

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075442	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/07/2024
NAME OF PROVIDER OR SUPPLIER 60 West		STREET ADDRESS, CITY, STATE, ZIP CODE 60 West Street Rocky Hill, CT 06067	

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 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47460</p> <p>Based on clinical record review, facility documentation review, and interviews for one of three residents (Resident #4) reviewed for abuse, the facility failed to ensure the clinical record was complete and accurate to include documentation of every 15-minute observations. The findings include:</p> <p>Resident #4's diagnoses included dementia, and schizoaffective disorder. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified that Resident #4 was severely cognitively impaired and had no behaviors.</p> <p>Review of the facility Reportable Event Form dated 7/22/2024 at 8:35 PM identified Resident #4 was involved in a resident-to-resident incident on 7/22/2024 at 7:15 PM. The residents were separated, and Resident #4 was placed on every 15-minute checks.</p> <p>A nursing note dated 7/22/2024 at 9:02 PM identified Resident #4 was involved in a resident-to-resident incident on 7/22/2024 at 7:15 PM. The residents were separated, and Resident #4 was placed on every 15-minute checks.</p> <p>Review of facility Every 15-minute Flowsheet dated 7/23/2024, directed the reason for observation was an altercation with another resident. Review identified during the 7 AM to 3 PM shift, LPN #2 failed to document every 15-minute checks were completed at 1:30, 1:45, 2:00, 2:15, 2:30, 2:45 and 3:00 PM, (7 out of 32 times).</p> <p>Interview and clinical record review on 8/7/2024 at 1:48 PM with LPN #2 stated he/she completed the every 15-minute checks on 7/23/2024 during the 7 AM to 3 PM shift. LPN #2 stated she forgot to complete the documentation for 1:30, 1:45, 2:00, 2:15, 2:30, 2:45 and 3:00 PM, and stated he/she should have completed the form.</p> <p>Interview and clinical record review with the DNS on 8/7/2024 at 2:06 PM identified LPN #2 should have documented the every 15-minute checks on the form.</p> <p>Although a documentation policy was requested, interview with RN #1 on 8/7/2024 at 10 AM identified the facility did not have a documentation policy.</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
---	-------	-----------