STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075288	A. Building B. Wing	05/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairview	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for one (1) of three (3) residents (Resident #2) reviewed for pressure injuries (ulcers), the facility failed to ensure a physician's order directing the settings for a pressure redistribution air mattress. The findings include: Resident #2's diagnoses included dementia with behavioral disturbances, weakness, pain, glaucoma (an eye condition that damages the optic nerve and can cause vision loss or blindness) and anxiety disorder. A physician's order dated 10/28/24 directed to check function of the air mattress every shift to maintain pressure reduction and evaluate for bottoming out with hand check every shift. A physician's order dated 12/31/24 directed to check low air loss mattress function every shift to maintain pressure reduction. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #2 had severely impaired cognition (Brief Mental Interview for Mental Status (BIMS) score of 2) and was dependent on staff for bed mobility and transfers. The MDS identified Resident #2 was at risk for pressure ulcers/injuries and that a pressure reducing device was in place to the bed. The Resident Care Plan (RCP) dated 4/10/25 identified Resident #2 had actual/potential impairment to skin integrity related to impaired mobility and agitation/combativeness. Interventions included an air mattress to Resident #1's bed and staff to check the function every shift to maintain pressure reduction and evaluate for bottoming out with hand check every shift. A Wound Care Specialist note dated 5/1/25 identified Resident #2 had 2 new unstageable wounds to the right medial foot and to the left medial foot. Observation and interview with the DNS on 5/5/25 at 10:34 AM identified Resident #2 sitting in the wheelchair to the left of his/her bed. A scoop air mattress was in place to the bed and the air mattress was set to normal pressure with the settings knob between 160 and 240, positioned slightly above 160. There were no markers to identify the exact air mattress setting. The DNS reported that although there were no markers to identify the exact setting of the air mattress, the air mattresses were to be set to the resident's weight, and staff estimate where the dial should be turned to. Review of the clinical record on 5/5/25 identified a weight of 122.2 pounds on 3/27/25. (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Re-interview with the DNS on 5/5/25 at 12:36 PM identified that the providers order should include air mattress settings according to the resident's weight to ensure the air mattress is set accurately each shift. She indicated that the air mattress was set to above 160 pounds and could not provide documentation to identify the settings were being checked by licensed staff. The DNS identified that the facility was currently having licensed staff push down on the air mattress every shift to ensure that the bottom of the bed could not be felt, which would indicate that the air mattress was inflated. Interview with the ADNS on 5/5/25 at 12:40 PM identified that inaccurate air mattress settings would put a resident at risk for skin breakdown. Review of the Fairview Use of Support Surfaces policy dated 4/1/24 directed, in part, that support surfaces will be used in accordance with evidence-based practice for residents with or at risk for pressure injuries. Except for the facility's standard mattresses and wheelchair cushions, support surfaces will be utilized in accordance with physician's orders. For powered devices, or those requiring air, the licensed nurse will check each shift and as needed for proper functioning and/or inflation. Guidelines for support surface selection may be utilized in obtaining physician's orders. The guidelines are to be used to assist in treatment decision making, but do not supersede physician clinical judgement or orders. Due to unique needs and situations of individuals, the guidelines may not be appropriate for use in all circumstances. The effectiveness of support surfaces will be monitored through ongoing assessment of the resident and/or wound.

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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	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** Based on review of the clinical record, facility documentation, facility policy and interviews for one (1) of five (5) residents (Resident #1) reviewed for falls, the facility failed to ensure a safe transfer for Resident #1 resulting in a fall with a closed head injury.The findings include: 1. Resident #1's diagnoses included paraplegia (paralysis/inability to voluntarily move the lower half of the body and the ability to walk), chronic pain, weakness and anxiety disorder. The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had intact cognition (Brief Mental Interview for Mental Status (BIMS) score of 13) and required partial assistance for bed mobility and was dependent on staff for transfers. The Resident Care Plan (RCP) dated 2/20/25 identified Resident #1 was at risk for falls related to paraplegia. Interventions included providing assistance with transfers and mobility as ordered. Review of the clinical record identified that on 3/7/25, Resident #1 weighed 76.6 pounds. Review of the facility Reportable Event (RE) dated 4/12/25 identified that at 11:00 AM Resident #1 was being transferred with the mechanical lift (A machine used to safely lift and move a person who can't stand or move on their own) by two (2) staff when he/she began to slide out of the sling (A fabric seat or support used with a mechanical lift to safely hold and move a person who cannot stand or walk on their own. It wraps around the person and attaches to the lift to help transfer them, such as from a bed to a chair) attached to the mechanical lift and the staff attempted to lower Resident #1 to the floor. The RE identified Resident #1 complained of moderate pain to the right backside of his/her head and was assessed by Registered Nurse (RN) #2 and the Medical Director (MD #1), was noted to have a small bump to the head and was observed to be at baseline. The RE identified that fifteen (15) to thirty (30) minutes later, Resident #1 was observed to have a change in Level of Consciousness (LOC), was evaluated by MD #1 and was transferred to the Emergency Department (ED) for evaluation. The RE identified that initial CT scans (imaging that uses x-rays to create detailed cross-sectional images) were negative for acute injury but that a follow-up CT scan of the head that same evening revealed a small subdural hematoma. A nurse's note dated 4/12/25 at 12:26 PM identified Resident #1 was observed laying on the floor next to his/her bed with the mechanical lift in front of him/her, with two (2) Nurse Aides (NAs) present and that initial neurological vital signs were stable. The note identified that Resident #1 was complaining of moderate pain to the right back side of the head, a small bump was noted, and a skin tear was noted to the left fourth finger. A nurse's note dated 4/12/25 at 12:57 PM identified that thirty (30) minutes after Resident #1 was observed on the floor, he/she was noted to be unresponsive, both eyes were slightly dilated (larger than normal) and he/she was not speaking or responding per baseline. The note identified MD #1 and the family were notified, Comfort Measures Only (CMO) status was discontinued and Resident #1 was sent to the ED. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A physician's progress noted dated 4/12/25 identified he was called to Resident #1's bedside after staff reported Resident #1 was dropped from the mechanical lift and hit his/her head on the left lower support of the mechanical lift. The note identified that upon entering the room, Resident #1 was observed on the floor, his/her head nearly under the bed, laying perpendicular to the middle of the bed, he/she was awake and alert, and a small contusion was noted to the right posterior (backside) skull with no bleeding. The note identified that the assessment was negative, Resident #1 appeared to be at his/her baseline and ice was ordered to be applied to the area. About 15 to 20 minutes later, Resident #1 was unresponsive to voice and deep sternal rub. The hospital CT of the head dated 4/12/25 at 12:56 PM, performed due to head trauma, identified no acute intracranial abnormality. The hospital CT of the head dated 4/12/25 at 10:18 PM, performed due to mental status change, identified there was a new acute left frontal subdural hematoma. The facility Summary Report dated 4/16/25 identified that following the 4/12/25 incident, both NA #1 and NA #2 were sent home pending an investigation. The report identified both NAs stated Resident #1 had been positioned properly on the small standard mechanical lift sling (standard sling) and while transferring Resident #1, he/she became fidgety, and his/her right side began to slip out of the right side of the standard sling. The report identified both NAs denied witnessing Resident #1 hitting his/her head but further identified NA #1 reported she quickly removed the standard sling leg strap from the mechanical lift bar and the mechanical lift bar may have struck the back of Resident #1's head. The report identified NA #1 could not locate the small full body mechanical lift sling (full body sling), as directed for use on the resident care card (RCC), so Resident #1 was instead transferred with a standard sling. Following the incident and Resident #1's transfer to the ED, Resident #1's hospital diagnoses included a right frontal subdural hematoma. The facility summary identified past non-compliance. Following the incident, an audit was conducted to ensure all residents who required mechanical lift transfer equipment had the proper transfer equipment indicated on the RCC and that the slings were available for use. The summary identified that NA and licensed staff education was initiated on 4/12/25 to include ensuring proper mechanical lift transfers and identified that hooks would be added to the back of resident room doors to provide a standard location for the mechanical lift slings. Random weekly audits were to be completed to ensure that the proper slings were being utilized for residents requiring mechanical lift transfers for sixty (60) days . Review of the RCC on 5/5/25 identified that Resident #1 required a mechanical lift with a small full body mechanical lift sling for transfers . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Interview with NA #1 on 5/5/25 at 1:03 PM identified that although she was aware that the RCC directed Resident #1 be transferred using the full body sling, she could not locate the full body sling and did not ask for assistance, she instead located a standard sling and thought it would be adequate. She identified that she placed the standard sling under Resident #1 in bed, attached the loops to the clips on the mechanical lift and then requested assistance from NA #2. NA #1 reported that she thought Resident #1 was positioned correctly in the standard sling, and NA #2 controlled the mechanical lift. As NA #2 lifted Resident #1 up, she (NA #1) guided Resident #1 and as they prepared to position him/her over the chair, Resident #1 started to slide out of the right side of the standard sling. NA #2 lowered Resident #1 but was unable to lower him/her in the chair. Instead, NA #2 lowered Resident #1 to the floor as she (NA #1) unclipped the right bottom hook from the loop to release Resident #1 and then tried to hold and lower Resident #1 to the floor. NA #1 identified she did not use the correct sling for the transfer which was the reason Resident #1 fell from the mechanical lift. Interview with NA #2 on 5/5/25 at 1:08 PM identified that on 4/12/25, NA #1 requested her assistance with transferring Resident #1 from the bed to the chair and identified that she (NA #2) was not familiar with Resident #1. She identified there was a red sticker outside of the room door indicating a size small sling was to be used for transfers and when she entered the room, the sling under Resident #1 was already hooked to the mechanical lift and had a red ribbon, so she assumed the correct sling was in place. She identified she was operating the mechanical lift with the controller and as she lifted Resident #1 off the bed, she turned the mechanical lift to face the chair (between the two beds) and while Resident #1 was suspended over the floor, Resident #1 was observed to be crooked in the sling and his/her right side began to slide out of the sling. She identified there was no safe way to lower Resident #1 into the chair so they lowered Resident #1 to the floor. She identified that she lowered Resident #1 quickly as NA #1 guided him/her down by the sling to the floor and that NA #1 detached one of the loops from the right side of the mechanical lift. She identified she should have ensured the correct sling was in pace prior to transferring Resident #1. Interview with the DNS on 5/5/25 at 1:47 PM identified that both NA #1 and NA #2 should have ensured that the correct mechanical lift sling was utilized prior to transferring Resident #1 and reported that the facility had since provided education to staff on mechanical lift transfers, installed hooks on the back of residents room doors to store the slings and that the color of the sling to be used for each resident and whether it is a standard or full body sling is notated on the RCC. Review of the Mechanical Lift Transfer Policy, revised 4/2025 identified that it is the responsibility of the NAs using the mechanical lift to ensure the proper sling size for the resident is being used and that the loops of the sling straps are securely in place before attempting the transfer and during the transfer. The proper sling size will be indicated on the resident's care card and a red sling is used for residents weighing between 75 and 124 pounds. The mechanical lift should be operated by a minimum of two staff members when safely transferring the resident.