STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075347	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Suffield House Rehabilitation and Healthcare Cente	1 Canal Road 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 (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48792 Based on clinical record review, observations, review of facility policy and interviews for 1 of 3 residents (Resident #26) reviewed for choices, the facility failed to honor the resident's request to be out of bed before breakfast. The findings include: Resident #26's diagnoses included Juvenile Rheumatoid Arthritis, Systemic Disorders of Connective Tissue, and adjustment disorder with anxiety. The Resident Care Plan dated 5/29/24 identified Resident #26 with a self-care deficit. Staff were directed to ensure the resident was out of bed before breakfast daily. Review of a Nurse's Aide Information Sheet dated 7/24/24 directed that Resident #26 be out of bed before breakfast daily. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #26 was cognitively intact and required supervision for personal hygiene, maximum assistance with showering, and upper body dressing. A physician's order dated 12/26/24 directed that Resident# 26 be out of bed before breakfast every morning per resident's request. 0n 1/3/25 1:38 PM during screening of Resident identified she /he would like to be out of bed by breakfast or 10:30 AM at the latest to attend exercise classes. Resident # 26 also indicated she/he would be out bed by 10:30 AM especially if the aides are not able ambulating her/him enough. Resident # 26 also indicated this does not happen consistently. Observation of Resident # 26 on 1/3/25 at 11:00 AM identified the resident still in bed. Further observation on 1/6/25 and 1/7/25 identified the resident was not out of bed before breakfast. In an interview with Registered Nurse (RN#1) on 1/8/25 nursing supervisor at 10:00 AM identified Resident # 26 is not consistently out of bed before breakfast due to her/his complex care needs and being short staffed. (continued on next page)

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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the Director of Recreation on 1/8/25 at 10:20 AM identified Resident # 26 loves to attend all activities. If she/he is up and ready Resident # 26 will attend the exercise program. The Director of Recreation also indicated Resident # 26 is not consistently at the exercise program. The Director of Recreation indicated she believes Resident # 26 does not attend the exercise program regularly because she/he is not out of bed in time. In an interview with Nurse Aide (NA#1) on 1/8/25 at 11:00 AM identified she doesn't usually get Resident # 26 out of bed until 10:00 AM or 11:00 AM due to staffing. Nurse Aide #1 also indicated that Resident # 26 wanted to be out of bed before breakfast. In an Interview with NA#2 on 1/8/25 at 11:45 AM identified she was not aware of any specific time Resident # 26 wanted to be out of bed. Review of the current Resident Rights policy, undated, directs in part, the resident has the right to participate in the development and implementation of his or her person-centered plan of care.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48792 Based on clinical record review, observations, review of facility policy and interviews for 1 of 3 residents (Resident # 26) reviewed for choices, the facility failed to ensure the resident was ambulated according to restorative care plan. The findings include: Resident #26's diagnoses included Juvenile Rheumatoid Arthritis, Systemic Disorders of Connective Tissue, and adjustment disorder with anxiety. The Resident Care Plan dated 5/29/24 identified Resident #26 with a self-care deficit. Interventions included an ambulation program which required Resident # 26 to ambulate with a platform walker in the hallway 1-2 times per day with supervision. A review of the Nurse's Aide Information Sheet dated 7/24/24 indicated Resident #26 was on a Restorative Ambulation Program which included supervised ambulation with a rolling platform walker. