

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075318	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/18/2024
NAME OF PROVIDER OR SUPPLIER  Pomperaug Woods Health Center		STREET ADDRESS, CITY, STATE, ZIP CODE  80 Heritage Rd Southbury, CT 06488	

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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50094</p> <p>Based on clinical record review, facility documentation, and interviews for one of three residents (Resident #2) reviewed for abuse, the facility failed to ensure the resident was transferred in accordance with physician orders. The findings include:</p> <p>Resident #2's diagnoses included difficulty in walking, and muscle weakness with a history of falls.</p> <p>The admission Minimum Data Set (MDS) dated [DATE] identified Resident #1 had moderately impaired cognition and required partial/moderate assistance with transferring from sitting to standing and from transferring from chair to bed.</p> <p>The Resident Care Plan (RCP) dated 7/25/2024 identified that Resident #2 was at risk for falls and required assistance with ADLs. Interventions directed to provide an assist of two (2) with transfers, and to ensure the residents call light and personal items are within reach.</p> <p>A physician's order dated 8/26/2024 directed to provide an assistance of two (2) when toileting and transferring with the Maximove lift.</p> <p>Facility reportable event form dated 9/5/2024 at 11:15 AM identified Resident #2 alleged NA #1 was rough when providing care and threw him/her into the chair and yelled lousy words and was unable to recall what was allegedly said. NA #1 was suspended, and an investigation initiated. Resident #2 had no injuries.</p> <p>Facility incident summary dated 9/5/2024 identified the roommate did not witness the alleged incident. The summary further identified Resident #2 had a history of directing staff to perform unsafe transfers and investigation identified NA #1 performed the transfer without a second staff member present.</p> <p>Although attempted, an interview with NA #1 but was not obtained during survey.</p> <p>Interview with the Director of Nursing (DON) on 9/18/2024 at 2:12 PM identified Resident #2 required two (2) staff for transfers, and NA #1 performed the transfer alone, without a second staff assistance. The DON stated NA #1's employment was terminated due to not transferring the resident in accordance with physician orders.</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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50094</p> <p>Based on clinical record reviews, facility documentation, and staff interviews for one of three residents (Resident #1) reviewed for accidents, the facility failed to ensure the resident was transferred with the assistance of two staff in accordance with the Resident Care Plan and as a result, the resident was not positioned safely in the chair and when staff directed the resident to reposition him/herself, the resident slid out of the wheelchair and sustained a femur fracture. The finding includes:</p> <p>Resident #1's diagnoses included osteoarthritis, dementia and muscle weakness.</p> <p>The quarterly Minimum Data Set (MDS) dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of twelve (12) indicating moderate impaired cognition and required substantial/maximal assistance with toileting and transfers.</p> <p>The Resident Care Plan dated 8/7/24 identified Resident #1 had limited mobility. Interventions directed to provide assistance of two (2) staff for toilet transfers.</p> <p>Review of the facility incident report dated 8/26/24 at 10:50 PM identified two (2) NAs were preparing to transfer Resident #1 from the wheelchair into bed and identified Resident #1 was not seated back far enough in the chair to initiate a safe transfer. Resident #1 was instructed by the NA to move him/herself back in the wheelchair, and when the resident leaned forward, and Resident #1 fell. Resident #1 complained of pain with a deformity noted of the left thigh, 9-1-1 was called, Resident #1 was transferred to the hospital and diagnosed with a left femur fracture.</p> <p>Review of the hospital's discharge summary dated 8/30/24 identified Resident #1 had a midshaft displaced femur fracture of the left leg and required an Open Reduction and Internal Fixation (ORIF).</p> <p>Record review identified Resident #1 was readmitted to the facility on [DATE].</p> <p>Facility documentation review identified NA #2 and NA #3 completed competency assessments using a mechanical lift prior to this incident in 2024.</p> <p>Interview with NA #3 on 9/18/24 at 12:30 PM identified she and NA #2 were preparing to transfer Resident #1 into bed. NA #3 stated when she entered the room with the Hoyer lift, Resident #1's buttocks was on the edge of the wheelchair with his/her shoulders against the back part of the wheelchair. NA #2 and NA #3 directed Resident #1 to scooch back in the wheelchair. NA #2 was standing behind the wheelchair and NA #3 was on the side of the wheelchair, and when Resident #1 attempted to move, he/she slid out of his/her wheelchair and onto the floor. NA #3 stated she and NA #2 did not lock the wheelchair before Resident #1 attempted to reposition him/herself in the wheelchair. NA #3 further indicated that she had transferred Resident #1 with a Hoyer prior to the incident.