STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075198	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/12/2025
NAME OF PROVIDER OR SUPPLIER Village Green Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 23 Fair Street Bristol, CT 06010	

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, review of policy and staff interviews for 1 of 1 resident (Resident # 2) reviewed for elopement, the facility failed to conduct elopement evaluations per facility policy and for 1 of 7 residents (Resident #124) reviewed for accidents, the facility failed to ensure a comprehensive care plan was in place for a resident with a history of seizures and for 1 of 4 for residents (Resident # 224) reviewed for Respiratory Care, the facility failed to ensure a comprehensive care plan for resident requiring respiratory care was develop. The findings included : 1. Resident #2's diagnosis included dementia with behavioral disturbances. An eMAR-Administration note dated 9/22/2023 at 2:50 PM directed to check the placement of the resident's Wander guard bracelet on the left ankle (a bracelet that alarms if a resident seeks to exit through a door that is equipped to detect the alarm). The documentation further indicated the wander guard was discontinued. An elopement evaluation dated 9/22/2023 at 3:09 PM indicated Resident #2 was able to walk and self-propel in wheelchair independently and has a history of wandering and elopement. Additionally, the evaluation noted the resident does not show one or more emotional states or behaviors that may result in exit seeking behavior. A general progress note dated 9/22/2023 at 3:21 PM indicated in part Resident #2 did not exhibit any elopement behaviors or made any verbal statement of wanting to leave the facility and per conversations with the nurse aides and other staff members Resident #2 had made no attempts to leave. The physician was updated, and an order was received to discontinue the use of the Wander guard bracelet alarm. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated in part Resident #2 was severely cognitive impairment, requires partial/moderate assistance of staff to ambulate 10 feet, uses a manual wheelchair requiring partial/moderate assistance to wheel 50-150 feet and no behaviors of wandering were exhibited. The care plan dated 2/18/2025, indicated in part, Resident #2 was at risk for elopement related to dementia. Interventions included to utilize and monitor code alert to left ankle, divert resident by giving alternative objects or activities. An interview and record review on 3/12/2025 at 10:56 AM with RN #4 the acting Director of Nursing Services (DNS) indicated not knowing why the elopement evaluation dated 9/22/2023 did not indicate a (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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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	score to determine the level of risk for elopement and she/he was unsure how the risk of elopement is determined using the evaluation once completed. RN# 4 further indicates she/he was aware elopement evaluation is completed on admission but unsure of its frequency after. RN #4 verified the last elopement evaluation was completed on 9/22/2023 indicating a history of elopement, having a wander guard but it was discontinued due to Resident #2 made no attempts to leave the facility. RN #4 further indicated Resident #2 was no longer at risk as h/she got out of bed in an adaptive type of wheelchair and could not wheel self in the wheelchair. The facility policy labeled Elopement of Patient dated 4/15/2025 indicated in part a Resident's elopement risk would be determined on admission, re-admission, quarterly and with a significant change in condition. 2. Resident #124 had diagnoses that included a history of epilepsy. The admission MDS assessment dated [DATE] identified Resident #124 was severely cognitively impaired with a BIMS of 4, required assistance of one with bed mobility, total assistance of two for transfers and toileting. The care plan dated 5/13/24 identified Resident #124 had impaired cognitive function, required assistance with ADL care and was at risk for falls. Interventions included : monitoring changes in cognitive function, providing assistance of one with ADL, assistance of two with transfers and to ensure the call bell was within reach. The care plan did not include a problem related to a history of seizure and interventions to reduce accident risks. A Reportable Event Summary dated 6/17/24 identified NA #7 reported during care the resident's body started to flop a lot. NA #7 checked to make sure the resident was receiving oxygen when his/her leg was noted off the side of the bed. NA #7 was unable to catch the resident's leg. The care plan was revised to include an air mattress/bed with bolsters. An interview with Nurse Practitioner (NP #1) on 3/11/25 at 8:43 AM identified her/her documentation occasionally noted Resident #124 was placed on seizure precautions and included padded rail when in use. NP #1 further identified that although she did not suspect a seizure at the time Resident #124 fell out of bed, a seizure protocol should be followed for any resident with a history of seizure activity. An interview with the DNS on 3/11/25 at 10:58 AM identified a care plan should have been in place that included padded while in bed. An interview with RN #4 identified she/he was responsible for completing the MDS assessments and participated in the development of resident care plans. RN #4 further identified any seizure protocol would be included in an individualized care plan and Resident #124 should have had a care plan in place for seizures given his/her history. A review of the facility policy for Person- Centered Care Plans dated 10/24/22 directed the facility