STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075382	A. Building B. Wing	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodlake at Tolland Rehabilitation & Nursing Cente	26 Shenipsit Lake Road Tolland, CT 06084

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47460 Based on clinical record review, facility documentation review, facility policy review, and interviews for one of three residents (Resident #1) reviewed for accidents, the facility failed to ensure staff did not move a resident with identified changes in mental status after a witnessed a fall with a head injury. The findings include: Physician order dated [DATE] directed independent with mobility in the room and hallways using a rollator (rolling walker). The Nurse Aide (NA) Kardex/care card directed as of [DATE], Resident #1 was independent with transfers and ambulation with a rolling walker. Resident #1's diagnoses included dementia, heart failure and insomnia. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of 7 out of 15, indicating severe cognitive impairment and ambulated with partial assistance. The Resident Care Plan (RCP) dated [DATE] identified a risk for falls. Interventions directed to encourage call bell use for assistance, ensure resident is wearing appropriate footwear/non-skid socking when ambulating, follow facility fall protocol and Resident #1 was independent ambulation with a rolling walker. Record review identified Resident #1 had code status Do Not Resuscitate (DNR), and was diagnosed with Norovirus (virus that causes vomiting and diarrhea) APRN note dated [DATE] identified the Norovirus was resolved. Review identified Resident #1 continued with diarrhea on ,d+[DATE] and had a large bowel movement on [DATE] with a stool specimen sent for Norovirus. Review failed to identify any elevated temperatures. Review of reportable event dated [DATE] at 11 PM indicated Resident #1 had an unwitnessed fall; staff witnessed Resident #1 turn around in the middle of the hall and fall. Resident #1 was noted to be weak after the fall, was not responding as usual and was unable to ambulate. The APRN was notified, resident sent via 911 to ED, family notified, and investigation was initiated. (continued on next page)

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of nursing note dated [DATE] identified RN #1 was called to assess Resident #1 who had a witnessed fall while self-ambulating in the hallway with a rollator. The Nurse Aide (NA) indicated Resident #1 hit his/her head on the floor. Resident #1 had altered mental status, was unable to follow commands, blood pressure was ,d+[DATE], heart rate 38, respirations 16, and unable to determine (blood) oxygen saturation level. Resident #1 was transferred to bed and placed on oxygen two (2) liters, the on-call provider was notified and ordered to send Resident #1 to the hospital and 911 was called. Emergency Medical Services (EMS) run sheet dated [DATE] identified EMS was called at 11:14 PM. The run sheet identified Resident #1 had non-reactive pupils, arms and legs were mottled. Vital signs obtained were: blood pressure ,d+[DATE], pulse 85, respirations 30. Review of facility SBAR (Situation Background Assessment Request) Communication Form and progress note dated [DATE] at 11:36 PM identified Resident #1 had a fall with change in condition. Increased confusion, new/worsening behavioral symptoms and decreased consciousness, weakness or hemiparesis, and shortness of breath were noted. Resident #1 was transferred to the hospital. Review of Taber's Medical Dictionary directed in part, when a resident falls with a head strike, to assess the severity of the head impact and evaluate for injuries. Observe for mental status changes, neurological abnormalities or bleeding. Residents with signs of neurological compromise should be immediately referred to the emergency department. Review of NA #1 written witness statement dated [DATE] identified NA #1 witnessed Resident #1 slumped over his/her walker in the hall. Before NA #1 could reach the resident he/she spun in a circle as if dizzy, fell on to his/her side and hit his/her head on the ground. The statement indicated the charge nurse and supervisor arrived and were unable to obtain vital signs. The nurse and two (2) NAs then transferred Resident #1 into a wheelchair, with the supervisor present. Staff were still unable to obtain vital signs, and the statement indicated Resident #1 seemed to have trouble breathing and Resident #1 was transferred into bed. Oxygen was applied and then 911 arrived. Review of hospital Emergency Department report dated [DATE] indicated diagnoses of acute encephalopathy (sudden brain dysfunction resulting in changes in mental status), hematemesis (vomiting blood) and syncope (temporary loss of consciousness caused by a sudden, temporary drop in blood flow to the brain) and further indicated resident expired [DATE] at 1:33 AM (2 hours and 33 minutes after the fall). Death certificate dated [DATE] identified Resident #1's cause of death was shock, respiratory failure and hematemesis. Interview and record review with NA #1 on [DATE] at 10:29 AM identified she last observed Resident #1 at 10:40 PM in the bathroom, wearing slippers and she assisted the resident back to bed. About 11 PM she observed Resident #1 walking in the hall wearing slipper socks and then observed him/her hunch over the walker. NA #1 stated she tried to get to Resident #1 to provide assistance, but before she could reach Resident #1, he/she spun in a circle and fell . Resident #1 fell on to his/her side and hit his/her head on the floor. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Interview, review of clinical record and facility documentation on [DATE] at 12:22 PM with APRN #1 identified that when a resident has a fall, the resident is typically assessed on the floor, and if there is an injury or change then EMS should be called right away. APRN #1 stated staff should not attempt to move a resident with a possible injury due to a fall and if they hit their head. APRN #1 stated a resident with a change in mentation and head injury should not be moved due to a possible spinal or head injury. Interview and facility documentation review on [DATE] at 12:44 PM with LPN #1 indicated she heard the fall, she heard a very loud sound when Resident #1 hit the floor. LPN #1 stated RN #1/supervisor assessed Resident #1 and directed staff to move Resident #1 into a wheelchair and back to bed. LPN #1 stated she had never seen a resident be moved after a fall with a head injury, and she thought they should have left Resident #1 on the floor and called 911, but RN #1 directed to move Resident #1 off the floor. LPN #1 further stated she should have questioned RN #1's decision to move the resident, but she did not say anything. Interview, clinical record review and facility documentation review on [DATE] at 1:10 PM with RN #1 identified she assessed Resident #1 while he/she on the floor after the fall on [DATE]. RN #1 stated Resident #1 had hit his/her head during the fall, had signs of altered mental status, could not answer questions, showed no expressions of pain, and RN #1 was unable to obtain a blood pressure. RN #1 stated staff lifted Resident #1 into a wheelchair and then transferred him/her into bed. Resident #1 had a low blood pressure, oxygen was started, and 911 was called. RN #1 stated it was her decision to move Resident #1 off the floor, and stated she should not have moved the resident. RN #1 stated she should have made Resident #1 comfortable on the floor and waited for EMS to arrive. Interview, clinical record and facility documentation review with the DNS on [DATE] at 2:15 PM identified Resident #1 ambulated independently and on [DATE] at 11 PM staff witnessed a fall with a head strike. Resident #1 was assessed by RN #1/supervisor and was identified to have mental status changes. Staff then transferred Resident #1 off the floor into a wheelchair and then into bed. The DNS stated Resident #1 should have remained on the floor pending EMS arrival for transfer to the hospital; staff should not have moved Resident #1 off the floor. Review of facility Accident and Incident Investigation Policy directed in part, any resident who sustains an injury to the head can be moved to a safe and comfortable place if no injury is noted.