STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075437	A. Building B. Wing	09/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avalon Health Care Center at Stoneridge	186 Jerry Browne Road Mystic, CT 06355

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47900 Based on observations, review of the clinical record, review of facility documentation, review of facility policy/procedures and interviews for one sampled resident (Resident #8) reviewed for positioning and range of motion, the facility failed to develop a comprehensive care plan to address the specific type of assistive device being utilized, how often the device should be worn, and the general care or monitoring of the device as it relates to the resident. The findings include: Resident #8 was admitted to the facility in August of 2024 with diagnoses that included rheumatoid arthritis of the left elbow, right pubis fracture, muscle weakness, and multiple rib fractures. The admission MDS assessment dated [DATE] identified Resident #8 was cognitively intact, had impaired range of motion to bilateral upper and lower extremities. It further identified the resident was dependent on staff for personal hygiene, lower body dressing, toileting hygiene, transfers, mobility, was non-ambulatory and utilized a wheelchair. Observation on 9/23/24 at 10:34 AM identified Resident #8 seated in a chair with an overbed table positioned in close proximity in front of him/her with a black colored splint that encompassed most off the upper and lower portion of the left arm. The resident identified that the splint was worn during the day and removed at bedtime. A review of the physician's orders for August/2024 failed to address the use of a splint to the left arm. A review of the care plan dated 8/23/24 failed to identify Resident #8 utilized a splint addressed the application of the splint and removal of the splint, and/or when to check the integrity of the resident's skin as it relates to the use of the splint. Resident #8's nurse aide care card failed to identify the use of the splint. Observation on 9/24/24 at 11:02 AM identified Resident #8 seated in a chair with the overbed table positioned in close proximity in front of the resident, with the black colored splint in place to the left arm. Observation on 9/26/24 at 9:54 AM identified Resident #8 was lying in bed with the black colored splint in place to the left arm. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation with the Charge Nurse (RN #4) on 9/26/24 at 11:29 AM identified Resident #8 lying in bed with the splint in place to the left arm. Interview with the day-shift Nursing Supervisor (RN #3) on 9/26/24 at 11:37 AM identified that the physician's orders did not contain an order directing the use of the splint to the left arm and the care plan also did not reflect the use of the splint. RN #3 further identified that a physician's order, the care plan, and the nurse's aide care card should reflect when the splint is to be applied, and removed, and to check the resident's skin integrity. Interview with NA #2 on 9/26/24 at 11:40 AM identified she applied the splint to the left arm as Resident #8 requested. NA #2 identified that when a resident utilizes a splint, it is usually written in the NA care card. Interview with the MDS Coordinator (RN #5) on 9/26/24 at 12:10 PM identified that he was responsible for completing the comprehensive care plans within 14 days after the resident is admitted to the facility. He also identified that Resident #8 should have had a physician's order for the use of the splint as the physician's order directs the care of the resident which is added to the care plan. RN #5 indicated that the physician's order would direct how and when to apply the splint, and the checking of skin integrity. Further, RN #5 was unable to identify why the care plan lacked the inclusion of the splint as it should have included the splint, as it was a part of Resident #8's care routine. Interview with the Occupational Therapy Assistant (OTA #1) on 9/26/24 at 12:00 PM identified that when a resident is admitted to the facility with a splint, the nursing staff is supposed to notify the therapy department for the device to be evaluated. OT #1 further identified that a physician's order would be required for the use of the splint to direct the appropriate care for the resident. Interview with the DNS on 9/26/24 at 12:28 PM identified that Resident #8 should have had a care plan and a physician's order directing the use of the splint to the left arm. The DNS identified that it was the responsibility of therapy to ensure that a physician's order was in place after they evaluated the resident and trained the staff on how to apply and remove the splint. She further identified that the splint was visible to staff, hence if the resident brought the assistive device in the facility after admission, it was the responsibility of the nurses to ensure that therapy was aware, and orders were in place. The DNS identified that the care plan should have been completed to indicate the use of the splint, when to apply and remove the splint, and for the checking of the skin on applying and removing of the splint. Interview with the Occupational Therapist (OT #2) and the Director of Rehabilitation on 9/27/24 at 11:40 AM identified that OT #2 completed Resident #8's admission evaluation and identified that Resident #8 utilized a splint to the left arm for positioning and comfort, following a surgery to the left elbow years ago. OT #2 further identified that she applied the splint to the left arm in the morning when caring for the resident. OT #2 identified that she had told the Director of Rehabilitation that Resident #8 utilized a splint but had not provided training to the staff. The Director of Rehabilitation identified that OT #2 mentioned that Resident #8 utilized a splint but assumed that she had followed the procedures that included an evaluation, and training of the staff. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Comprehensive Care Plan policy identified that the facility is to develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The policy further identified that assessments are ongoing, and care plans are revised as information about the resident and resident's conditions change. Review of the Assistive Device and Equipment policy identified that recommendation for the use of devices and equipment are based on comprehensive assessment and documented on the resident care plan.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17723 Based on observations, review of the clinical record, review of facility documentation, review of facility policy/procedures and interviews for one sampled resident (Resident #8) reviewed for positioning and range of motion, the facility failed to ensure a physician's order was in place directing the use of an assistive device. The findings include: Resident #8 was admitted to the facility in August of 2024 with diagnoses that included rheumatoid arthritis of the left elbow, right pubis fracture, muscle weakness, and multiple rib fractures. The admission MDS assessment dated [DATE] identified Resident #8 was cognitively intact, had impaired range of motion to bilateral upper and lower extremities. It further identified the resident was dependent on staff for personal hygiene, lower body dressing, toileting hygiene, transfers, mobility, was non-ambulatory and utilized a wheelchair. Observation on 9/23/24 at 10:34 AM identified Resident #8 seated in a chair with an overbed table positioned in close proximity in front of him/her with a black colored splint that encompassed most off the upper and lower portion of the left arm. The resident identified that the splint was worn during the day and removed at bedtime. A review of the physician's orders for August/2024 failed to address the use of a splint to the left arm. A review of the care plan dated 8/23/24 failed to identify Resident #8 utilized a splint addressed the application of the splint and removal of the splint, and/or when to check the integrity of the resident's skin as it relates to the use of the splint. Resident #8's nurse aide care card failed to identify the use of the splint. Observation on 9/24/24 at 11:02 AM identified Resident #8 seated in a chair with the overbed table positioned in close proximity in front of the resident, with the black colored splint in place to the left arm. Observation on 9/26/24 at 9:54 AM identified Resident #8 was lying in bed with the black colored splint in place to the left arm. Observation with the Charge Nurse (RN #4) on 9/26/24 at 11:29 AM identified Resident #8 lying in bed with the splint in place to the left arm. Interview with NA #3 on 9/26/24 at 11:20 AM identified that the nurses' aides apply splints and other assistive devices after therapy provides them with training, she further noted that after training, it is placed on the care cards. In addition, she noted that sometimes therapy applies the splint and removes the splint. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and review of Resident #8's physician's orders and administration records with RN #4 on 9/26/24 at 11:29 AM failed to reflect a physician's order directing the use of a splint to the left arm. RN #4 identified that whenever a resident utilized a splint a physician's order should be in place that directed how and when the splint should be worn, and when to complete skin checks. RN #4 identified that she had not applied the splint that morning, and assumed the resident had a physician's order. She further identified that it would have been the responsibility of the admitting nurse to obtain an order. Interview and review of Resident #8's clinical record with the day-shift Nursing Supervisor (RN #3) on 9/26/24 at 11:37 AM failed to reflect physician's orders directing the use of the splint to the left arm. RN #3 identified that a physician's order, should have been completed to indicate when the resident to wear the splint, to check skin integrity and when to remove for care, as it was a part of the resident's care. Interview with the NA #2 on 9/26/24 at 11:40 AM identified that she was the nurse aide who took care of Resident #8 and had applied the splint to his/her left arm on all the days she worked since the beginning of the week, which was Monday, Wednesday and Thursday, as the resident had requested the splint to be applied. NA #2 identified that if a resident utilized a splint or splint it would be written in the electronic nurse's aide care card. However, upon reviewing the nurse aide care card of resident #8's with NA #2, she failed to identify on the care card that Resident #8 utilized a splint to the left arm. Interview with the Occupational Therapist Assistance (OT #1) on 9/26/24 at 12:00 PM identified that when a resident utilizes a splint/splint at home and it is brought into the facility, the nursing staff should notify the therapy department for it to be evaluated. OT #1 was asked if a physician's order