

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075441	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2024
NAME OF PROVIDER OR SUPPLIER Springs at East Hill, The		STREET ADDRESS, CITY, STATE, ZIP CODE 611 East Hill Road Southbury, CT 06488	

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 0550</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 a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40172</p> <p>Based on review of the clinical record, facility documentation, facility policy, and interviews for one (1) of three (3) residents (Resident #2) reviewed for abuse, the facility failed to ensure the resident was treated with respect and dignity. The findings include:</p> <p>Resident #2 had diagnoses that included multiple sclerosis, generalized muscle weakness, need for assistance with personal care, and abnormalities of gait and mobility</p> <p>The quarterly admission MDS assessment dated [DATE] identified Resident #2 had intact cognition, was frequently incontinent of bowel, occasionally incontinent of bladder, and required moderate assistance with transfers and toileting.</p> <p>The care plan dated 10/28/23 identified Resident #2 had a diagnosis of multiple sclerosis with interventions that directed to provide the assistance of one with ADLs and ambulation.</p> <p>Review of Resident #2's undated care card identified Resident #2 required assistance of one with toileting and modified independence with ambulation using a rolling walker.</p> <p>Review of facility documentation identified a grievance form dated 11/3/23 identified Resident #2's daughter reported that when Resident #2 asked NA #2 to go to the bathroom NA #2 told Resident #2 h/she could go by h/herself. Resident #2's daughter reported on the way to the bathroom Resident #2 soiled h/herself. The grievance form further identified that SW #1 notified RN #2 (former DON) an investigation was initiated, DPH was notified, and NA #2 was taken off the schedule.</p> <p>The Facility Accident and Incident Report dated 11/3/23 at 4:00 P.M. identified Resident #2's daughter reported that when Resident #2 had asked NA #2 to take h/her to the bathroom NA #2 told the resident h/she could do it h/herself. Resident #2 voided on h/himself when ambulating to the bathroom.</p> <p>The facility's summary report dated 11/8/23 identified per statements obtained the allegations have been substantiated that NA #2 failed to honor Resident #2's request in a timely manner and assist to the bathroom.</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of NA #2's personnel file on 9/11/24 identified on 11/3/23 a resident family member put in a complaint that the resident was told to go by yourself to the restroom. NA #2 was the nurse aide caring for Resident #2 on 11/3/23 and Resident #2 is a one (1) person assist and should not be walking unattended. Although the resident required assistance, you left the resident's room, resulting in the resident attempting to go by h/herself to the restroom with assistance. NA #2 did return and assist Resident #2 after that. NA #2 was terminated on 11/3/23 for failure or refusal to render services to a resident within the normal scope of the associate's job duties.</p> <p>Interview with the DNS on 9/11/24 at 11:15 A.M. identified she would have expected NA #2 to assist Resident #2 to the bathroom when the resident as the resident required assistance of one staff member. The NA #2 should not have told Resident #2 to go by h/herself to the bathroom.</p> <p>Although attempted, an interview with NA #2 was not obtained.</p> <p>Review of facility's Resident Rights policy dated 2/24/2023 directed in part that the rights of residents are to be recognized by all staff members at all times, and residents assume their responsibilities to enable personal dignity, well-being, and proper delivery of care and the facility must treat each resident with respect and dignity.</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40172</p> <p>Based on review of the clinical record, facility documentation, facility policy, and interviews for one (1) of three (3) residents (Resident #1) reviewed for abuse, the facility failed to ensure the resident was free from verbal sexual abuse. The findings include:</p> <p>Resident #1 had diagnoses that included metabolic encephalopathy, retroperitoneal hematoma, generalized muscle weakness, and the need for assistance with personal care.</p> <p>A physician's order dated 7/27/24 directed to provide Resident #1 a shower on day/evening shift on Thursday 7-3 every day shift and Tuesday 3-11 every evening shift.</p> <p>The care plan dated 7/29/24 identified Resident #1 has an ADL self-care deficit related to post-op retroperitoneal hematoma with interventions that directed to encourage the resident to participate to the fullest extent possible with each interaction.