

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075366	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/28/2024
NAME OF PROVIDER OR SUPPLIER Hamden Rehabilitation & Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1270 Sherman Lane Hamden, CT 06514	

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 0689</p> <p>Level of Harm - Minimal harm or potential for 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** 43184</p> <p>Based on clinical record reviews, facility documentation, facility policy and interviews for one (1) of two (2) sampled residents (Resident #2) who required a wheelchair for mobility within the facility, the facility failed to ensure when being assisted by staff the leg rests were present on the wheelchair to prevent the resident from falling out of the wheelchair. The findings include:</p> <p>Resident #2's diagnoses included cerebrovascular accident, unspecified dementia, hemiplegia on the right dominant side and muscle weakness.</p> <p>A physician's order dated 6/17/24 directed pop-over transfers with the assist of two (2) staff members, and the resident was non-ambulatory.</p> <p>The quarterly Minimum Data Set assessment dated [DATE] identified Resident #2 rarely or never made decisions regarding tasks of daily life, was dependent with getting in and out of the bed and chair, had range of motion impairment of both upper extremities, was non-ambulatory and utilized a wheelchair for mobility.</p> <p>The Resident Care Plan dated 8/1/24 identified Resident #2 was a fall risk. Interventions directed to encourage the resident not to get up alone, encourage non-skid footwear and non-skid socks, educate on use of the call bell for assistance, and place commonly used items within reach.</p> <p>The nurse's note dated 8/7/24 at 3:37 PM identified at 2:30 PM Resident #2 was being pushed in the wheelchair during the recreation program, when Resident #2 fell forward out of the wheelchair and was noted with an open area to the right lateral scalp, actively bleeding. The note identified Resident #2 had intact neurological assessment, no changes in range of motion, no complaints of pain and no shortening/lengthening of extremities. The note indicated staff could not get the bleeding under control, the physician's assistant was notified, and a new order was obtained to send Resident #2 to the emergency department.</p> <p>The nurse's note dated 8/9/24 at 9:41 PM identified Resident #2 was readmitted to the facility at approximately 8:30 PM, sutures to the right temporal laceration were intake, and there were no changes in cognition and neuro were at baseline.</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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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NAME OF PROVIDER OR SUPPLIER Hamden Rehabilitation & Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1270 Sherman Lane Hamden, CT 06514	
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with the 7AM-3PM Nursing Supervisor, Registered Nurse (RN) #1, on 8/28/24 at 12:11 PM identified on 8/7/24 it was reported to her Resident #2 had fallen out of the wheelchair. RN #1 identified Resident #2 was in the wheelchair without the benefit of having the leg rests on and Resident #2 put his/her foot down to the ground which caused Resident #2 to fall forward out of the wheelchair. RN #1 indicated Resident #2 should have had the leg rests on the wheelchair.</p> <p>Interview with the Director of Nursing (DON) on 8/28/24 at 12:17 PM identified Resident #2 sustained a fall forward from the wheelchair during transport. The DON identified the 7AM-3PM nurse aide, (Nurse Aide) #3, did not have the leg rests on the wheelchair at the time of the fall and the facility policy directs to always have the leg rests on the wheelchair.</p> <p>Interview with NA #3 on 8/28/24 at 12:29 PM identified she was pushing Resident #2 in the wheelchair without the benefit of leg rests on the wheelchair, and when she stopped the wheelchair, Resident #2 put his/her foot down on the floor and fell out of the wheelchair. NA #3 identified there should have been leg rests on the wheelchair while transporting Resident #2 but she forgot to put them on.</p> <p>Review of the facility policy titled Wheelchair, directed, in part, when wheelchair transporting any resident the leg rest must be used, and leg rests must always be used when transported by others.</p>		