

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075425	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/01/2025
NAME OF PROVIDER OR SUPPLIER Vanderman Place		STREET ADDRESS, CITY, STATE, ZIP CODE 595 Valley Street Willimantic, CT 06226	

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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** [NAME], [NAME] P.</p> <p>Based on clinical record review, facility documentation review, facility policy review, and interviews for four of four residents (Resident #1 and #3) reviewed for comprehensive care plans, the facility failed to ensure the care plans included bed rail usage/interventions. The findings include:</p> <p>1.</p> <p>A.</p> <p>Resident #1's diagnoses included dementia and contractures.</p> <p>Physician order dated 1/28/2025 directed to provide half side rails on every shift.</p> <p>The Significant Change Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of zero out of fifteen (0/15), indicative of severe impaired cognition and was dependent with ADLs (activities of daily living). The Resident Care Plan (RCP) dated 2/15/2025 identified Resident #1 had an ADL self-care deficit related to dementia. Interventions directed required staff to turn and reposition in bed and allow staff to maximize independence with turning and repositioning in bed.</p> <p>A nursing quarterly evaluation dated 2/15/2025 identified Resident #1's side rail/grab bar recommendation was to use bilateral side rails. The side rail/grab bar decision indicated that the side rail(s) were indicated and serve as an enabler to promote independence at this time.</p> <p>Record review failed to identify a care plan that directed use of the side rails.</p> <p>B.</p> <p>Resident #3's diagnoses included dementia and anxiety disorder.</p> <p>Physician order dated 2/6/2025 directed to provide two, quarter side rails bilaterally on every shift.</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 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A nursing quarterly evaluation dated 3/20/2025 identified Resident #3's side rail/grab bar recommendation was bilateral side/grab rails. The side rail/grab bar decision indicated that the side rail/grab bar(s) were indicated and serve as an enabler to promote independence at this time.</p> <p>The Quarterly MDS assessment dated [DATE] identified Resident #3 had a BIMS score of thirteen out of fifteen (13/15), indicative of cognitively intact and required assistance with ADLs. The RCP dated 4/2/2025 identified Resident #3 has an ADL self-care deficit related to dementia with the inability to initiate or follow through consistently. Interventions directed to assist with ADLs and was independent for bed mobility and moving side to side.</p> <p>Intermittent observations on 4/30 and 5/1/2025 during the 7:00 AM to 3:00 PM shift identified bilateral top bed rails were being utilized.</p> <p>Record review failed to identify a care plan that directed use of the side rails.</p> <p>Interview with DON on 5/1/2025 at 2:50 PM identified the care plans for Resident #1 and Resident #3 did not include a side rail indication or include side rail use. The DON identified all residents should have care plans reflecting the use of side rails. The DON was unable to indicate why Resident #1 and Resident #3's care plans did not include use of side rails.</p> <p>Review of the Side Rail Policy dated 5/2017 directed in part, upon admission, re-admission, significant change, a change in bed mobility, and as needed, the resident will be evaluated for the need for partial side rails to assist with bed mobility. The resident/significant other/responsible party will be provided with education regarding the decision on use of partial side rails to assist with bed mobility. The use of side rails or partial side rails will be documented on the resident's plan of care.</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation review, facility policy review, and interviews for four of four residents (Resident #1, #2, #3, and #4) reviewed for quality of care, the facility failed to provide education and obtain consents for use of bed rails, and the facility failed to date completed bed rail testing/audits, and failed to perform bed rail audits at six-month intervals in accordance with facility policy, and failed to ensure staff accurately performed a side rail test for risk of entrapment per device manufacture guidelines. The findings include:</p> <p>1.</p> <p>A.</p> <p>Resident #1's diagnoses included dementia and contractures.