</p> <p>The admission MDS dated [DATE] identified Resident #1 had moderately impaired cognition, was frequently incontinent of bowel, occasionally incontinent of bladder and required moderate assistance with ADLs.</p> <p>The undated care card identified Resident #1's shower days were on Thursday during the 7 A.M.-3 P.M. shift and on Tuesday during the 3 P.M. to 11 P.M. shift.</p> <p>Review of a Concern/Grievance Report dated 8/14/24 identified Resident #1's spouse filed the concern/grievance related to an issue that occurred on 8/13/24 at 7:30 P.M. in Resident #1's room. The description indicated when NA #1 was asked about Resident #1's shower in front of Resident #1's spouse NA #1 stated she would wash Resident #1's b*lls real good and get h/her h*rd and excited. Resident #1's spouse felt uncomfortable with statements said by NA #1 and RN #1 notified the DNS. The form identified the DNS was the individual who completed the form, an investigation was conducted, and the actions taken to resolve the issue and/or prevent the reoccurrence NA#1 removed from care setting out pending investigation, staff education and in servicing, reported to DPH, and Resident #1's spouse verbalized h/she was fine with the resolution.</p> <p>The Facility's Accident and Incident Report dated 8/14/24 at 3:30 P.M. identified an allegation was made that NA #1 verbalized sexually inappropriate comments to Resident #1 prior to giving a shower on 8/13/24 around 7:00 P.M. The initial report did not expand upon the topic fully when the DNS was notified of the verbal interaction; however, after an interview with Resident #1's spouse on 8/13/24 at 3:30 P.M. more information was ascertained.</p> <p>The facility's summary report dated 8/16/24 identified the facility substantiated the allegation the date of the event and time of the event was 8/13/24 at 7:00 P.M. NA #1 made sexually inappropriate comments to Resident #1 on how she was going to give h/her a shower that evening. The findings identified the allegation was substantiated and NA #1 was terminated.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with NA #3 on 9/11/24 at 10:37 A.M. identified on 8/13/24 at approximately 7:00 P.M. Resident #1's spouse asked what day the resident's shower was he replied it was that evening. NA #3 identified NA #1 who was assigned to Resident #1 then stated to Resident #1 I am going to scrub those b*lls and told h/her spouse to get h/her h*rd and excited. NA #3 indicated NA #1 repeated this to Resident #1 three (3) times then walked away while he and LPN #2 were standing there. NA #3 identified Resident #1's spouse told him and LPN #2 that h/she was not comfortable with NA #1 giving Resident #1 a shower. NA #3 identified later in the evening during rounds he heard water running in the shower room and observed NA #1 showering Resident #1.</p> <p>Interview with the DNS on 9/11/24 at 11:15 A.M. identified on 8/13/24 she was notified by RN#1 (3 P.M.-11 P. M. supervisor) at approximately 7:00 P.M. that NA #1 had an inappropriate interaction with Resident #1 regarding h/her shower. The DNS indicated RN #1 reported NA #1 said to Resident #1 she was going to wash h/her b*lls real good and Resident #1's spouse wanted to discuss the interaction further with her tomorrow. The DNS identified she directed that RN #1 remove NA #1 from caring for Resident #1 for the remainder of the shift and RN #1 agreed and she would follow through. The DNS identified although on 8/13/24 she directed RN #1 to remove NA #1 from Resident #1's assignment for the remainder of the shift she was aware that NA #1 did shower Resident #1 on 8/13/24 and the DNS could not explain why. The DNS indicated on 8/14/24 she met with Resident #1's spouse who provided further information regarding the interaction between NA #1 and Resident #1. The DNS identified Resident #1's spouse reported when h/she asked about the shower schedule NA #3 stated Resident #1's shower was tonight and NA #1 said she was going to scrub Resident #1's b*lls real good, directed Resident #1's spouse to get him h*rd and excited, and NA #1 was also singing in the hallway she liked to wash naked men. The DNS identified once she was aware of the context and all the comments NA #1 made to Resident #1, she immediately imitated an investigation, notified DPH, and the police. The DNS identified based on her investigation the allegation of verbal sexual abuse was substantiated and NA #1 was terminated.