STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075395	A. Building B. Wing	05/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurel Ridge Center for Health & Rehabilitation	642 Danbury Road Ridgefield, CT 06877

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 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** Based on review of clinical records, interviews, and review of facility documentation and policy for one (1) of three (3) residents (Resident #1) reviewed for accidents, the facility failed to ensure a change of condition was reported to the provider on two occasions in accordance with facility policy. The findings included: Resident #1 was admitted to the facility in December of 2024 with diagnoses that included unspecified dementia, Type 2 diabetes mellitus, and anxiety disorder. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had severe cognitive impairment and was dependent with eating, oral and personal hygiene, and independent with ambulation. Review of the Resident Care Plan (RCP) dated 2/26/25 identified Resident #1 wandered related to dementia with behaviors and had the potential for falls due to poor safety awareness. Interventions directed to ensure Resident #1's room and the surrounding environment were safe and free from hazards that could cause harm and to monitor for changes in mental status such as new onset confusion, sleepiness, behavioral and neurological changes. 1. A nurse's note by LPN #1 dated 3/31/25 at 3:50 PM identified Resident #1 was alert, confused, and lethargic, had care provided with the assist of one (1) person, ate 0% of breakfast, 50% of lunch, fluid intake was encouraged, and APRN #1 was informed. Interview with APRN #1 on 5/2/25 at 1:47 PM identified LPN #1 failed to inform him/her that Resident #1 was lethargic (sleepy) on 3/31/25, but that LPN #1 informed him/her of Resident #1's decreased meal consumption and that Resident #1 was otherwise at his/her baseline. APRN #1 further identified that she was at the facility on 3/31/25 and, had he/she been made aware of lethargy (sleepiness), he/she would have formally seen Resident #1 to further evaluate him/her. Interview with LPN #1 (first shift charge nurse from 7:00 AM to 3:30 PM) on 5/6/25 at 9:47 AM identified Resident #1 was still ambulating on and off throughout the day on 3/31/25 but appeared lethargic (sleepy). LPN #1 indicated he/she updated the provider with Resident #1's status, however was unable to recall exactly what he/she reported. 2. A nurses note by LPN #1 dated 4/1/25 at 2:31 PM identified Resident #1 was observed wandering next to the nurse's station, tripped and lost balance after bumping into another resident's walker, and was able to hold onto the bench as he/she lowered himself/herself onto the floor. (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The 4/1/25 Change of Condition Evaluation completed by RN #1 identified Resident #1 sustained a fall that morning (4/1/25), was awake and responded to name when called, was not in pain, did not grimace or moan, range of motion to both upper and lower extremities was unlimited and moving well without pain, bilateral lower extremities were equal in length, and no mental status changes were observed. RN #1 further indicated the provider was notified and recommended to monitor Resident #1. Resident #1 was immediately assisted to his/her wheelchair and transferred back to bed. Review of RN #1's note dated 4/2/25 at 1:59 PM identified Resident #1 911 was called due to a change in Resident #1's level of consciousness. Review of the hospital Discharge summary dated [DATE] identified Resident #1 was admitted to the hospital with diagnoses that included hyperosmolar hyperglycemic state, hypernatremia, acute metabolic encephalopathy, and right clavicle fracture. Interview with SW #1 on 5/2/25 at 9:58 AM identified he/she returned a call from Person #1 on 4/2/25 who voiced concerns regarding Resident #1's health status, indicating he/she did not appear well and that Person #1 thought something was wrong. SW #1 indicated he/she informed both the Administrator and Director of Nurses following the phone call and Resident #1 was sent to the hospital shortly thereafter. Interview with LPN #1 (7:00 AM to 3:00 PM charge nurse) on 5/2/25 at 11:47 AM identified Resident #1 would constantly walk on the unit, however after he/she fell on 4/1/25, Resident #1 remained in bed the remainder of the afternoon until LPN #1's shift ended at 3:00 PM. LPN #1 further identified it was unusual for Resident #1 to stay in bed but the provider was not notified of the change in Resident #1's activity level during his/her shift. Interview with LPN #2 (3:00 PM to 11:00 PM charge nurse on 4/1/25) on 5/2/25 at 12:27 PM identified Resident #1 would walk up and down the hallways of the facility all the time, however after his/her fall on 4/1/25, remained in bed. LPN #2 further identified that was unusual for Resident #1 as he/she normally walked unless he/she was being fed or assisted to bed, and would normally attempt to get out of bed after being assisted to bed. LPN #2 identified that because Resident #2 had sustained a fall earlier that day, he/she did not expect Resident #1 to get out of bed. LPN #2 indicated he/she did not inform the provider of Resident #1's change of condition. Interview with APRN #1 on 5/6/25 at 12:50 PM identified labs were ordered following Resident #1's fall on 4/1/25 and that he/she was not aware Resident #1 remained in bed following his/her fall the remainder of the day (4/1/25). APRN #1 further identified that Resident #1's lack of activity and remaining in bed was a change in condition as he/she was normally very active, and that a provider should have been informed. Interview with the Director of Nurses on 5/7/25 at 12:15 PM identified the standard of practice for a change of condition was to perform a change of condition evaluation, and to notify the provider and family/patient representative of the concern. Review of the Change of Condition policy directed the facility would inform the resident, resident's healthcare provider, and the resident's family/legal representative when there was a significant change in the resident's physical, mental, or psychosocial status, and to ensure a resident's change of condition was evaluated and documented properly.