STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075310	A. Building B. Wing	11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Colonial Health & Rehab Center of Plainfield, LLC	16 Windsor Ave Plainfield, CT 06374

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 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** 47460 Based on clinical record review, facility documentation review, facility policy review, and interviews for one of three residents (Resident #2) reviewed for abuse, the facility failed to ensure resident was free from mistreatment. The findings include: Resident #2's diagnoses included dementia with behavior disturbances, anxiety and depression. The quarterly Minimum Data Set (MDS) dated [DATE] identified that Resident #2 had a Brief Interview for Mental Status (BIMS) score of five out of fifteen, indicative of severe cognitive impairment and was dependent for ADLs. The Resident Care Plan (RCP) dated 10/10/2024 identified Resident #1 had a self-care performance deficit. Interventions directed two (2) staff for ADLs. Review of facility reportable event dated 11/16/2024 at 4:49 PM identified Resident #2 was alert and confused. Two NAs were providing care when NA #2 was scratched by Resident #2. The other NA reported NA #2 then grabbed Resident #2's arm and hit him/her on the chest with an open hand. When interviewed, Resident #2 stated the NA hit him/her. Review of the facility summary dated 11/19/2024 identified Resident #2 became combative while care was being provided by NA #2 and #5 on 11/16/2024 and began scratching and slapped NA #2 on the arm. NA #5 reported that NA #2 grabbed the resident's arm and hit the resident on his chest with an open palm. NA #2 was alleged to have told Resident #2 no, you don't hit. The summary indicated NA #2 denied the allegation described by NA #5. A resident skin assessment was completed, and the resident was observed with self-inflicted scratches to the chest and no additional evidence of injury to the area. Additionally, a pain assessment was conducted without findings and no negative effects were noted. The summary further indicated the facility substantiated the event and NA #2's employment was terminated. Review of NA #2's written statement dated 11/16/2024 identified when NA #2 provided care, Resident #2 scratched NA #2. NA #2 told the resident to stop doing that and it's not nice to do that to the NAs. held his/her hand while asking the other NA to help to be able to provide care. Review of NA #5's written statement dated 11/16/2024 identified while she and NA #2 were providing care, Resident #2 scratched and slapped NA #2's arm. After NA #2 was scratched, she quickly glanced at her arm and then proceeded to slap the resident on the chest very hard. NA #2 told Resident #2, no, you don't hit and NA #5 reported the incident to the supervisor. (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

