

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENTIFICATION NUMBER <b>075138</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED <b>09/16/2020</b>
NAME OF PROVIDER OF SUPPLIER <b>BLOOMFIELD HEALTH CARE CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP <b>355 PARK AVENUE BLOOMFIELD, CT 06002</b>	
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 0658  <b>Level of harm</b> - Minimal harm or potential for actual harm  <b>Residents Affected</b> - Few	<p><b>Ensure services provided by the nursing facility meet professional standards of quality.</b> **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, review of facility documentation, review of facility policy, and interviews for one sampled resident (Resident #1) reviewed for Medication Administration, the facility failed to administer the resident's timely to meet professional standards. The findings include: Resident #1's [DIAGNOSES REDACTED]. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 was without cognitive impairment, was independent in locomotion on and off the unit and was on antipsychotic medications. The Resident Care Plan (RCP) dated 8/30/30 identified Resident #1 had behavioral problem related to hallucinations and hitting. Interventions directed to administer medications as ordered, explain all procedures, approach and speak in a calm manner, divert attention, and take to alternate location as needed. A physician's orders [REDACTED]. A physician's order [REDACTED]. A physician's orders [REDACTED].#1's Medication Administration Record [REDACTED].M, and 9:00P.M. daily and [MEDICATION NAME] doses documented as administered at 8:00 A.M. and 8:00 P.M. daily as ordered. Review of facility documentation of Resident #1's Administration History Report August 19, 2020 through September 9, 2020 documented the precise time of medication administration, indicated ten of the 41 doses of [MEDICATION NAME] (24.3%) and 2 of the 41 doses of [MEDICATION NAME](4.8%) were not administered within the one hour timeframe of order time and as outlined by the facility's policy. Review of the facility Medication Administration and Documentation Policy indicated medications are to be administered within a two- hour time frame that is one hour before or after the medication order time.</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER  
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.