and grimacing) and a T8 (thoracic spine) fracture, was placed on spine precautions, neuro checks, monitoring of airway given the location of platysma hematoma and was admitted to the surgical intensive care unit. Further review indicated CT Scan of thoracic/lumbar spine T8 level spine new discontinuity of unknown chronicity, but new from [DATE], and [DATE] CT scan of thoracic spine re-demonstrated acute/recent appearing fracture involving the anterior (front) and posterior (back) of T8 vertebral body, extending to the T8-9 disk posteriorly, increased displacement of fracture fragments both in superior-inferior and anterior and posterior directions, and widening of T8-9 facet joint, also new from prior. Further indicated was Resident #1 expired [DATE]. Interview and record review with LPN #1 on [DATE] at 11:18 AM identified she last observed Resident #1 at 1:30 AM in his/her bedroom for as needed medication administration, the call bell was within reach and clamped to the blanket, she elevated Resident #1's head of bed, bed rails were up, and at the time of Resident #1's fall, she was on break. Interview on [DATE] at 11:32 AM with NA #2 identified she last saw Resident #1 at 4 AM lying in bed with bed rails up. NA #2 indicated when she arrived to the room after the fall incident, Resident #1 was on the floor and indicated he/she was trying to go to the bathroom. NA #2 indicated RN #1 (RN supervisor), directed her (NA #2) to assist RN #1 and two (2) other aides to assist Resident #1 back to bed via the mechanical lift. Interview and record review on [DATE] at 11:52 AM with RN #1 identified she last saw Resident #1 during rounds at 4 AM, laying on his/her back, asleep in bed, with the bed rails up. RN #1 further indicated she was called to the room around 4:30 AM when Resident #1's roommate called for help. Resident #1 was observed face down on the floor near his/her bed, his/her head was near the head of the bed under the bedside table and his/her neck was on the bar under the bedside table. She rolled Resident #1 over for assessment, called 911, and assisted Resident #1 back into bed with assistance from NAs. She identified that they rolled Resident #1 to the side, tucked the mechanical lift sling under Resident #1, and used the mechanical lift to transfer Resident #1 into bed. RN #1 indicated that, based on her assessment, Resident #1 had head injuries, left wrist pain, and could have injured his/her back/spine but she wanted to make Resident #1 comfortable, therefore, transferred Resident #1 back to bed. RN #1 indicated she should have made Resident #1 comfortable on the floor while awaiting EMS. Interview with APRN #1 on [DATE] at 12:32 PM identified Resident #1 should not have been moved while awaiting EMS arrival after the fall out of bed on [DATE]. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with NA #1 on [DATE] at 12:45 PM identified she was responsible for providing care for Resident #1 on [DATE], last provided incontinence care at 2:30 AM, and last observed Resident #1 lying in bed at 4 AM with the call bell within reach and bed rails up. She further indicated that around 4:30 AM she assisted RN #1 and other NAs to roll Resident #1 onto the mechanical lift sling and transfer Resident #1 to bed. Interview on [DATE] at 2:15 PM with the DNS identified she could not determine if the staff working on [DATE] should have transferred Resident #1, who sustained a visible head injury and potential spinal injury, back to bed, or if Resident #1 should have been made comfortable and remained on the floor while waiting for EMS arrival. Review of facility Falls: Minimizing Risk of Injury Policy directed, in part, its purpose is to minimize injuries when a fall occurs. Review of Taber's Medical Dictionary directed in part, when a resident falls with a head strike, to assess the severity of the head impact and evaluate for injuries. Observe for mental status changes, neurological abnormalities or bleeding.