

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075001	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/22/2024
NAME OF PROVIDER OR SUPPLIER St Joseph's Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<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** 50094</p> <p>Based on clinical record review, facility documentation, and staff interviews for one of four residents (Resident #2) reviewed for neglect, the facility failed to ensure wound care was provided in accordance with physician orders. The findings include:</p> <p>Resident #2 had a diagnosis of gangrene, type 2 diabetes, chronic kidney disease, and peripheral vascular disease. The quarterly Minimum Data Set (MDS) dated [DATE] identified Resident #2 had a Brief Interview for Mental Status (BIMS) score of 11 indicative of moderately impaired cognition and had one (1) Deep Tissue Injury (DTI) and three (3) venous and arterial ulcers. The Resident Care Plan (RCP) dated 7/24/2024 identified Resident #2 had an alteration in skin integrity, and was at risk for skin breakdown. Interventions directed to apply treatments as ordered and observe for signs of skin breakdown.</p> <p>Physician order dated 9/24/2024 directed staff to cleanse the left heel with wound cleanser and apply a foam dressing every evening shift.</p> <p>Review of the Treatment Administration Record (TAR) from 9/24 to 9/30/2024 identified documentation that Resident #2's wound treatment was completed as ordered. Addition review identified LPN #6 signed the TAR on 9/28 and 9/29 to indicate the dressing changed.</p> <p>Review of the facility incident report dated 10/1/2024 identified Resident #2 did not have her/his dressing changed from 9/24 to 9/30/2024 (7 days).</p> <p>Review of written statement by LPN #6 dated 10/2/2024 identified Resident #2 refused the dressing change on 9/28 and 9/29/2024, and she forgot to change her documentation to reflect the refusals.</p> <p>Interview with LPN #4 on 10/21/2024 at 2:01 PM identified he did not change Resident #2's left heel dressing from 9/25 to 9/27/2024 and on 9/30/2024, because there was no calcium alginate available. LPN #4 identified he failed to call the pharmacy to order additional supplies and did not notify his supervisor that calcium alginate was not available. LPN #4 stated he should have followed up to obtain the supplies needed for the treatment, and should have notified the supervisor.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 075001
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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 RN #3/DNS #2 on 10/22/2024 at 11:50 AM identified although Resident #2 refused the dressing change on 9/28 and 9/29/2024, Resident #2 did not receive wound care treatments per physician orders on 9/24, 25, 26, and 27, 2024 (4 days). The RN #3/DNS #2 stated the treatments should have been provided as ordered.</p> <p>Review of facility Abuse Prohibition policy dated 2/23/21 directed in part, neglect was the failure of staff to provide goods and services to a patient that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50094</p> <p>Based on clinical record review, facility documentation, and staff interview for two of four residents (Resident #1 and #3) reviewed for quality of care, the facility failed to ensure dressing changes and wound care care was provided in accordance with physician orders. The findings include:</p> <p>1. Resident #1 had a diagnosis of osteomyelitis to the right ankle and foot, diabetes mellitus, and methicillin-resistant staphylococcus aureus. The admission Minimum Data Set (MDS) dated [DATE] identified Resident #1 had a Brief Interview for Mental Status Score (BIMS) of 13 indicative of intact cognition and had an Intravenous (IV) access. The Resident Care Plan dated 9/30/2024 identified a central line due to infection. Interventions directed to provide dressing changes per policy and as needed.</p> <p>Physician order dated 9/24/2024 directed nursing staff to change the intravenous (IV) catheter site transparent dressing every seven (7) days on the day shift.</p> <p>Record review identified the IV catheter site dressing was due to be changed on 9/25/2024. Additional record review identified the Medication Administration Record (MAR) was signed by LPN #1 to indicate the IV dressing was changed on 9/25/2024.