develops and implement care plans to provide effective person centered care. The care plan should include services to be furnished, goals and expected outcomes, type, amount and frequency of care (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and any other factor related to the effectiveness of the care plan. 3. Resident #224's diagnoses included Chronic Obstructive Pulmonary Disease (COPD), pneumonia, acute respiratory failure. A physician's order dated 1/14/2025 directed to provide oxygen at 3 liters per minute via a trach mask (a mask that covers and provides oxygen through Resident #224's tracheostomy stoma site located in the neck area) with 28% humidification at bedtime and off in the AM and as needed. A physician's order dated 1/14/2025 directed to change the orange stoma (trach stoma) button every day and to change the blue stoma button at every bedtime. A physician's order dated 1/14/2025 directed to cleanse around the stoma site with peroxide and sterile water before replacing the adhesive dressing every other day and as needed. The resident may do self-care of the stoma site with monitoring or assistance and provided supplies as needed. The care plan dated 1/17/2025 indicated Resident #224 was at risk for Multiple Drug-Resistant Organisms (MDRO) due to having a tracheostomy. An intervention was put into place to maintain Enhanced Barrier Precautions. The admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #224 was cognitively intact required oxygen therapy, no suctioning and no tracheostomy care. On 3/12/25 at 11:18 AM an interview and record review with RN #4 identified no evidence of a respiratory care plan initiated for Resident #224 during the resident's stay at the facility. RN#4 further indicated there should have been a care plan. The facility policy labeled Person Centered Care Plan dated 4/15/2025 indicated the facility would develop a comprehensive individualized care plan within seven days after the completion of the comprehensive assessment on admission and no more than 21 days after admission. The care plan would be revised as needed to reflect the changing needs of the resident.

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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** Based on clinical record review, observation, facility documentation, review of facility policy and interviews for 1 of 7 sampled residents (Resident #124) reviewed for accidents, the facility failed to ensure necessary care and services were immediately sought and provided to ensure Resident # 124 safety and prevent a fall with major injury, when Resident # 124 exhibited a change in condition, subsequently fell out of bed and sustained an eyelid laceration and fracture to the face and failed to ensure the area designated for smoking was free from accident hazards. The findings included: 1. Resident #124's diagnoses included a history of Cerebrovascular Accident (CVA) with right sided hemiparesis/hemiplegia (weakness and paralysis), epilepsy and chronic respiratory failure with tracheostomy (trach). The admission MDS assessment dated [DATE] identified Resident #124 was severely cognitively impaired with a BIMS of 4, required assistance of one with bed mobility, total assistance of two for transfers and toileting. The care plan dated 5/13/24 identified Resident #124 had impaired cognitive function, required assistance with ADL care, was at risk for falls and at risk for respiratory complications related to the tracheostomy. Interventions included: monitoring changes in cognitive function, providing assist of one with ADL, assistance with two with transfers, to ensure the call bell was within reach, observe/report increased wheezing and lower activity tolerance. The care card for 6/2024 directed assistance of one for care and for dressing maximal assistance. The resident required partial assistance with mobility. A Physical Therapy Evaluation and Resident Plan of Care dated 6/13/24 identified Resident #124 was hospitalized [DATE] through 6/12/24 for encephalopathy, SIRS (systemic inflammatory response syndrome) and urinary tract infection. Resident #124's functional capacity was determined as moderate assistance of one for rolling (in bed) and maximum (two people) for transfers. The physician's orders dated 6/14/24 directed to cap the trach as tolerated 8:00 AM to 8:00 PM and add nasal cannula to keep oxygen saturation above 90% every day and evening shift. A respiratory progress noted dated 6/14/24 identified Resident #124 was stable, capped and placed on nasal cannula 2 l PM (liters per minute) and tolerating well new orders for patient to be capped from 8:00 AM to 8:00 PM as tolerated. A Nurse Practitioner (NP #1) note dated 6/14/24 at 00:00 identified Resident #124 rolled out of bed to ground, and the incident was witnessed by nursing staff. Resident #1 was alert and responded to commands and noted with bleeding from nose and right lower eyelid, with no other visible injury/ bleeding. Oxygen via trach/ mask was 94-97% range (within normal limits), moving upper and lower extremities within baseline and no loss of consciousness. Resident #124 had a previous history of left frontal hemorrhagic stroke resulting in right sided hemiparesis, has a trach, and history of seizure disorder (nursing reported s/he was flapping hands prior to incident). Resident #124 was sent to the emergency department (ED) for a Computed Tomography CAT(CT) scan, evaluation to rule out an acute injury or fracture complication. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A nurse's note dated 6/14/2024 at 1:25 PM (written by RN #6) identified Resident #124 fell out of bed, sustaining a bloody nose and right cheek bone bleeding was stopped with ice. The NP was aware and completed an assessment. Resident #124 was transferred to the ED for evaluation/ CT scan of the head. The Inter-Agency Patient Referral Report dated 6/14/24 at 8:57 PM identified Resident #124 was evaluated following a fall. Per Emergency Medical Services (EMS), staff were turning the resident when s/he rolled out of bed. A CT scan dated 6/14/24 of the facial bones identified severe comminuted fracture or the right maxillary sinus and orbital floor fracture and corneal abrasion. Resident #124 returned to the facility on 6/14/25 with 2 sutures in the right lower eye with instructions that directed follow-up with the primary care physician and Oral and Maxillofacial Surgery in one week and to continue erythromycin for treatment of the corneal abrasion. A Safety Report (no date) identified on 6/14/24 after 12:00 PM, a request was made for NA #9 to change Resident #124's brief , gown and bed (while in bed).NA #9 recalled from previous interactions, Resident #124 moved around a lot but was able to turn h/her side to side without difficulty until the last turn when Resident #124 started to flop h/her body around a lot NA #9 went to check if Resident #124 was receiving oxygen when h/her legs began to fall off the bed. NA 9 ran to catch Resident #124 but was too late. Resident #124 fell flat on h/her face. NA #9 then ran out of the room and yelled for help later returning with the nurse. A Reportable Event Summary dated 6/17/24 identified NA #9 reported during care the resident's body started to flop a lot. NA #9 checked to make sure the resident was receiving oxygen when his/her leg was noted off the side of the bed. NA #9 was unable to catch the resident's leg. The respiratory therapist had previously capped the resident around 12:30 PM. Resident # 124 was transferred to the hospital and later identified with a maxillary sinus fracture and right orbital fracture. The resident received two sutures on the right eye lid. The care plan was revised to include assistance of two staff who received education on to suspend care if resident anxious or agitated and to ensure the resident is calm before continuing with care, air mattress/bed with bolsters and fracture management. An interview with RN #6 on 3/11/25 at 9:24 AM identified h/she was the assigned nursing supervisor on 6/14/25 during the 7:00 AM to 3:00 PM shift at the time RN #6 was called to Resident #124's room with a report of a fall out of bed. Although unclear of all the details, RN #6 indicated Resident #124 was new to having h/her trach capped and started moving around a lot in bed while NA #9 who was finishing a complete bed change. The RN# 6 identified Resident # 124 was moving around a lot, perhaps in discomfort from being new to capping. NA #9, who was on the other side of the bed, left the side of the bed to check Resident #124's oxygen on the opposite side. During that moment Resident #124's legs started falling off the side of the bed and gravity took over and Resident #124 fell out of bed. RN #6 further identified Resident #124 used enable rails to assist with positioning and normally would have been able to assist with positioning. An interview with the Director of Nursing Services (DNS) on 3/11/25 at 10:58 AM identified NA #9 was at the top of the bed between the wall and head of bed completing a bed change for Resident #124 when s/he observed Resident #124 moving around a lot and in questionable distress. The DNS identified (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	the root cause of the fall was NA #9 not calling for help when Resident #124 began moving around and showing questionable signs of distress and being unable to intervene when his/her legs began to fall off the side of the bed while focusing her attention on oxygen equipment. Education was subsequently provided to stop and call for the nurse for a questionable change of condition. An interview with the Medical Director on 3/11/25 at 12:09 PM identified the nurse aide should have called for help for any change of condition and focused on the resident while providing care. An interview with the Director of Rehabilitation on 3/14/25 at 10:19 AM identified while Resident #124 could normally assist with positioning side to side with the use of enabler bars, any change of condition could compromise h/her ability to do so. The nurse aides should be calling for help if a resident was experiencing a questionable change of condition. Additionally, the Director of Rehabilitation indicated the nurse aides should not be at the head of the bed between the wall and bed when providing care and instead at the side of the bed. NA #9 would not have been able to effectively intervene to prevent a fall if she was at the head of the bed. Although requested, a policy for nurse aide reporting of a change of condition was not provided. Attempts to interview NA #9, who is no longer employed at the facility, were unsuccessful. 2. A review of the facility smoking list identified (4) residents, Resident # 16, Resident #18, Resident #41 and Resident #125 actively smoked. An observation on 3/11/25 at 9:04 AM identified a canopy set up in the designated smoking area. The top of the canopy cover was made up of cloth like material. The label directed to keep away from all flames. An interview with the Director of Maintenance on 3/11/25 at 9:14 AM identified the canopy was placed the evening before as a replacement to the previous canopy damaged in the storm. The canopy was subsequently removed after surveyor inquiry with a plan to research adequate accommodations for the designated smoking area. A review of the manufacturer guidelines related to safety directed to keep all flame and heat sources away from the tent fabric. The tent may burn if left in continuous contact with any flame source. Although requested, a facility policy for ensuring a safe environment was not provided.