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #26 was cognitively intact and required supervision for personal hygiene, maximum assistance with showering, and upper body dressing. A review of the Nurse Aide flow sheets dated December 2024 indicated Resident #26 was not provided supervised ambulation on the evening shift or the night shift but was provided supervised ambulation on the day shift for 10 days (12/1, 12/10, 12/17, 12/17, 12/18, 12/22, 12/28/ 2024) out of 31 days for the month. Review of a Special Instruction sheet dated 1/8/25 identified Resident # 26 was on an Ambulation Program. In an interview with Physical Therapist (PT #1) on 1/8/25 at 9:20 AM identified Resident # 26 was no longer on therapy services; however, the resident was on a restorative ambulation program which indicated Resident # 26 should be ambulated every shift with NA supervision. PT #1 further identified Resident # 26 was able to ambulate 150 feet with 2 turns using a platform walker and should ambulate every shift as tolerated. PT#1 taught his/her primary nurse aide how to use the platform walker. In an interview and review of the Resident Care Plan with RN#1(nursing supervisor) on 1/8/24 at 10:00 AM identified Resident # 26 should be ambulated with NA supervision every shift. RN # 1 further indicated there are times when the facility is short on nurse aides and indicated Resident # 26 is very complex so there is not enough time to ambulate the resident. In an interview with NA#1 on 1/8/25 at 11:00 AM identified she cannot always ambulate the r resident secondary to staffing issues. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an Interview with NA#2 on 1/8/25 at 11:45 AM identified she works 1 day per week and that is Resident #26's shower day. NA #2 indicated she does not ambulate Resident # 26 as she does not have the time. The resident's shower takes 45 minutes and then she has other tasks on the floor that leave her no time to ambulate the resident per care plan. Review of the current Comprehensive Care Plans Policy, undated, directed in part, qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made.

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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 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** 37721 Based clinical record review, review of policy and interviews for 1 of 1 resident (Resident #110) who required a when needed medication for palpitation, the facility failed to ensure the when needed medication was administered in accordance with physician's orders. The findings include: Resident #110 had diagnoses that included atrial fibrillation and hypertension. The Minimum Data Set, MDS assessment dated [DATE] identified Resident #110 was cognitively intact and independent with Activities of Daily Living (ADL). The Resident Care Plan (RCP) dated 9/17/24 identified Resident #110 had an alteration in cardiac status related to atrial fibrillation, hypertension and mitral valve regurgitation. Interventions directed to monitor for signs and symptoms of cardiopulmonary distress including chest pain and administer medications as ordered. The physician's orders dated 12/1/24 directed Diltiazem HCL Extended Release 240 mg by mouth one time a day for atrial fibrillation and Diltiazem HCl 30 Milligram (MG) by mouth every 24 hours PRN (as needed) for palpitations (heart flutter). The nurse's note dated 12/16/24 identified Resident #110 complained of palpitations at 10:50 PM and was requesting when needled (PRN) Diltiazem HCl 30 mg. The Medication Administration Record dated 12/1/24 through 12/31/24 identified Diltiazem HCl 30 mg was administered one time on 12/16/24 at 10:55 PM. The afterhours emergency after hours medication cart identified Diltiazem HCL 30 mg was included in the emergency stock. An interview with Resident #110 on 1/08/25 at 1:50 PM identified she/he had prescription medication to take when experiencing palpitations that was fast acting. Resident #110 repeatedly asked about the PRN medication as she/he wanted to ensure the medication was on hand in the event it was needed with no response. Resident #110 identified she/he had experienced symptoms at some point recently. However, the fast-acting medication prescribed to her/him was not available. The nurse ended up giving her/him prescribed morning dose of the same medication which was in in a different dose and not fast acting. Resident #110 reported feeling relieved from symptoms after taking the medication but indicated the medication took a little longer than usual. An interview with Licensed Practical Nurse, LPN #2 on 1/09/25 at 10:14 AM identified she was the assigned nurse during the 3-11:00 PM shift on 12/16/24. LPN #2 identified Resident #110 reported having symptoms of palpitations. LPN #2 identified she notified Nurse Practitioner, NP #1 and gave Resident #110 her/his morning dose of Diltiazem HCL extended release 240 mg instead of Diltiazem HCL 30 mg prescribed PRN as she did not realize the different dosage and mechanism of action. LPN #2 further identified she did ask someone, uncertain who, if Diltiazem HCL 30 mg was in the emergency medication cart and was told it was not. LPN #2 was unable to explain why she would have asked about the availability in emergency stock if she was unaware of the dose discrepancy. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with the Director of Nursing Services (DNS) on 1/09/25 at 10:59 AM identified the Diltiazem HCL 30 mg was ordered on admission. However, the pharmacy was told not to send as it was available in house and required only as needed. The DNS indicated she would expect all medications be administered according to physician's orders and nursing staff to refer to the after hours emergency list posted at all nursing stations to check availability of a prescribed medication not readily available in the medication cart. An interview with NP #1 on 1/9/25 at 11:32 AM identified she was notified Resident #78 was experiencing palpitations. She gave the order to give the PRN Diltiazem HCL 30 mg. NP #1 was not aware Resident #110 had received Diltiazem HCL extended release 240 mg instead. Although no harm came to Resident #110, NP #1 would have preferred the dosages been discussed with her and if discussed she/he may have considered an alternate plan. A review of the facility policy for Medication Administration directed that medications are administered by licensed nurses, or other staff legally authorized to do so, as ordered by the physician and in accordance with professional standards of practice. 46046 48792

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F 0689 Level of Harm - Minimal harm or potential for 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** 37721 Based on observations, clinical reviews, review of facility documentation, policy reviews and interviews for 2 of 5 residents reviewed for Accidents for (Resident # 59), the facility failed to apply footrest to the resident's wheelchair according to the plan of care to prevent an accident and for (Resident # 78), the facility failed to ensure a resident requiring assistance with transfers was free from accidents resulting in an injury. The findings included: 1. Resident #59 's diagnoses included displaced avulsion fracture, difficulty walking and spinal stenosis lumbar region without neurogenic claudication. The quarterly Minimum Data Set (MD) assessment dated [DATE] identified Resident #59 as cognitively intact and noted the resident required maximal assistance with bed mobility. The assessment identified dependent from chair to bed and toilet with transfers. Additionally, the assessment noted the utilization of a manual wheelchair. The Resident Care Plan (RCP) dated 6/19/24 for potential/ actual alteration in mobility. An intervention (updated 10/28/24) directed to place footrests on wheelchairs when transporting Resident #59. A nursing progress note dated 10/28/24 at 10:38AM identified Resident #59 as alert and pleasant. The note further indicated Resident #59 complained of pain to his/her right ankle and foot. Resident #59 stated when he/she was in his/ her wheelchair yesterday (10/27/24) a staff member (Recreational Assistance #1) offered to push him/her in the wheelchair. Resident #59 reported during the transport by Recreational Assistance #1 on 10/27/24 she/he twisted her/his ankle because her/his foot was not lifted. The Nurse Practitioner was updated regarding Resident # 59's complaint of pain to the right ankle and directed staff to obtain an X-ray of the resident's right ankle and foot. A nursing progress note dated 10/28/24 at 1:53 PM identified Resident #59 complained of increased right ankle pain from yesterday (10/27/24). Resident # 59 reported during the transport on 10/27/24 in the wheelchair by Recreational Assistant #1 her/his foot touched the ground, and her/his ankle got twisted. Resident # 59 reported she/he did not have the footrests on her/his wheelchair as she/he likes to move around in room without them. The APRN was notified today of the incident. An x ray of the right ankle identified negative results. An intervention was put in place which directed staff to ensure footrests are applied to wheelchairs when transporting residents. The Accidents and Incident Report dated 10/28/24 indicated Resident# 59 complained of pain and reported yesterday (10/27/24) when she/he requested assistance with transportation Recreational Assistant #1 transported her/him in the wheelchair at which time her/his foot touched the ground, and his/her ankle twisted. Resident #59 complain of increased pain. For Disposition the report noted right foot and ankle assessed and noted with redness, bruising and swelling. