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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075320 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/18/2024 |
| NAME OF PROVIDER OR SUPPLIER Ark Healthcare & Rehabilitation at St. Camillus | | STREET ADDRESS, CITY, STATE, ZIP CODE 494 Elm St Stamford, CT 06902 | |

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) |
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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>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40172</p> <p>Based on a review of clinical records, facility documentation, and interviews for one (1) of three (3) residents (Resident #1) reviewed for accidents, the facility failed to ensure that staff provided the resident with the required assistance with bed mobility and as a result, Resident #1 fell out of bed and sustained a left femur (thigh bone) fracture. The finding includes:</p> <p>Resident #1 had diagnoses of Parkinson's, dementia, abnormalities of gait and mobility and generalized muscle weakness.</p> <p>The quarterly Minimum Data Set assessment dated [DATE] identified Resident #1's Brief Mental Interview (BIMS) score of six (6) indicative of severely impaired cognition, was always incontinent of bowel and bladder, and was dependent with bed mobility and Activities of Daily Living (ADLs).</p> <p>A physician's order dated 8/29/24 directed to provide extensive assistance of 2 with bed mobility and 1/4 bed rails as an enabler, to assist with turning and repositioning.</p> <p>The care plan dated 9/10/24 identified Resident #1 at risk for ADL self-care performance deficit with interventions that directed to provide total care for ADLs and required an extensive assistance of 2 with bed mobility with a 1/4 bed rail.</p> <p>Review of the facility's accident and incident report dated 9/23/24 identified at 7:30 P.M. Registered Nurse (RN) #2 was called to Resident #1's room by Nurse Aide (NA) #1 and upon arrival to Resident #1's room she observed Resident #1 laying on his/her left side on the floor in a fetal position (a position when the body is curled up into a ball). RN #2 assessed Resident #1 and no injuries were identified.</p> <p>A nurse's note dated 9/23/24 at 8:00 P.M. written by RN #2 identified she was notified that Resident #1 had a fall, and upon arrival to the room she found Resident #1 on the floor. A NA was providing incontinent care and when she turned Resident #1, the resident rolled out of bed.</p> <p>The nurse's note dated 9/24/24 at 6:30 A.M. written by RN #1 identified NA #2 was providing care to Resident #1 and observed swelling and a deformity to Resident #1's left leg. RN #1 noted that APRN #1 directed to send Resident #1 to the hospital for further evaluation and treatment.</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.

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| 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>Review of APRN (Advanced Practice Registered Nurse) #1's note dated 9/24/24 at 3:01 P.M. identified Resident #1 had a fall on 9/23/24 on the 3:00 P.M. - 11:00 P.M. shift and had subsequent left thigh swelling and a deformity noted. APRN #1 identified when Resident #1's left thigh area was palpated Resident #1 exhibited grimacing.</p> <p>Review of Resident #1's Hospital Discharge Summary dated 9/30/24 identified Resident #1 was admitted to the hospital on 9/24/24. Resident #1 sustained a fracture of unspecified neck of left femur and a displaced (bones no longer aligned) spiral fracture (a fracture that wraps around the bone with a corkscrew appearance) fracture of shaft of left femur requiring intramedullary nailing (surgical nails to provide the bone with stability).</p> <p>An interview with NA #1 on 10/18/24 at 3:30 P.M. identified on 9/23/24 she found Resident #1 in bed incontinent of bowel and prepared to provide incontinent care. NA #1 identified that both 1/4 side rails were up, and although Resident #1 required the assistance of two (2) for bed mobility, NA #1 did not ask anyone to help her because the other NA's on duty were very busy and she thought she could do it by herself. NA #1 identified when she turned Resident #1 on to his/her right-side, Resident #1's foot slid off the mattress and fell out of bed onto the floor.</p> <p>An interview with the Director of Nursing Services (DNS) on 10/18/24 at 10:45 A.M. identified on 9/23/24 at approximately 7:30 P.M. while NA #1 was providing incontinent care to Resident #1, the resident rolled out of bed and fell to the floor. The DNS identified that Resident #1's physician's orders directed to provide extensive assistance of two (2) with bed mobility with the use of the bed rail. The DNS identified NA #1 did not follow Resident #1's physician's orders and NA #1 should not have provided care to Resident #1 alone. The DNS indicated Resident #1's physician orders were in place to prevent Resident #1 from falling out of bed.</p> <p>Review of the facility's Fall Prevention and Management policy; in part, identified residents will be assessed for risk of falling and an individualized care plan will be developed and updated as needed to identify interventions to prevent falls.</p> |