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Interview and record review with Physical Therapist #1 on 9/18/24 at 12:58 PM identified Resident #1 had an order for assistance of two via the Hoyer lift to get the resident in and out of the bed and chair and the assistance of two staff when transferring Resident #1 on and off the toilet. The Hoyer lift and toilet transfer order was in place since 4/15/24.</p> <p>Interview with NA #2 on 9/18/24 at 1:42 PM identified she transferred Resident #1 off the toilet and into the wheelchair by herself. When NA #3 came into the room they identified Resident #1 was not properly positioned in the wheelchair and needed the resident to move back further before using the Hoyer lift. Resident #1's buttocks was observed on the edge of the wheelchair when NA #2 and #3 directed Resident #1 to scooch back. NA #2 was standing behind the wheelchair and NA #3 was on the side of the wheelchair with the wheelchair unlocked, and when Resident #1 attempted to reposition in the wheelchair, he/she slid out of his/her wheelchair and onto the floor. NA #2 stated she doesn't usually care for the resident and believed Resident #1 only required one person assistance for toileting.</p> <p>Interview with the Director of Nursing (DON) on 9/18/24 at 1:10 PM identified Resident #1 required two (2) staff for transfers, and on 8/26/24 NA #2 transferred Resident #1 from the toilet into the wheelchair alone, and Resident #1 was not properly positioned in the chair. NA #2 and NA #3 then directed Resident #1 to reposition in the chair, and Resident #1 slid out of the wheelchair onto the floor. The DON stated NA #2 should have had a second staff member present for the transfer off the toilet and was unable to identify why NA #2 performed the transfer without the benefit of a second staff member assisting.</p> <p>Although requested the facility stated they do not have a policy on transferring residents.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50094</p> <p>Based on clinical record review, facility documentation, and staff interviews for one of three residents (Resident #1) reviewed for accidents, the facility failed to ensure the clinical record was complete and accurate to include transfer status orders. The findings include:</p> <p>Resident #1's diagnoses included osteoarthritis, dementia and muscle weakness.</p> <p>The quarterly Minimum Data Set (MDS) dated [DATE] identified Resident #1 had moderately impaired cognition, required substantial/maximal assistance with toileting, and required substantial/maximal assistance with transfers.</p> <p>The Resident Care Plan (RCP) dated 8/7/2024 identified Resident #1 had limited mobility. Interventions directed to provide an assistance of 2 staff for toilet transfers and for Hoyer lift at night for all transfers.</p> <p>Although requested the facility did not provide physician orders for Resident #1.</p> <p>Review of the facility incident report dated 8/26/2024 at 10:50 PM identified 2 NAs were preparing to transfer Resident #1 from the wheelchair into bed and identified Resident #1 was not seated far back enough in the chair to initiate a safe transfer. Resident #1 was instructed by the NA to move back in the wheelchair and the resident abruptly leaned forward in the wheelchair. The NA attempted to intercept the resident to prevent the fall, but the NA was unable to prevent Resident #1 from falling out of the wheelchair. Resident #1 complained of pain with a deformity noted of the left thigh. 9-1-1 was called, Resident #1 was transferred to the hospital and diagnosed with a left femur fracture.</p> <p>Interview with NA #3 on 9/18/2024 at 12:30 PM identified she and NA #2 were preparing to transfer Resident #1 into bed. NA #3 stated when she entered the room with the Hoyer lift, Resident #1's buttocks was on the edge of the wheelchair with his/her shoulders against the back part of the wheelchair. NA #2 and NA #3 directed Resident #1 to scooch back in the wheelchair. NA #2 was standing behind the wheelchair and NA #3 was on the side of the wheelchair, and when Resident #1 attempted to move, he/she slid out of his/her wheelchair and onto the floor. NA #3 stated she and NA #2 did not lock wheelchair before attempting to reposition Resident #1 in his/her wheelchair.</p> <p>Interview with NA #2 on 9/18/2024 at 1:42 PM identified Resident #1 was on the toilet when she entered the room. NA #2 stated she transferred Resident #1 by herself off the toilet and into his/her wheelchair, placing Resident #1 on top of the Hoyer pad. NA #3 came into the room and NA #3 said Resident #1 needed to move further back in the wheelchair before using the lift, and they directed Resident #1 to scooch back in the wheelchair. NA #2 was standing behind the wheelchair and NA #3 was on the side of the wheelchair, and when Resident #1 attempted to move, he/she slid out of his/her wheelchair and onto the floor. Interview identified NA #2 did not properly position Resident #1 in the wheelchair when she transferred Resident #1 off the toilet by herself. NA #2 was unable to explain why she did the transfer without a second staff present.</p> <p>(continued on next page)</p>		

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F 0842  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Interview with the Director of Nursing (DON) on 9/18/2024 at 1:10 PM identified the facility was unable to provide physician orders for Resident #1's transfer status prior to the fall. Although records were requested, they were not provided prior exiting the facility, and were not received as of 10/2/2024.		