</p> <p>Nursing note dated 9/28/2024 at 7:11 AM identified Resident #1's Peripherally Inserted Central Catheter (PICC) line dressing had been reinforced with tape and the dressing was dated 9/18/2024. The dressing was noted to have dry blood underneath it, the insertion site was unable to be viewed and bulging was noted under the dressing. The resident denied pain or discomfort and refused a dressing change when informed the dressing needed to be changed. Resident #1 was transferred to the hospital for further evaluation.</p> <p>Hospital emergency note dated 9/28/2024 at 7:41 AM identified there were no signs or concerns for infection and the PICC line dressing was changed.</p> <p>Nursing note dated 9/28/24 at 11:25 AM indicated the resident returned from the hospital with no new orders.</p> <p>The facility incident report dated 9/30/2024 identified Resident #1's PICC line dressing had not been changed in accordance with physician orders, and Resident #1 was transferred to the hospital for evaluation. LPN #1's statement dated 10/2/2024 identified on 9/25/2024 she did not change the dressing.</p> <p>Interview with LPN #1 on 10/21/2024 at 10:50 AM identified she did not change Resident #1's PICC line dressing as ordered on 9/25/2024 and stated she had paged the supervisor for help to change the PICC line dressing. LPN #1 stated she did not receive a response from the supervisor, and the dressing was not changed. LPN #2 stated the dressing should have been changed.</p> <p>Interview with RN #1 on 10/21/2024 at 1:31 PM identified she was the supervisor on 9/25/2024 and stated she did not receive a request to assist with a PICC line dressing change for Resident #1.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview and record review with the DNS on 10/21/2024 at 1:43 PM identified Resident #1's PICC line dressing was last changed on 9/18 and it was due to be changed on 9/25/2024. The DNS stated the dressing should have been changed as ordered.</p> <p>Review of facility Infusion Therapy policy dated August 2021 directed in part, to change the dressing every seven (7) days and as needed for central venous access devices.</p> <p>2. Resident #3 had diagnoses that included venous insufficiency, muscle weakness, and Parkinson's. The quarterly MDS dated [DATE] identified Resident #3 had a BIMS of 15 indicating the resident was alert and oriented, and had no wounds.</p> <p>The RCP dated 8/27/2024 identified Resident #3 had a wound on the left dorsal (upper part) foot, and was at risk for skin breakdown. Interventions directed to observe for signs of skin breakdown, and to provide wound care per treatment order.</p> <p>Physician order dated 9/20/2024 directed staff to cleanse left dorsal foot wound with wound cleanse, pat dry, apply calcium alginate and cover with dry dressing every day shift.</p> <p>Record review of the Treatment Administration Record (TAR) identified on 9/30/2024 the treatment was signed to indicate it was completed.</p> <p>Review of the facility incident report dated 10/1/2024 identified LPN #3 signed to indicate the treatment was completed on 9/30/2024, but the dressing was noted to be dated 9/29/2024. The facility investigation determined the wound care treatment was not completed.</p> <p>Interview with LPN #3 on 10/22/2024 at 9:34 AM identified she did not complete Resident #3's dressing treatment as ordered, but signed that the treatment was completed. LPN #3 stated she reported to the next shift, LPN #4, that the dressing needed to be changed.</p> <p>Interview with LPN #4 on 10/22/24 at 12:05 PM indicated that he received report from LPN #3, and LPN #3 reported she still had to do Resident #3's dressing changes. LPN #4 stated that he did not tell LPN #3 that he would do the dressing changes for her.</p> <p>Interview with RN #3/DNS #2 on 10/22/2024 at 11:50 AM identified the dressing should have been changed as ordered by the physician.</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50094</p> <p>Based on clinical record review, facility documentation, and staff interviews for one of four residents (Resident #4) reviewed for accidents, the facility failed to ensure the resident was transferred in accordance with facility policy and was not moved off the floor prior to the completion of an assessment. The findings include:</p> <p>Resident #4 had a diagnosis of muscle weakness, abnormalities of gait and mobility, and cognitive communication deficit. The quarterly MDS dated [DATE] identified Resident #4 had a Brief Interview for Mental Status score (BIMS) of 3 indicating severe cognitive impairment and required maximal assistance with transfers. The RCP dated 10/16/2024 identified a risk for falls and required assist with ADLS. Interventions directed assistance of one (1) for transfers.