</p> <p>Interview with RN #1 (3 PM - 11 PM supervisor) on 9/11/24 at 11:50 A.M. identified on 8/13/24 she overheard a conversation between LPN #2 and NA #3 about an incident that happened between NA #1 and Resident #1 regarding h/her shower. RN #1 identified LPN #2 and NA #3 said that NA #1 told Resident #1 I will wash your b*lls real good RN #1 indicated she notified the DNS on 8/13/24 around 7:00 P.M. that NA #1 had an inappropriate interaction with Resident #1 regarding h/her shower and NA #1 said to Resident #1. RN #1 identified the DNS directed that NA #1 was not to provide a shower to Resident #1. RN #1 indicated she spoke with NA #1 and told her she was not to shower Resident #1 and NA #3 was directed to shower Resident #1. RN #1 identified although she directed NA #1 not to give Resident #1 a shower that evening NA #1 gave Resident #1 a shower anyway. RN #1 indicated once she was aware that NA #1 gave Resident #1 a shower, she went to see Resident #1. RN #1 indicated she spoke Resident #1 h/she felt safe and declined NA #1 be removed from h/her assignment.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with LPN #2 (3 PM- 11 PM charge nurse) on 9/11/24 at 12:00 P.M. identified on 8/13/24 while NA #1 was speaking to Resident #1 about a shower she heard NA #1 say only three words penis, shower, and hard. LPN #2 identified she did not know the context of NA #1's conversation with Resident #1 and did not think it was unusual when she heard NA #1 use the three words. LPN #2 indicated shortly after she heard NA #1 speaking to Resident #1 on 8/13/24 between 7:00 - 7:30 P.M. Resident #1's spouse stopped her in the hallway, expressed concerns h/she had regarding NA #1. LPN #2 identified Resident #1's spouse asked her if NA #1 was always like this making inappropriate comments. LPN #2 indicated Resident #1's spouse did not provide any additional information what comments were made by NA #1. LPN #2 identified she offered to provide Resident #1 with a different NA, but Resident #1's spouse declined. LPN #2 identified she notified RN #1 that Resident #1's spouse was uncomfortable with NA #1 and RN #1 notified the DNS.</p> <p>Review of facility abuse, neglect, injuries of unknown origin, misappropriation of property, and exploitation policy dated 6/25/2024 directed in part, identified verbal abuse is the willful use of oral, written, or gestured language that includes disparaging and derogatory terms to residents and their families and mental abuse includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32738</p> <p>Based on review of the clinical record, facility documentation, facility policy, and interviews for one (1) of three (3) residents (Resident #1) reviewed for abuse, the facility failed to ensure that an employee was suspended after alleged verbal abuse. The findings include:</p> <p>Resident #1 had diagnoses that included metabolic encephalopathy, retroperitoneal hematoma, generalized muscle weakness, and the need for assistance with personal care.</p> <p>A physician's order dated 7/27/24 directed to provide Resident #1 a shower on day/evening shift on Thursday 7-3 every day shift and Tuesday 3-11 every evening shift.</p> <p>The care plan dated 7/29/24 identified Resident #1 has an ADL self-care deficit related to post-op retroperitoneal hematoma with interventions that directed to encourage the resident to participate to the fullest extent possible with each interaction.</p> <p>The admission MDS dated [DATE] identified Resident #1 had moderately impaired cognition, was frequently incontinent of bowel, occasionally incontinent of bladder and required moderate assistance with ADLs.</p> <p>The undated care card identified Resident #1's shower days were on Thursday during the 7 A.M.-3 P.M. shift and on Tuesday during the 3 P.M. to 11 P.M. shift.</p> <p>Review of a Concern/Grievance Report dated 8/14/24 identified Resident #1's spouse filed the concern/grievance related to an issue that occurred on 8/13/24 at 7:30 P.M. in Resident #1's room. The description indicated when NA #1 was asked about Resident #1's shower in front of Resident #1's spouse NA #1 stated she would wash Resident #1's b*lls real good and get h/her h*rd and excited. Resident #1's spouse felt uncomfortable with statements said by NA #1 and RN #1 notified the DNS. The form identified the DNS was the individual who completed the form, an investigation was conducted, and the actions taken to resolve the issue and/or prevent the reoccurrence NA#1 removed from care setting pending investigation, staff education and in servicing, reported to DPH, and Resident #1's spouse verbalized h/she was fine with the resolution.</p> <p>The Facility's Accident and Incident Report dated 8/14/24 at 3:30 P.M. identified an allegation was made that NA #1 verbalized sexually inappropriate comments to Resident #1 prior to giving a shower on 8/13/24 around 7:00 P.M. The initial report did not expand upon the topic fully when the DNS was notified of the verbal interaction; however, after an interview with Resident #1's spouse on 8/13/24 at 3:30 P.M. more information was ascertained.</p> <p>(continued on next page)</p>		

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