

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075411	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/15/2023
NAME OF PROVIDER OR SUPPLIER  Matulaitis Nursing Home		STREET ADDRESS, CITY, STATE, ZIP CODE  10 Thurber Rd Putnam, CT 06260	

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 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41682</b></p> <p>Based on clinical record review, facility documentation review, facility policy review and interviews for one of three residents (Resident #1), reviewed for abuse, the facility failed to ensure the resident with treated with dignity. The findings include:</p> <p>Resident #1's diagnoses included dementia with psychotic disturbances, infection to cystostomy catheter, heart failure, and depression. The admission Minimum Data Set assessment dated [DATE] identified Resident #1 had severely impaired cognition, had no behaviors in the prior seven (7) days, and required extensive assistance with bed mobility and transfers. The Resident Care Plan (RCP) dated 10/22/23 identified Resident #1 has a history of exhibiting behavioral symptoms including rejection of care, cursing, spitting, and hitting. Interventions directed to provide diversional activities as needed, repeat yourself in a polite manner as needed and to provide simple cueing as needed. Always approach in a calm and friendly manner.</p> <p>Facility incident report and investigation dated 10/25/2023 at 1:00 AM identified NA #2 reported an allegation that NA #1 had slapped Resident #1. NA #1 was immediately removed from care and Resident #1 was assessed for injuries, and no injuries were identified.</p> <p>Interview with NA #2 on 11/15/23 at 10:00 AM identified on 10/25/2023 during the 11:00 PM to 7:00 AM shift, Resident #1 was restless and attempting to get out of bed throughout the night. NA #2 indicated RN #2 went to obtain a recliner chair for Resident #1, and NA #2 went to check on Resident #1. As NA #2 entered Resident #1's room, she observed NA #1 hunched over, and saw NA #1 raise her hand and slap Resident #1 in the face. Resident #1 then stated, get out, you hit me. NA #2 indicated he/she immediately confronted NA #1 and requested her to leave the room. NA #2 reported the allegation to RN #2 and LPN #1 and indicated the facility initiated an investigation.</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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<p>F 0557</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with NA #1 on 11/15/23 at 11:20 AM identified on 10/25/2023 during the 11:00 PM to 7:00 AM shift, Resident #1 was attempting to get out of bed, yelling and shouting during the night. NA #1 indicated when RN #2 went to obtain a recliner chair Resident #1's roommate (Resident #2) began yelling at Resident #1 to shut him up. Both Resident #1 and Resident #2 were yelling at this point, and NA #1 identified she first placed her finger over Resident #1's mouth and indicated to shhh. When this didn't work, NA #1 identified she placed her hand over Resident #1's mouth and indicated to shhh. NA #1 identified she never slapped Resident #1 during this interaction, and NA #2 was not present during this interaction until possibly the ending. NA #1 identified she was removed from Resident #1's care and schedule pending an investigation and was subsequently terminated from her position after this event.</p> <p>Interview with DON on 11/15/2023 at 12:15 PM identified the facility was unable to substantiate that abuse occurred due to conflicting statements. Further, the DON indicated NA #1 should not have put her hand over the resident's mouth and should have waited for RN #2 to arrive with the recliner chair; further NA #1 could have attempted to de-escalate the situation with Resident #2 by providing reassurance. The DON identified the facility terminated NA #1's employment for not treating the resident with dignity.</p> <p>Review of the facility Quality of Life - Dignity Policy directed in part, each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, feeling of self-worth, and self-esteem, and residents are to be treated with dignity and respect at all times.</p>		