STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075416	A. Building B. Wing	03/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Candlewood Valley Health & Rehabilitation Center	30 Park Lane East New Milford, CT 06776

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for one (1) of three (3) residents (Resident #3) reviewed for accidents, the facility failed to ensure neurological assessments were completed following an unwitnessed fall per physician's order. The findings include:Resident #3 was admitted to the facility on [DATE] with diagnoses that included pneumonia, clostridium difficile, atrial fibrillation, depression, and lung cancer with brain metastasis. The Resident Care Plan (RCP) dated 8/14/24 identified Resident #3 was at risk for falls and bleeding related to anticoagulant therapy. Interventions directed to keep the call bell and commonly used items within reach, encourage call light use, administer medications per physician orders, monitor for signs and symptoms of bleeding and bruising, and maintain a safe environment. The physician's order dated 8/14/24 directed to administer Eliquis (blood thinner) 2.5 milligram twice a day, monitoring every 30 minutes for 24 hours due to fall risk and document interventions in the nursing progress notes. The admission Minimum Data Set (MDS) dated [DATE] identified Resident #3 had moderately impaired cognition, was frequently incontinent of bowel, occasionally incontinent of bladder, and required maximum assistance for toileting hygiene, lower body dressing, and personal hygiene. Facility reportable event documentation dated 8/20/24 at 7:30 PM identified Resident #3 was found sitting on the floor in his/her room after self-transferring from the bathroom. Resident #3 was alert and oriented with occasional forgetfulness and required one-person assistance using a rolling walker for transfers, ambulation, and toileting. MD #1 was notified at 7:45 PM. The fall investigation completed by RN #1 identified NA #1 last toileted Resident #3 at 5:30 PM, at which time the resident was incontinent of bladder. RN #1 indicated Resident #3 told a family member he/she needed to use the bathroom; however, the family member left the facility without notifying staff. The intervention included educating family members not to leave Resident #3 unattended in the bathroom. The nursing note dated 8/20/24 at 8:05 PM written by RN #1 identified at approximately 7:30 PM, a visitor reported Resident #3 had fallen while ambulating to the bathroom without assistance. Resident #3 was found seated on the floor with a laceration above the right eyebrow measuring approximately 1.5 centimeter (cm) by 1.0 cm and a superficial laceration to the left index finger. RN #1 indicated both areas were cleansed, Steri-Strips were applied to the eyebrow laceration, and a band-aid was applied to the finger. RN #1 identified Resident #3's neurological assessments were initiated and within normal limits and he/she denied pain or discomfort. RN #1 indicated Resident #3 reported he/she lost balance while moving the walker out of the bathroom. MD #1 was notified and ordered a STAT X-ray, resident representative was notified, and Resident #3 was reminded to use the call light for assistance. The physician's order dated 8/20/24 directed to neurological checks every 15 minutes for one hour, every 30 minutes for 2 hours, every 4 hours for 20 hours, and every 8 hours for six shifts. Review of the Medication Administration Record (MAR) dated 8/20/24 identified Resident #3's neurological assessments were initiated at 7:30 PM and documented at 7:45 PM, 8:00 PM, and 8:15 PM. The MAR identified at 9:15 PM, 9:45 PM, and 10:15 PM on 8/20/24 neurological assessments were not completed. The MAR dated 8/21/24 further directed neurological assessments every 8 hours (continued on next page)

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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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	through 8/23/24. Further review of the MAR identified on 8/22/24 at 9:15 PM the neurological assessment was not completed. The nurse's note dated 8/21/24 at 8:58 AM written by RN #2 identified Resident #3 neurological assessment and vital signs were within normal limits. Resident #3 denied any pain or discomfort. Resident #3's representative was present at the bedside and requested a CT scan of the head due to Resident #3's recent fall. MD #1 was notified and ordered Resident #3 to be transferred to the emergency department for evaluation. Resident #3 was transferred to the emergency room. The emergency room discharge instructions dated 8/21/24 identified Resident #3 was diagnosed with a fall, head injury, facial laceration, and shoulder abrasion. The discharge instructions identified a CT scan of the head and brain was reviewed and the results were preliminary. The instructions further indicated that the physician and Resident #3 would be notified if any changes to the findings or diagnosis were identified upon final review. The nurse's note dated 8/21/24 at 1:35 PM written by Licensed Practical Nurse (LPN) #1 identified Resident #3 returned from the emergency room and the CT scan showed no changes. Interview with the Assistant Director of Nursing (ADNS) on 3/26/26 at 4:30 PM indicated nursing staff are expected to follow the facility's neurological assessment policy for residents who experience an unwitnessed fall. Interview and clinical record review with the Director of Nursing Services (DNS) on 3/30/26 at 7:15 AM identified Resident #3 had one unwitnessed fall at the facility on 8/20/24. The DNS indicated neurological assessment including a full set of vital signs should be conducted status following an unwitnessed fall. The DNS identified Resident #3's neurological assessments were not completed on 8/20/24 and 8/22/24 per physician's order because the physician's order was not transcribed correctly. Review of the facility Neurological Observations Policy identified neurological assessments are performed in a systematic, hierarchal approach from the highest level of function to the lowest. Neurological observation is used to record and track neurological assessment findings and will be done if a resident had an unwitnessed fall or fall with a head strike. Ascertain the resident's level of consciousness by asking him/her their full name. If the resident is aware of person, place, and time and if the language is clear, concise, and the quality. Check bilaterally to see if resident is having pain. Always check motor behavior bilaterally. Examine pupils for size and shape, eye movement and compare the two eyes for equality. Also note if pupils are positioned in or deviated from the midline. Test pupils' response to light. Evaluate motor function and strength to all extremities. Test plantar reflex by stroking the bottom of the foot and normally will show flexion of the toes. Take residents vital signs, the pulse noting the difference between systolic and diastolic and is especially important because widening pulse pressure can indicate increasing Intracranial Pressure (ICP). For falls neurological assessments are to be done, they must be completed every 15 minutes for 1 hour, then every 30 minutes for 2 hours, then every hour for 4 hours, every shift for 48 hours. Review of the facility Assessing Falls and their Causes Policy identified the purpose was to provide guidelines for assessing a resident after a fall and to assist staff in identifying causes of the falls. Falls are the leading cause of morbidity and mortality among elderly in nursing homes. Residents must be assessed upon admission and regularly afterward for potential risks for falls. Relevant risk factors must be addressed promptly. After a fall notify the physician and the resident's family in an appropriate amount of time. Observe for delayed complications of a fall for approximately 48 hours after the fall and will document findings in the medical record. Document any observed signs and symptoms of pain, swelling, bruising, deformity, and/or decreased mobility, and any changes in responsiveness/consciousness and overall function. Complete an incident report for resident falls no later than 24 hours after the fall occurs.