

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075288	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/17/2024
NAME OF PROVIDER OR SUPPLIER Fairview		STREET ADDRESS, CITY, STATE, ZIP CODE 235 Lestertown Rd Groton, CT 06340	

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 0609</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48950</p> <p>Based on review of staff interviews, review of the clinical records, facility documentation, and facility policy for two sampled residents (Residents #50 and Resident #55) reviewed for a resident to resident altercation, the facility failed to notify Adult Protective Services (APS) of the altercation. The findings include:</p> <p>1. Resident #50's diagnoses included dementia, insomnia, and anxiety.</p> <p>The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #50 was moderately cognitively impaired, required supervision/touching assist for eating, oral hygiene, transferring, and personal hygiene, and partial moderate assist for toilet hygiene.</p> <p>The Resident Care Plan (RCP) dated 5/2/24 identified Resident#50 was at risk of wandering.</p> <p>and had insomnia. Interventions included to identify patterns of wandering, distract the resident from wandering and to communicate resident's potential for wandering to staff at the unit, try to improve sleep, preferred hours of sleep routine, decrease noise level after, and maximize daily activities.</p> <p>2. Resident #55's diagnoses included dementia, contracture (prevents normal movement), and weakness.</p> <p>The quarterly MDS assessment dated [DATE] identified Resident #55 was severely cognitively impaired, dependent on staff for oral hygiene, eating, toileting, personal hygiene, and dressing, requiring the assist of 2 for transfers with a mechanical lift.</p> <p>The Resident Care Plan dated 5/15/24 identified Resident #55 was at risk for falls related to dementia, and poor safety awareness. Interventions included to anticipate and meet the resident's needs, be sure that Resident #55's call light was within reach and encourage the resident to use it.</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 0609</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>A Reportable Event form dated 5/21/24 identified at 12:45 AM, Licensed Practical Nurse (LPN) #7 heard yelling down the hall get out of my bed. LPN #7 told Nurse Aide (NA) #1 that she would be right back as she headed down the hall from the nurse's station. LPN #7 was walking by Resident #50's room and it was empty. LPN #7 followed the yelling and observed Resident #50 trying to pull Resident #55 out of bed by squeezing and shaking Resident #55's head. Resident #55 was contracted, and his/her legs were hanging off the side of the bed. LPN #7 identified that the railing held Resident #55 in bed. Both residents were immediately separated and assessed. Resident #55 had 2 discolored areas noted, 1 to his/her left eye and the other to the left side of his/her face. LPN #7 returned Resident #50 to his/her room with assistance, was placed on one-to-one supervision, Psychiatric and Social Services were provided.</p> <p>Interview with LPN #7 on 7/10/24 at 2:02 PM identified on 5/21/24 that Resident #50 had been wandering and that they had placed her/him near the nurse's station. LPN #7 identified that she heard yelling, and that Resident #50's room was empty and found her/him in Resident #55's room. LPN#7 identified that Resident #50 was attempting to pull Resident #55 out of bed while yelling get out of my bed. LPN #7 reported the occurrence to the supervisor and a motion sensor was placed at Resident #50's doorway.</p> <p>Additional review of the Reportable Event form dated 5/21/24 at 12:45 AM failed to identify Adult Protective Services were notified of the resident to resident altercation.</p> <p>Interview with the Director of Nursing Services (DNS) on 7/11/24 at 10:33 AM identified she did not feel the situation warranted notifying Adult Protective Services and that she had never notified Adult Protective Services in the past when the situation involved a resident to resident altercation even though the facility policy identified that the agency should be notified within 3 days. The DNS identified she was unaware of the state guidelines regarding notifying Adult Protective Services.</p> <p>Facility's Resident Abuse policy identified reporting requirements include notifying Adult Protective Services within 3 days.</p>		