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nursing progress note dated 10/29/2024 at 10:59 AM identified Resident #59 was transferred to the Emergency Department (ER) per Advanced Practiced Registered Nurse (APRN) order for further imaging of right foot. The X-ray performed yesterday in the facility was inconclusive, showing possible mildly displaced fractures of right foot. Resident #59 refused to go to hospital yesterday due to family visiting and facility Halloween party. Resident #59 and family were agreeable to the transfer to hospital today. Resident 59 was transferred via Emergency Medical Services (EMS) at this time. The resident's family was notified of transfer and will meet Resident #59 at the hospital. A nursing progress note dated 10/29/24 at 9:31 PM identified Resident #59 returned from the emergency room with a diagnosis of a Fractured Talus, (Talus Avulsion Fracture). A boot was given to Resident #59 to wear when weight bearing. Further instructions directed the following: boot does not need to be worn when in bed or when seated, patients need to follow-up with New England Orthopedics. A physician's order dated 10/29/24 directed to elevate right leg on pillows while in bed, to elevate right leg lower extremity while seated in wheelchair and to wear walking boot when weight bearing standing/ walking. Additionally,the physician order directed no boot on while seated in bed. The RCP dated 12/6/24 noted a diagnosis on 10/29/24 for right talus avulsion fracture (small break in the ankle bone). Interventions included: checking Circulation, Motion and Sensory (CMS) of affected area every shift, elevating right leg on pillows while in bed, elevating right lower extremity while seated in wheelchair every shift. Follow-up medical appointments as needed, ice pack to right ankle as ordered, physical therapy, occupational screen/evaluation as needed. 0n 1/3/25 11:15 AM observation of Resident # 59 identified the resident sitting in the room with his/her right foot elevated with a foot device on. Resident #59 reported she/he has a broken his/her ankle due to twisting of foot in the wheelchair. Interview with Recreation Assistant #1 on 1/07/25 at 12:42 PM identified the day in question (10/27/24) there was a game planned for recreation. She also indicated she/he assists residents who are not able to ambulate on their own to and from activities. Recreation Assistance #1 reported, Resident #59 appeared to be struggling making it back to his/her room, therefore she offered to assist Resident # 59. She directed Resident #59 to pick up his/her feet during the transport secondary to the resident not having foot/ pedals on the wheelchair. Recreation Assistant #1 also indicated prior to the in-service after the incident residents who used their foot to scoot, never had a foot pedal on their wheelchair. However, since the in-service; all residents in a wheelchair have a foot pedal. She also indicated now residents have to put their foot on the pedal prior and during transport. Interview with Director of Nursing Service (DNS) on 1/8/25 at 8:31 AM identified Resident #59 historically self-propels. Resident #59 on the day of the incident was returning to his/her room from a recreation activity when Resident # 59 signaled Recreational Assistant #1 to help get her/him back to the room. The DNS further indicated the first choice is to put foot pedals on, however, if residents are alert and oriented and request transport and can put their foot up, staff would help. The DNS indicated the facility policy directs residents to be transported in a wheelchair with foot pedals on. DNS also indicated staff were made aware of this policy prior to the incident involving Resident #59. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Medical Director (MD) 1 on 1/8/25 at 10:38 AM identified any support of the ankle would have prevented the injuries. He believes the foot pedal would have provided the support needed to prevent the injury. The Medical Director also indicated the facility should be aware of the need for foot pedals and in servicing is required with staff is not aware. An interview with the Rehabilitation Director Occupational Therapist (OT #1) on 1/8/25 at 10:58 AM indicated proper use of a wheelchair would require residents to have leg rest while being transported. She also indicated that every resident should have a footrest. The Rehabilitation Director further indicated that without the proper leg rest the risk of injury is imminent. After inquiry, the Facility Wheelchair Transport/ Leg rest Policy was reviewed and revised on 10/30/24. The wheelchair Transport/ Leg rest policy in part notes, leg rests will be utilized on wheelchairs when transporting any resident that cannot hold their legs up independently. 