STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075001	A. Building B. Wing	12/11/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Joseph's Center	6448 Main Street Trumbull, CT 06611

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47826 Based on clinical record reviews, facility documentation, facility policies and interviews for one of three sampled residents (Resident #1) who were reviewed for an injury of unknown origin, the facility failed to conduct a thorough investigation when bruising was first noticed. The findings include: Resident #1's diagnoses included neurocognitive disorder with Lewy bodies, anxiety disorder, insomnia, anemia, and hallucinations. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 rarely or never made decisions regarding tasks of daily living, was dependent of one (1) person for toileting and showers, required substantial assistance of one (1) person for dressing and personal hygiene, utilized a wheelchair for mobility and was at risk of skin breakdown. The nurse's note dated 11/14/23 at 11:15 AM identified during a skin check new injuries were found and described as three (3) circular bruises to the right anterior shoulder/bicep yellow and purple in color and a softball size circular bruise to the right shin/knee area. The Facility Reported Incident form dated 11/14/23 at 12:08 PM identified Resident #1 verbalized I got beat up last night, a body check was done by the Unit Manager, Registered Nurse (RN) #1, bruises were noted, the police were called, and the Advanced Practice Registered Nurse (APRN) ordered an x-ray of the right humerus. The report identified RN #1 assessed Resident #1 at 10:30 AM and the assessment noted five (5) bruises (the right shin/knee, the left lateral knee and the right anterior shoulder had three (3) small bruises) and one (1) linear red mark to the left side of the neck. The Facility Reported Incident and investigation failed to reflect documentation staff were interviewed and a summary of the facility's findings of possible causes. The social worker's note dated 11/14/23 at 3:18 PM identified at 10:30 AM Resident #1 stated to her I was beaten up last night and look at my neck., the Social Worker noted a reddened area on the neck and discoloration on the shoulder area, the floor nurse and the Unit Manager were notified, and the Unit Manger notified the Director of Nursing, APRN and police. The social worker's note dated 11/15/23 at 1:57 PM identified the Social Worker met with Resident #1 in follow up from the visit the day before and the Resident stated that nothing happened last night. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility summary dated 11/17/23 identified four (4) bruises that were noted, a 4 centimeters (cm) x 0.5 cm on the neck, 3cm x 2 cm on the right arm, 5.5 cm x 3.5 cm on the right lower leg and a 3.5 cm x 2 cm on the left lateral knee. Interview with the Administrator on 12/11/23 identified she was familiar with the Facility Reported Incident for Resident #1, however she was unable to locate all components of the investigation, the staff statements and summary of findings could not be located, and she was unable to reach the former Director of Nursing who had conducted the investigation. Review of the facility policy for Abuse Prohibition directed the facility to report the results of their investigation to the state agency and to thoroughly document the results of the investigation in the Risk Management Portal including witness interviews.

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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	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** 47826 Based on clinical record review, facility documentation, facility policies and interviews for 1 of 3 sampled residents (Resident #1) who were reviewed for an injury of unknown origin, the facility failed to review and revise the Resident Care Plan to provide safety measures for a resident who exhibited behavioral symptoms, i.e. kicking, combativeness. The findings include: Resident #1 diagnoses included neurocognitive disorder with Lewy bodies, anxiety disorder, insomnia, anemia, and hallucinations. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 rarely or never made decisions regarding tasks of daily living, was dependent of one (1) person for toileting and showers, required substantial assistance of one (1) person for dressing and personal hygiene, utilized a wheelchair for mobility and was at risk of skin breakdown. The Resident Care Plan dated 11/10/23 identified Resident #1 utilized 1/4 bed rails as an enabler, required full assistance of one for personal care, had Lewy Body dementia with hallucinations, was at risk for falls, and was at risk for skin breakdown. Interventions directed to assist with personal care, monitor for changes in cognitive status and decline in activities of daily living, provide psychiatric services as needed, provide floor mats around bed, keep bed in the low position, promote self-management strategies when resident exhibits signs of anxiety, observe for signs of hallucinations, determine cause of anxiety, provide medication as ordered, observe for skin breakdown and check skin frequently throughout the shift. Upon further review the Resident Care Plan failed to reflect documentation that the care plan was reviewed and revised to provide specific safety measures when Resident #1 exhibited increased agitation. The Psychiatric Evaluation and Consultation note dated 10/27/23 at 3:30 PM identified Resident #1 was being seen per staff request for increase in behaviors, staff reported Resident #1 was tearful, anxious, and restless and a physician's order directed to start a trial of Trazadone 12.5 milligrams every twelve (12) hours as needed for fourteen days (14) days. The nurse's note dated 11/14/23 at 11:15 AM identified during a skin check new injuries were found and described as three (3) circular bruises to the right anterior shoulder/bicep yellow and purple in color and a softball size circular bruise to the right shin/knee. The nurse's note dated 11/14/23 at 3:25 PM identified Resident #1 was observed to have an injury to the left neck, right shoulder, and right shin/knee, this was reported to the unit manager between 10:00 AM and 10:30 AM. The note indicated Resident #1 was unable to articulate events or answer direct questions asked by staff or the police. The note identified Resident #1 had exhibited increased behaviors over the past ten (10) to twenty (20) days with a referral to psychiatry and an evaluation by the Advanced Practice Registered Nurse (APRN). The note indicated Resident #1 would throw pillows and positioning supports on the ground, became upset and agitated when being moved from the wheelchair, and if placed in bed for a nap would wake up and yell and attempt to get out of bed independently. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A late entry nurse's note dated 11/14/23 at 4:05 PM identified Resident #1 had a change in condition, Resident #1 was exhibiting worsened hallucinations and physical and verbal aggression. Interview with the 3-11PM charge nurse, Licensed Practical Nurse (LPN) #1, on 12/11/23 at 12:45 PM identified Resident #1 exhibited hallucinations, was resistant to care, became combative at times, and often turned his/her body while in bed so that his/her head was facing the bottom of the bed. Interview with the 11PM-7AM charge nurse, LPN #2, on 12/11/23 at 1:16 PM identified Resident #1 had gotten very agitated and kicked while in the bed or chair and has flipped themself around while in bed. Interview with the 7AM-3PM charge nurse, LPN #4, on 12/11/23 at 1:20 PM identified Resident #1 gets combative and will cry, kicks his/her legs, and shakes themself. Review of the facility policy for Person-Centered Care Plans directed the facility to develop, review and update an individualized plan of care based on assessments and care area triggers and observations. Review of the facility policy on Dementia care directed the facility to review the care plan for effectiveness and revise as needed.