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	Review of local police Summary Report dated 11/16/2024 at 7:56 PM identified that when police spoke to resident, he/she remembered NA #2 hitting him/her. Interview and review of facility documentation on 11/26/2024 at 8:46 AM with NA #2 identified that Resident #2 was on her assignment on her 11/16/2024 shift. Resident #2 required two (2) staff for care and NA #5 was assisting her to provide care when the Resident #1 scratched her and she said, not nice to do that to the NA giving you care and NA #2 put the resident's hand down. NA #2 stated she removed Resident #2's shirt and Resident #2 scratched his/her chest, and then scratched her again. She told Resident #2, no don't do that and told him/her to put his/her hand down and don't scratch. NA #2 stated they completed care (trimmed nails, shaved and transferred Resident #2 into bed. NA #2 denied that she hit Resident #1 at any time during care. She further indicated that when the resident was resistive to care, he/she will calm down and relax when staff talk to him/her and explain what they are doing. Interview, clinical record review and review of facility documentation on 11/26/2024 at 10:50 AM with DNS identified that on 11/16/2024 NA #5 reported that while she and NA #2 were providing care to Resident #2, the resident became combative and scratched NA #2. NA #5 alleged that NA #2 told the resident, no don't hit and NA #2 hit the resident with an open hand on the chest. The DNS stated when attempt to redirect Resident #2 when he/she becomes combative because that works to calm him/her down; Resident #2 responds well to redirection and has a history of pinching and scratching staff. When Resident #2 was interviewed by staff and interviewed by the local police, Resident #2 indicated NA #2 had hit him/her. The facility substantiated abuse and NA #2's employment was terminated (NA #2 had already given her notice two (2) weeks prior 11/16/2024 was her last scheduled workday). Although several attempts were made, NA #5 was unable to be interviewed during the survey. Review of Conduct and Behavior policy directed in part, to adhere to professional practices in matter of conduct and behavior and exhibit high degrees of personal integrity at all times. Employees are required and expected to maintain professional conduct and attitudes as well as treating residents, their families and visitors and fell ow coworkers courteously. Review of Abuse Prohibition policy directed in part, to prohibit abuse for all residents. Abuse was defined as the willful infliction of physical, verbal, mental, sexual injury or harm, that may or may not include mental anguish or discomfort associated with such actions. Facility documentation review identified staff education was initiated on 11/14/2024 regarding resident abuse and the facility policy regarding abuse. A QAPI meeting was held on 11/18/2024, and audits were initiated on 11/22/2024. Based on review of facility documentation, past non-compliance was identified.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47460 Based on clinical record review, facility documentation review, facility policy review, and interviews for one of three residents (Resident #1) reviewed for abuse, the facility failed to ensure staff reported an allegation of abuse timely. The findings include: Resident #1's diagnoses included dementia, anxiety and depression. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of three out of fifteen, indicative of severe cognitive impairment, required assistance with toilet use, ADLs, and was frequently incontinent of bowel and bladder. The Resident Care Plan (RCP) dated 9/27/2024 identified Resident #1 had impaired cognitive function/impaired though processes related to diagnosis of dementia and functional bladder incontinence. Interventions directed to provide incontinent care. The facility reportable event dated 11/11/2024 at 8:15 PM identified Resident #1 alleged a male NA (NA #1) touched him/her inappropriately during the night and gave a description of the NA. Resident #1 was unable to give a time of the incident, and stated the male NA did not work on 11/11 or the night prior. Assessment identified no injuries were noted, and the accused NA was suspended pending investigation. Review of RN #10 statement dated 11/11/2024 identified RN #10 was approached by NA #4 with NA #3 in tow about 8:20 PM. NA #4 reported NA #3 told her that last week Resident #1 alleged a male staff member touched him/her inappropriately. NA #4 stated she was reporting it immediately after the conversation with NA #3 because she told NA #3 she should have reported it when she was initially informed of the alleged abuse. NA #3 confirmed that she was told about the alleged abuse last week but she thought the resident was not in her right mind. Interview and record review with NA #3 on 11/25/2024 at 11:34 AM identified that Resident #1 reported the allegation of abuse to her (NA #3) on 11/8/2024, however she did not report the allegation to the facility when it was reported to her. Interview with NA #4 on 11/25/2024 at 11:45 AM identified when NA #3 told her about the allegation made by Resident #1, and she encouraged NA #3 to report the allegation. Interview with the DNS on 11/25/2024 at 1:47 PM identified Resident #1 made an allegation of abuse to NA #3 on 11/8/2024 and NA #3 did not report the allegation until 11/11/2024. The DNS stated NA #3 should have reported the allegation when Resident #1 made the allegation to her on 11/8/2024 and an investigation was initiated upon notification on 11/11/2024. Facility documentation review identified NA #3 completed the facility NA training and abuse training during 9/2024, and had not taken the NA state exams. Further review identified a employee warning was given and signed by NA #3 on 11/14/2024 for NA #3 due to she failed to report a potential allegation of abuse in a timely manner. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Colonial Health & Rehab Center of Plainfield, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE: 16 Windsor Ave Plainfield, CT 06374	

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility Personnel Policies - Resident Abuse directed in part, employees must immediately report any incident or suspected incident of resident neglect, abuse. Review of facility Abuse Prohibition Policy directed in part, anyone who receives a report of an allegation of abuse is to report the incident to his/her supervisor immediately. Review of facility Reportable Event policy in part directs regardless of how minor an actual or suspected accident, incident, abuse or neglect situation may be, it must be reported to the department supervisor immediately/at the time of occurrence. Facility documentation review identified staff education was initiated on 11/14/2024 regarding resident abuse and the facility policy regarding abuse, to include reporting of allegations timely. A QAPI meeting was held on 11/18/2024, and audits were initiated on 11/22/2024. Based on review of facility documentation, past non-compliance was identified.