2. Resident #78 had diagnoses that included dementia, anxiety and depressive disorders. The Minimum Data Set, MDS assessment dated [DATE] identified Resident #78 as severely cognitively impaired and required substantial maximum assist sitting to standing and transfers. The Resident Care Plan, RCP dated 10/14/24 identified Resident #78 had an actual self-care deficit related to cognition, decreased range of motion, was at risk for falls with a previous fall history and a potential alteration in mood due to anxiety. Interventions directed resident to have the assistance of two for all hands-on care, pivot transfer with assist of two using a pivot disk (assistive device to aide in transfers) and ensure needs were being met. The physician's orders dated 11/2/24 directed assist of two for all hands-on care every shift. The nurse's note dated 11/18/2024 at 10:42 PM identified at 8:40 PM, Resident #78 was found laying on floor between beds following a witnessed fall by Nurse Aide,(NA #5). NA #5 stated Resident #78 pushed off the wheelchair to transfer to bed at which time the wheelchair rolled backwards, and Resident #78 slid to the floor. Resident #78 did not hit h/her head but sustained an abrasion to the left side of the back with no other injuries noted on assessment. All appropriate parties were notified and an anti-rollback device was placed on the wheelchair. A facility Reportable Event dated 11/18/24 identified NA #5 was transferring Resident #78 back to bed when Resident #78 pushed off the wheelchair and slid to the floor sustaining an abrasion to the left side of h/her back requiring a dressing and Tylenol for complaint of discomfort. Actions taken included the anti-rollbacks being placed on the back of the wheelchair. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with Registered Nurse, RN #1 on 1/08/25 at 11:17 AM identified she was the assigned nursing supervisor during the 3:00 PM to 11:00 PM shift on 11/18/24. RN #1 identified she was notified Resident #78 was on the floor in h/her room between the two beds. On arrival, RN #1 observed Resident #78 laying face up towards the bottom of the bed with the wheelchair at the end of the bed. RN #1 identified NA #5 was in the room with Resident #78 who reported Resident #78 fell after the wheelchair rolled out from under h/her while she was attempting to transfer h/her to bed. NA #5 assisted in lowering Resident #78 to the floor. RN #1 identified there was no other staff involved in the incident and that although she was in part responsible for determining the root cause, she did not determine whether the wheelchair was locked at the time of the occurrence and was unaware Resident #78 required the assistance of two with transfers into bed with an assistive device. An interview with NA #5 on 1/08/25 at 11:55 AM identified she was the assigned nurse aide for Resident #78 during the 3:00 PM to 11:00 PM shift on 11/18/24 and well known to her. NA #5 identified using one hand to lift the back of Resident #78's pant and the other hand under h/her armpit, NA #5 attempted to transfer Resident #78 from the wheelchair at the side of the bed to the bed. During the transfer, Resident #78 became nervous and began dropping to the floor. NA #5 assisted lowering Resident #78 causing the wheelchair to be pushed back in the locked position and resident #78 sliding against the edge of the wheelchair while being lowered to the floor. NA #5 identified she/he was working alone with Resident #78 at the time of the incident and was unaware Resident # 78 required the assistance of two staff during transfers into bed using an assistive device. An interview and clinical record review with the Director of Nursing Services (DNS) on 1/9/25 at 9:07 AM identified determining the primary cause of an accident was a collaborative effort between herself and nursing staff. The DNS identified after reviewing the details of the incident, she determined NA #5, was working alone with Resident #78 at the time of the fall. The root cause was determined as accidental as Resident #78, who could become anxious at times, was exhibiting such behavior at the time of the fall. The DNS identified that although NA #5 could have paused during care when Resident #78 was exhibiting anxious behavior, nothing was incorrect in the way Resident #78 was transferred. The DNS further identified she was unaware Resident #78 required the assist of two with transfers into bed with an assistive device. A review of the facility policy for Fall Prevention identified a fall as being defined as an event where an individual unintentionally comes to rest on the ground, floor, or other level as a result of an external force. A near miss is also considered a fall, where the resident would have fallen if someone else had not caught the resident from doing so. When any resident experiences a fall, the facility will assess the resident, complete a post fall assessment, complete an incident report, notify the physician and family, review the care plan and update as indicated, document all assessments and actions and obtain witness statements in the case of an injury. 49100

