STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075367	A. Building B. Wing	07/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Meadowbrook of Granby	350 Salmon Brook Street Granby, CT 06035

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29050 Based on a clinical record review, review of facility documentation and staff interviews for one of three sampled residents reviewed for hospitalization (Resident #1), for the newly admitted resident, the facility failed to ensure a baseline care plan was developed and implemented to address the residents fractured (broken) ribs. The findings include: Resident #1 was admitted to the facility on [DATE] with diagnoses that included diabetes, hypertension, metabolic encephalopathy and dementia with behavioral disturbances. Review of Resident #1's Chest CT (computed tomography) performed at Hospital #1 on 4/15/23 (prior to admission to the long term care facility) identified the resident with an acute/subacute nondisplaced left posterior, 10th rib fracture. Further review of hospital documentation identified the resident with pleural effusion and a malignancy was suspected. Review of Hospital #1's discharge summary dated 4/22/23 (printed on 7/3/24) identified the resident with recurrent falls and an acute/subacute nondisplaced left posterior 10th rib fracture. Review of Hospital #1's Inter-Agency Referral Report (W-10) dated 4/22/23 failed to identify that the resident had a rib fracture. Review of Resident #1's clinical record identified a handwritten, undated note with the resident's name written on top of the page. Further review of this documentation identified the resident had a fall, was incontinent, and had bruising with intact skin and had a R (right) rib fracture. Review of a pain evaluation dated 4/22/23 identified the resident was unable to vocalize pain. Non-verbal pain evaluation identified the resident with non-verbal symptoms present, facial expressions, protective body movements or posture and the resident was able to point and/or indicate level of pain hurts even more. Review of the History and Physical Examination Form dated 4/23/23 by MD #1 identified the resident had a fall with R (right) sided rib #. Further review directed to monitor rib pain and administer Tylenol (analgesic) as needed. (continued on next page)

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

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nurse's note dated 4/23/23 identified that Resident #1 was alert and confused lying in bed moaning, restless and rubbing rib area. Tylenol was given with good relief; and the resident fell asleep. Review of Resident #1's care plan initiated on 4/24/23 and last revised on 4/28/23, identified there was no documented evidence that facility's staff developed a care plan with goals and interventions to address the resident's fractured ribs. The APRN #1 progress note dated 4/25/23 identified Resident #1 was admitted to the facility following hospitalization after a fall without injuries. The resident denied pain. Review of Resident #1's 72 Hour Meet and Greet Admission Meeting form dated 4/25/23 failed to identify that the resident had rib fracture. A Resident Care Card (communication mechanism to caregivers) last updated on 4/26/23 indicated Resident #1 was incontinent of bowel and bladder and required assistance of two staff with care. However, no interventions addressing the resident's rib fracture injury were identified. The 5-day MDS assessment dated [DATE] identified Resident #1 had severe impaired cognition and required extensive assistance of two for bed mobility, transfer, dressing, toilet use and personal hygiene. Review of Resident #1's clinical record identified the resident had two falls while at the facility on 4/25/23 and on 4/28/23, the resident was assessed after each fall and no injuries were noted. The nurses note dated 4/28/23 identified Resident #1 had abnormal blood work results, APRN was notified and ordered to send the resident to the hospital. Further review failed to provide evidence that the hospital was notified of the resident's rib fracture. Review of Resident #1's whole-body CT performed at Hospital #2 on 4/29/23 identified the resident with multiple acute nondisplaced right 4th through 10th rib fracture, pleural effusion and age-indeterminate T6 fracture. Further review identified the assessment and plan included optimizing pain control for rib fractures as well as respiratory optimization with breathing treatments as much as the resident can tolerate. Interview and physical therapy note review with the Director of Physical Therapy on 7/3/24 at 10:50 AM identified the rehabilitation department should have been notified of the resident's diagnosed rib fracture on admission to the facility. Had they been notified PT and OT would have assessed the resident and not necessarily have changed the treatment but would have exercised caution of his/her rib pain, especially when the resident had no complaints of pain during therapy. Additionally, on 4/27/23 physical therapy documented Resident #1's participation was limited by complaints of pain, but the resident had difficulty expressing exactly where the pain was. It was further stated during this interview, if aware,the rehabilitation department would have worked with nursing on developing and implementing a plan of care to improve the resident's comfort and increase participation in care. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and clinical record review with ADNS on 7/3/24 at 12:51 PM identified she would have expected Resident #1 to have had a care plan addressing his/her diagnosed rib fracture. The ADNS further identified the handwritten note filed in the resident's clinical record with the resident's name and medical information including right rib fracture information, it was a report from the hospital taken on the telephone by the facility nurse prior to the resident's admission to the facility on [DATE]. The ADNS identified the Inter-Agency Referral Report (W-10) dated 4/22/23 was available for nursing staff to review when the resident was admitted to the facility, but the report had no information about the resident's rib fracture. The ADNS further identified that although the hospital discharge summary dated 4/22/23 identified the resident with a nondisplaced left 10th rib fracture, the handwritten report from the hospital written by the facility nurse identified right rib fracture, and MD #1 examination form dated 4/23/23 identified concern with right sided rib, the information probably was not available and/or not reviewed by the facility. Additionally, the ADNS failed to identify a care plan that was developed to reflect the resident had fractured ribs and therefore no interventions were in place to address on how to care for the resident with multiple rib fractures. The facility failed to communicate that the resident had a fractured rib and failed to notify the hospital when the resident was transferred on 4/29/23. Although attempted, an interview with MD #1 was not obtained. Interview with RN #2 on 7/3/24 at 2:40 PM identified that had he been aware that Resident #1 had a rib fracture, he would have requested the rehabilitation department to assess the resident to direct the resident's care needs. Interview with the Administrator on 7/3/24 at 2:48 PM identified the facility will investigate the incident to determine where this information that the resident had fractured ribs came into a halt and will train staff to ensure that this will never happen again. After surveyor enquiry, on 7/3/24, MD #2 at Hospital #1 reviewed Chest CT images dated 4/15/23 and identified that in addition to left rib fracture, the resident also had nondisplaced fractures of a few right-sided ribs. Evaluation was limited due to decreased bone mineral density and respiratory artifact affecting multiple ribs. Further review identified there was a subtle irregularity of the right 7th, 8th, 9th and 10th rib. All these fractures were nondisplaced and might be acute, subacute, or chronic in nature. Interview with MD #2 on 7/3/24 at 3:05 PM identified the resident's rib fractures were consistent with falls. The resident had recurrent falls and diagnosed rib fractures prior to admission to the facility. MD #2 further identified if the facility had questions about the rib fractures identified at the hospital, they should have called Hospital #1 for clarification. Review of the facility Care Planning policy identified an interim plan of care is developed within 24-hours of admission to the facility based on information obtained during the admission process as a guide for care until the interdisciplinary care plan is developed. The process included to obtain physician orders upon admission, complete the nursing admission assessment, begin interdisciplinary assessment process, review inquiry and transfer information, interview resident and family if appropriate, develop interim plan of care and initiate care plan.