</p> <p>Physician order dated 1/28/2025 directed to provide half side rails on every shift.</p> <p>The Significant Change Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of zero out of fifteen (0/15), indicative of severe impaired cognition and was dependent with ADLs (activities of daily living). The Resident Care Plan (RCP) dated 2/15/2025 identified Resident #1 had an ADL self-care deficit related to dementia. Interventions directed required staff to turn and reposition in bed and allow staff to maximize independence with turning and repositioning in bed.</p> <p>A nursing side rail quarterly evaluation dated 2/15/2025 identified Resident #1's side rail/grab bar recommendation was to use bilateral side rails. The side rail/grab bar decision indicated that the side rail(s) were indicated and serve as an enabler to promote independence at this time.</p> <p>Review of Resident #1's clinical record failed to identify a consent was obtained for bed rail use.</p> <p>B.</p> <p>Resident #2's diagnoses included dementia with behavior disturbance and anxiety disorder.</p> <p>The Quarterly MDS assessment dated [DATE] identified Resident #2 had a BIMS score of twelve out of fifteen (12/15), indicative of moderately impaired cognition and was independent with ADLs.</p> <p>A nursing side rail quarterly evaluation dated 2/28/2025 identified Resident #2's side rail/grab bar recommendation was side rails were not indicated at this time.</p> <p>The RCP dated 3/7/2025 identified Resident #2 had an ADL self-care deficit related to dementia, arthritis, left shoulder pain, and weakness. Interventions directed use of side rails to include one (1) grab bar and one and half (1 &frac12;) side rails on the window side of the bed.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Physician order dated 4/28/2025 directed to provide one (1) grab bar and one (1) half side rail (window side) to assist with bed mobility.</p> <p>Intermittent observations on 4/30/2025 and 5/1/2025 during the 7:00 AM to 3:00 PM shift identified bilateral top bed rails were being utilized.</p> <p>Review of Resident #2's clinical record failed to identify consent of bed rail use was obtained.</p> <p>C.</p> <p>Resident #3's diagnoses included thrombocytosis, dementia and cerebral infarction.</p> <p>Physician order dated 2/6/2025 directed to provide two (2) quarter side rails bilaterally on every shift.</p> <p>A nursing side rail quarterly evaluation dated 3/20/2025 identified Resident #3's side rail/grab bar recommendation was to use bilateral grab bars. The side rail/grab bar decision indicated that the side rail/grab bars were indicated and serve as an enabler to promote independence at this time.</p> <p>The Quarterly MDS assessment dated [DATE] identified Resident #3 had a BIMS score of thirteen out of fifteen (13/15), indicative of cognitively intact and required assistance with ADLs.</p> <p>The RCP dated 4/2/2025 identified Resident #3 has an ADL self-care deficit related to dementia with the inability to initiate or follow through consistently. Interventions directed assist with ADLs and was independent for bed mobility and moving side to side.</p> <p>Intermittent observations on 4/30/2025 and 5/1/2025 during the 7:00 AM to 3:00 PM shift identified bilateral top bed rails were being utilized.</p> <p>Review of Resident #3's clinical record failed to identify consent of bed rail use was obtained.</p> <p>D.</p> <p>Resident #4's diagnoses included Parkinson's disease, dementia, and morbid obesity.</p> <p>Physician order dated 2/11/2025 directed to provide two (2) quarter side rails.</p> <p>The Quarterly MDS assessment dated [DATE] identified Resident #4 had a BIMS score of zero out of fifteen (0/15), indicative of severely impaired cognition and was dependent with ADLs.</p> <p>The RCP dated 4/7/2025 identified Resident #4 required assistance with bed mobility. Interventions directed two (2) &frac14; side rails up as ordered while in bed</p> <p>A nursing side rail quarterly evaluation dated 4/7/2025 identified Resident #4's side rail/grab bar recommendation was bilateral side rails. The side rail/grab bar decision indicated that the side rails were indicated and serve as an enabler to promote independence at this time.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review failed to identify the resident and/or family were educated on the risks associated with side/grab bar use.</p> <p>Intermittent observations on 4/30/2025 and 5/1/2025 during the 7:00 AM to 3:00 PM shift identified bilateral top bed rails being utilized.