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48792 Based on clinical record review, review of facility policy and interview for 1 of l resident (Resident # 223) at risk for dehydration, the facility failed to consistently monitor the resident's intake and output per policy. The findings include: Resident #223's diagnosis includes End Stage Renal Disease. The Dietary Nutrition assessment dated [DATE] indicated Resident #223's daily (24 hour) fluid needs of 1440 Cubic Centimeter (CC). A physician's order dated 1/27/24 at 9:03 PM directed to monitor Intake and output every shift for 3 days or until the goal has been met and laboratory blood work orders are reviewed by the physician or Advanced Practice Registered Nurse (APRN). The admission MDS assessment dated [DATE] indicated Resident #223 was cognitively intact and received transfusions and specialized services while not a resident A review of Resident # 223's Comprehensive Intake and Output Record dated 1/28/23 through 2/20/23 identified 9 missing entries from 1/28/23 through 2/13/23, 5 missing entries from 2/15/23 through 2/20/23 and no documentation from 2/3/23 through 2/7/23. The care plan dated 2/10/23 indicated Resident #223 was at risk for dehydration. Intervention included: dietician to provide estimated fluid needs, monitor, document, and report any signs or symptoms of dehydration including decreased or no urinary output, obtain laboratory blood work as ordered and notify physician/APRN with any changes, encourage fluids if not contraindicated. The care plan 2/10/23 further indicated Resident #223 requires specialized treatment and noted at risk for shortness of breath, blood pressure elevation and edema due to specialized treatments. Interventions included, in part, arranging specialized treatment visits on Monday, Wednesday, and Friday, and to monitor intake and output as ordered. Interview and record review with the Director of Nursing Services (DNS) on 1/8/25 at 1:32 PM indicated there really is no fluid goal for any resident to meet. Fluid goals are nursing judgment along with the physician or APRN who determines if monitoring of intake and output is needed or no longer needed. After reviewing the Comprehensive Intake and Output Record for Resident #232 dated 1/28/23 through 2/20/23 identified 9 missing entries from 1/28/23 through 2/13/23, 5 missing entries from 2/15/23 through 2/20/23 and no documentation from 2/3/23 through 2/7/2023 noted for the resident's intake and output. On the above dates there was no way to identify if Resident # 223 met his/her fluid goal based on the dietician assessment/31/23. The DNS further indicated there was no other location for documentation of Resident # 232's intake and outputs and she/he was unsure if in 2023 the electronic system utilized by the facility had documentation and indicated she/he could not access the above records. The DNS also could not explain why Resident # 223's intake and output from 1/28/23 through 2/20/23 was incomplete and had missing intake and output entries. The amount taken in and out over the 14-hour period had no total during Resident #223's stay. The DNS indicated it is the 3-11 PM nurses' responsibility to total the 24-hour intake and output for residents. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075347	A. Building B. Wing	01/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Suffield House Rehabilitation and Healthcare Cente	1 Canal Road 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 (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility policy, in effect during Resident #223's stay labeled Intake and Output indicated in part nursing personnel would keep an accurate record of a resident's fluid balance per the physician's orders. The policy also indicated the 11-7 AM nurse implements a new weekly Intake and Output worksheet every Sunday night and the 3-11 PM nurse would total the 24-hour amounts taken in and out on the worksheet at the end of the shift. The 7-3 PM nurse would update the residents' physician and family if the residents' 24-hour totals were not consistently meeting the daily required amount over a 3-day period.