would be needed if the splint was not a part of the occupational therapy care goals, which she identified that a physician's order would be required as the order would direct how and when to apply and remove the device and when to check the resident's skin integrity. OT #1 identified that an order was necessary so that staff would be able to provide the resident with the appropriate care when utilizing the assistive device to meet the goal/purpose of the device usage. Interview with the DNS on 9/26/24 at 12:28 PM identified that Resident #8 should have had a physician's order directing the use of the splint to the left arm. The DNS identified that it was the responsibility of therapy to ensure that a physician's order was in place after they had evaluated the resident and trained the staff on how to apply and remove the splint. She further identified that the splint was visible to staff, and it was the responsibility of the nurses to ensure that therapy was aware, and orders were in place. Interview with the Charge Nurse (LPN #1) on 9/27/24 at 10:33 AM identified that she had observed Resident #8 wearing the splint to the left arm since admission to the facility and had assumed that all the necessary paperwork was completed (physician's order, nurse's aide care card, and care plan) and in place. Interview with the DNS on 9/27/24 at 11:10 AM identified that although the policy does not mention the requirement of a physician's order for assistive devices, it is the practice of the facility to have a physician's order in place along with a therapy evaluation, and education provided to staff. (continued on next page)

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Occupational Therapist (OT #2) and the Director of Rehabilitation on 9/27/24 at 11:40 AM identified that OT #2 completed Resident #8's admission evaluation and identified that Resident #8 utilized a splint to the left arm for positioning and comfort, following a surgery to the left elbow years ago. OT #2 further identified that she applied the splint to the left arm in the morning when caring for the resident. OT #2 identified that she had told the Director of Rehabilitation that Resident #8 utilized a splint but had not provided training to the staff. The Director of Rehabilitation identified that OT #2 mentioned that Resident #8 utilized a splint but assumed that she had followed the procedures that included an evaluation, and training of the staff followed by a written order in the resident's chart as this was the facility's practice. Review of the Assistive Devices and Equipment policy identified that the facility would maintain and supervise the use of assistive devices and equipment for residents.

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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 0689 Level of Harm - 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** 46117 Based on clinical record review, review of facility documentation, review of facility policy, and interviews for one of three sampled residents (Resident #3) reviewed for accidents, the facility failed to ensure the wheelchair leg rests were in place during resident transport resulting in a fall with injury. The findings include: Resident #3's diagnoses included Parkinson's disease, fibromyalgia, hypertension, and anemia. The care plan dated 4/19/24 identified Resident #3 was at risk for falls related to decreased mobility and history of falls. Care plan interventions directed to encourage resident to wear appropriate footwear when ambulating or mobilizing in wheelchair, be sure the call light is within reach, physical and/or occupational therapy as ordered, and monitor and document to ensure appropriate use of safety and assistive devices. The admission MDS assessment dated [DATE] identified Resident #3 had intact cognition and required extensive assistance with bed mobility, dressing, toileting, hygiene, and transfers. It further identified the resident utilized a wheelchair and was dependent on staff for mobility. The fall risk assessment dated [DATE] identified Resident #3 at risk for falls. The nurse's notes dated 6/22/24 at 6:40 PM identified Resident #3 was being transported in the wheelchair from the dining room by the NA #1 back to his/her room when he/she put his/her right foot on the floor and Resident #3 fell forward from the wheelchair in the hallway. Resident #3 remained alert and oriented but forgetful, vital signs were noted as; blood pressure: 180/80, heart rate: 88 respirations:18. Resident #3 had 2 skin tears above his/her eye brow. The first skin tear was documented as 2.5 centimeters (cm) in length by 0. 5 cm in width and the second skin tear was documented as 0.5 cm in length by 0.4 cm in width. Resident #3 complaint of a severe throbbing headache. The physician was notified the accident ordered the resident be sent to the hospital for evaluation. The Responsible party was also notified and agreed with the plan of care. The facility's accident and incident report dated 6/22/24 at 6:40 PM identified that during the transport and Resident #3's subsequent fall from the wheelchair, the wheelchair did not have the leg rests in place. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The hospital admission history and physical dated 6/22/24 at 11:50 PM identified Resident #3 was admitted from the skilled nursing facility after sustaining a fall from a wheelchair. Resident #3 identified that he/she was being transported in the wheelchair by the facility staff and he/she put his/her right foot down while the wheelchair was in motion and was thrown from the wheelchair. Resident #3 hit his/her head, but did not lose consciousness and sustained a 2 cm laceration to the left eye brow which was approximated with derma bond (medical glue) for wound closure. The documentation further noted that a Computed Tomography (CT)-scan of the head was performed (an imaging procedure to create a detailed picture of the organ) and identified an acute subdural hematoma along the left cerebral convexity that measured 3 millimeter (mm) in thickness. There was no evidence of mass effect or midline shift. A CT-scan of the head, face, and neck were also done, and all diagnostic imaging tests did not indicate any bone fractures. The hospital treatment plan included admitting Resident #3 to the trauma unit, obtaining a neurosurgical consult, a repeat of the CT-scan of the head in 6 hours and Keppra (anti-seizure medication) 500mg by mouth twice a day for 7 days. The hospital neurosurgery consultation notes dated 6/23/24 at 11:42 AM identified Resident #3 was admitted for observation and repeat CT-scan of the head was done to verify the subdural hematoma. The repeat CT-scan of the head did not identify a concern for subdural hematoma, Keppra was discontinued, and no neurosurgical intervention follow-up was recommended. The hospital discharge summary dated 6/23/24 at 12:44 PM identified Resident #3 remained stable, and the repeat CT-scan of the head did not identify a concern with the subdural hematoma and no neurosurgical intervention follow-up was recommended. The nurse's note dated 6/23/24 at 3:30 PM identified Resident #3 was readmitted to the facility. Interview with RN #1 (3-11 shift nursing supervisor) on 9/24/24 at 10:15 AM identified NA#1 was transporting Resident #3 from the dining room to his/her room when the accident occurred. She identified that Resident #3 did not have the leg rests on the wheelchair. She also identified that Resident #3 fell forward when he/she put his/her right foot on the floor, fell forward to the floor out of the wheelchair and hit his/her head on the floor. She identified that Resident #3 was able to self-propel for short distances and that it is the facility's policy to transport with leg rests in place to prevent injuries to residents. RN #1 further noted that Resident #3 refused to have the leg rests on the wheelchair at the time of the accident. Interview with PTA #1 (rehab director) on 9/26/24 at 10:30 AM identified that leg rests should always be used when transporting a resident in a wheelchair. She identified that a risk of injury could occur if a resident does not use leg rests while being transported in the wheelchair. She further identified Resident #3's accident could have been avoided if the leg rests were used during the wheelchair transport. She further identified the staff should re-approach a resident, re-direct resident attention and/or staff assistance from the other staff when a resident refuses to use leg rests during wheelchair transport. She identified that Resident #3 was able to self-propel in his/her wheelchair for short distances. She further identified that she was not aware that Resident #3 had refused his/her leg rests when being transported in the wheelchair. (continued on next page)

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Interview with NA #2 (7-3 shift nursing aide) on 9/26/24 at 1:00 PM identified that Resident #3 has never refused to use the wheelchair leg rests when she has transported the resident. She identified that the facility policy is to use the leg rests when a resident is being transported in the wheelchair. She identified that she never asks the residents' permission to place leg rests, but she explains to the resident that she is going to put his/her leg rests on the wheelchair for his/her safety. She further identified that she would let the nurse know if a resident refused to use the leg rests prior to transporting the resident. Interview with NA #1 (3-11 shift nursing aide) on 9/26/24 at 1:40 PM identified that she was transporting Resident #3 from the dining room to go back to his/her room without the leg rest on the wheelchair and Resident #3 put his/her right foot down on the floor when Resident #3 fell forward from his/her wheelchair near the recreation room. She identified that she transported Resident #3 in the wheelchair without leg rests because Resident #3 refused to use the leg rests. She identified that she did not attempt to put the leg rests on the wheelchair, but she asked Resident #3 whether he/she would like to use the leg rests. She further identified she was aware that the leg rests must be used while transporting residents in wheelchairs. Additionally, she identified that she did not let the nurse know that Resident #3 had refused to put the leg rests on the wheelchair, and she did not attempt to re-approach or re-direct Resident #3 when he/she refused the leg rests. Interview with Resident #3 on 9/27/24 at 10:15 AM identified that she could not recall the details of his/her fall from the wheelchair but identified that he/she had not refused to have his/her leg rests applied to the wheelchair. The Wheelchairs policy identified that in order to provide safe and comfortable transportation and to provide mobility for residents who are unable to walk the leg rests must be used during transport to prevent injury and when a resident refuses to use the leg rests, the staff should re-approach the resident.