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Form Approved OMB
No. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075347 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing | (X3) DATE SURVEY COMPLETED 10/10/2024 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Suffield House Rehabilitation and Healthcare Cente | 1 Canal Road<br>Suffield, CT 06078 |

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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32738<br><br>Based on review of the clinical record, facility documentation, facility policy, and interviews for one (1) of two (2) residents (Resident #1) reviewed for abuse, the facility failed to ensure a resident was free from staff abuse. The findings include:<br><br>Resident #1 had diagnoses that included fracture of the left leg, dementia and major depressive disorder.<br><br>The nursing admission assessment dated [DATE] identified Resident #1 was only oriented to person (not place or time), had limited range of motion due to left hip surgical repair and required a mechanical lift and wheelchair.<br><br>The accident and incident form (A & I) dated 8/10/23 at 8:00 AM identified Resident #1 became combative and agitated with staff on 8/9/23 - 8/10/23 during the 11:00 PM - 7:00 AM shift and was attempting to strike at staff. NA #1 and LPN #2 were in the resident's room when the charge nurse, LPN #1, heard yelling and went to the room to help. She identified she heard NA #1 repeatedly telling the resident you have the wrong aid and was observed tapping Resident #1 on the forehead with her finger. The nursing supervisor was alerted and asked NA #1 to leave the building immediately.<br><br>The Social Worker note dated 8/10/23 at 12:06 PM identified she was informed by the DNS about an incident that occurred on 8/9/23 with staff. Resident #1 was visited by the Social Worker and Resident #1 was alert to self with forgetfulness due to dementia. Resident #1 appeared calm, relaxed, pleasantly confused, not in any distress and stated he/she had a good night with no issues.<br><br>Interview with LPN #1 on 10/10/24 at 1:02 PM identified on 9/9/23 around 11:45 PM she heard Resident #1 yelling and went to see what was wrong. She identified NA #1 and LPN #2 were in Resident #1's room giving care, she observed NA #1 jab her fingers at Resident #1's forehead while stating you have the wrong aid. LPN #1 identified she positioned herself between Resident #1 and NA #1 in an attempt to separate NA #1 from Resident #1. Simultaneously, NA #1 attempted to take the Resident #1's blood pressure and grabbed Resident #1 by the upper arm and shook his/her arm. She identified NA #1 aggressively stated you're going to remember my face. Resident #1 then became more combative, and LPN #1 and LPN #2 told NA #1 multiple times to leave Resident #1's room. Once NA #1 left Resident #1's room, she left the room and immediately told the nursing supervisor. NA #1 was then told to leave the facility by the nursing supervisor.<br><br>(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 |
|---|---|---|

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| NAME OF PROVIDER OR SUPPLIER Suffield House Rehabilitation and Healthcare Cente | | STREET ADDRESS, CITY, STATE, ZIP CODE 1 Canal Road Suffield, CT 06078 | |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview with LPN #2 on 10/10/24 at 12:48 PM identified on 9/9/24 around 11:45 PM she heard Resident #1 screaming. She went to the room and witnessed Resident #1 was trying to hit NA #1, NA #1 squeezed Resident #1's left arm with malicious intent and stated you have the wrong aid. She identified Resident #1 became more agitated and LPN #1 stepped in between Resident #1 and NA #1. She identified LPN #1 and herself told NA #1 to leave Resident #1's room.<br><br>Although multiple attempts were made, an interview with NA #1 was not obtained.<br><br>Interview with DNS on 10/10/24 at 12:31 PM identified there is no policy on combative behaviors but staff are educated to step back from the resident, ensure the resident is safe, exit and then reapproach. She identified NA #1 actions were inappropriate and NA #1 should have made sure Resident #1 was safe, left Resident #1 alone, reapproached at a later time or asked another staff member to complete care.<br><br>Review of the resident rights policy identified residents have the right to be free from abuse and neglect.<br><br>Review of the abuse, neglect and exploitation policy identified abuse as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish, which can include staff to resident abuse. |