STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075420	A. Building B. Wing	07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summit at Plantsville, The	261 Summit Street Plantsville, CT 06479

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **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 mistreatment, the facility failed to ensure resident was treated with respect. The findings include: Resident #1's diagnoses included Alzheimer's and left sided hemiparesis. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified that Resident #1 had moderate cognitive impairment and was dependent for toileting, ADLs, transfers, and independent with manual wheelchair use. The Resident Care Plan (RCP) dated 6/24/2024 identified Resident #1 required assistance with ADLs. Interventions directed encourage independent mobility in wheelchair, assist if needed and give the resident sufficient time to accomplish each task. Review of nurse aide care card directed dependent with wheelchair use. Review of Facility Reportable Event Form dated 7/3/2024 at 2:30 PM identified the hairdresser reported a NA pushing Resident #1 quickly down the hallway, and Resident #1 wanted the NA to slow down. The NA pushed Resident #1's wheelchair into the resident's room and Resident #1's hand got stuck between wheelchair wheel and door frame. Redness was noted to the left hand, and a new order was obtained for an x-ray. Review of facility indicated summary (titled Final Report) dated 7/8/2024, identified when NA #1 was pushing Resident #1 quickly in his/her wheelchair, the NA turned into Resident #1's room and Resident #1's hand hit the doorframe causing the resident to call out. The summary identified the x-ray was negative. Facility investigation identified although Resident #1 had requested NA #1 to slow down, NA #1 continued to push the wheelchair quickly. Interview and facility documentation review on 7/22/2024 at 11:04 AM with NA #1 identified that on 7/3/2024 around 2:30 PM, Resident #1 was in his/her wheelchair in the middle of the hallway when the laundry staff was trying to get by. NA #1 stated Resident #1 was trying to wheel him/herself down the hallway and then just completely stopped. NA #1 indicated that she and another NA asked Resident #1 to move his/her chair, but he/she did not, and NA #1 then pushed the resident at a regular speed as she would push any other resident and Resident #1 did not ask her to slow down. NA #1 stated she assumed Resident #1's hand got caught between the wheelchair and doorframe when Resident #1 said ow and Resident #1 stated he/she was o-[NAME]. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075420	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Summit at Plantsville, The	261 Summit Street Plantsville, CT 06479

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview, clinical record review, and facility documentation review with the DNS on 7/22/2024 at 1:18 PM identified NA #1 should have slowed down when Resident #1 requested and should have been careful going through the doorway to prevent hitting his/her hand. Review of facility Residents' [NAME] of Rights directed in part, you (resident) have the right to be treated with consideration, respect and full recognition of your dignity and individuality.