</p> <p>Review of Resident #4's clinical record failed to identify consent of bed rail use was obtained.</p> <p>Interview and record review with DON (Director of Nursing) on 5/1/2025 at 2:50 PM identified residents and/or the responsible parties should be provided education regarding use of side rails, and consents should be obtained. The DON indicated she had reviewed Resident #1, #2, #3, and #4's records, and was unable to provide documentation that education was provided and that consents were obtained for the use of the bedrails/side rails. The DON identified she was informed that the previous DON had removed the consent for bedrails that had been located within the admission paperwork, and indicated that was why the residents did not have consent paperwork.</p> <p>Review of the Side Rail Policy dated 5/2017 directed in part, The resident/significant other/responsible party will be provided with education regarding the decision on use of partial side rails to assist with bed mobility. The Policy further directed, use of partial side rails will be documented on the resident's plan of care.</p> <p>2.</p> <p>Review of facility documentation for Resident #1, #2, #3, and #4's bed, mattress, side rail, entrapment and safety audit form identified all resident's beds had passed inspection in March and April 2025 and May 2024. Additionally, there was no date listed on any of the audit forms.</p> <p>Documentation review failed to identify the side rails were audited twice a year.</p> <p>Interview with DOM (Director of Maintenance) on 5/1/2025 at 1:45 PM identified he performs the audits on the bed rails annually. The DOM indicated if there is an open time in his schedule to perform the audits on a random basis (the beds are not assigned a scheduled time), he will conduct them, but he does not document the dates of the audits on the paperwork. The DOM was unable to provide documentation of the dates that the beds were audited.</p> <p>Review of the Bed and Side Rail Safety, Assessment, and Audit Policy dated 8/01/2023 directed in part, twice annually, at six-month intervals, and as needed, the residential site manager, or the manager's designee, shall visibly assess the bed and side rails, using the Bed and Side Rail Safety Checklist. Any issues identified in the checklist shall be documented by the person completing the checklist along with a proposed plan to address the identified issues.</p> <p>3.</p> <p>Observation of Resident #3's bed on 4/30/2025 at 12:45 PM identified the left upper side railing was loose and was able to extend outward by approximately three (3) to four (4) inches.</p> <p>Interview with DOM on 4/30/2025 at 1:30 PM identified the facility utilized the Bionix B4000 Bed System Measurement Device (BSMD) to perform entrapment assessments on all resident beds.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the Bionix B400 BSMD instruction manual for Zone 3 (side rail zone) directed in part the following instructions: 1. Firmly push the mattress away from the rail being measured until it stops. 2. Put the cone near the rail being tested and attach the safety strap. 3. Put the cone horizontally in the gap. Do not push the tool down into the gap. 4. Turn the cone until the line on the end is horizontal. 5. Let the cone sink into the space by its own weight. If the cone is tilted, use one hand to gently level it. Do not push the tool down in the gap. 6. Determine whether the cone's center sinks completely below the surface of the mattress. 7. Interpret test results and record the results on the data sheet.</p> <p>Interview and observation of an audit of the Bionix B4000 BSMD guidelines performed on Resident #3's bed on 4/30/2025 at 2:00 PM with the DOM identified DOM did not accurately perform Zone 3 of the testing requirements. The DOM did not follow the manufacture guidelines for Zone 3, and instead, the test DOM performed was indicated for Zone 4. The test for Zone 3 was not performed.</p> <p>Subsequent to surveyor inquiry, Resident #3's bed side railing was fixed, prior to retesting for Zone #3 on 5/1/2025.</p> <p>Interview with DOM on 5/1/2025 at 1:45 PM identified although he did not test Zone #3 accurately, he believed Resident #3's bed passed the test due to all other zones had passed the testing/audit and met the expected range of distance allowed of 4 &frac34; (four and three-quarter) inches within the gaps. The DOM was unable to explain how the bed would pass if Zone 3 was not tested.</p>		