</p> <p>Facility incident report dated 10/2/2024 identified two NAs moved Resident #4 after a fall; NA #1 and NA #2 moved Resident #4 off the floor without notifying the nurse before moving the resident.</p> <p>Nursing note dated 10/1/2024 at 5:28 AM identified Resident #4 was status post witnessed fall, day one (1). The note indicated Resident #4 had a fall with no changes noted in mental status and had skin tears to the left inner pinky and left upper arm.</p> <p>Interview with NA #1 on 10/22/2024 at 1:33 PM identified about 4 PM on 9/30/2024, Resident #4 needed to use the bathroom. NA #1 stated when she transferred Resident #4 from his/her wheelchair to the toilet without the use of a gait belt, the resident lost his/her balance and NA #1 guided the resident to the floor. NA #1 stated after the resident fell, she asked another NA to help get the resident off the floor and onto the toilet. NA #1 further stated she failed to notify the charge nurse or nursing supervisor at the time of the fall, and stated she notified the charge nurse at some point later in the shift. Interview failed to identify why the nurse was not notified at the time of the fall, and NA #1 was unable to explain why a gait belt was not used for the transfer.</p> <p>Although attempted, an interview with NA #2 was not obtained during the survey.</p> <p>Interview with LPN #2 on 10/22/24 at 2:41 PM identified she was the charge nurse on 9/30/2024 and she was not notified when Resident #4 fell. LPN #2 stated the supervisor notified her that Resident #4 had dried blood on his/her hand and the resident said he/she fell. LPN #2 then asked NA #1 if the resident fell and NA #1 stated Resident #4 had a fall and hit his/her hand on the rail in the bathroom.</p> <p>Interview and record review with the DNS on 10/22/2024 at 3:53 PM identified NA #1 should have notified the nurse prior to assisting Resident #4 off the floor to ensure an RN assessment was completed to identify potential injuries. Further the DNS stated NA #1 should have used a gait belt for the transfer.</p> <p>Review of facility Safe Resident Handling/Transfer Equipment policy dated 3/1/2024 directed staff to use a gait belt with residents (for transfers) with limited assistance or perform stand pivot transfer with limited assistance with one staff member.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of Falls Management Policy dated 3/15/2024, directed in part, in the event a fall occurs, an assement will be condudated to determine any possible injury.</p>

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<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** 50094</p> <p>Based on clinical record review, facility documentation, and staff interview for three of four residents (Resident #1, #2, and #3) reviewed for documentation, the facility failed to ensure the record was complete an accurate regarding wound care. The findings include:</p> <p>1. Resident #1 had a diagnosis of osteomyelitis to the right ankle and foot, diabetes mellitus, and methicillin-resistant staphylococcus aureus. The admission Minimum Data Set (MDS) dated [DATE] identified Resident #1 had a Brief Interview for Mental Status Score (BIMS) of 13 indicative of intact cognition and had an Intravenous (IV) access. The Resident Care Plan dated 9/30/2024 identified a central line due to infection. Interventions directed to provide dressing changes per policy and as needed.</p> <p>Physician order dated 9/24/2024 directed nursing staff to change the intravenous (IV) catheter site transparent dressing every seven (7) days on the day shift.</p> <p>Record review identified the IV catheter site dressing was due to be changed on 9/25/2024. Additional record review identified the Medication Administration Record (MAR) was signed by LPN #1 to indicate the IV dressing was changed on 9/25/2024.</p> <p>Nursing note dated 9/28/2024 at 7:11 AM identified Resident #1's Peripherally Inserted Central Catheter (PICC) line dressing had been reinforced with tape and the dressing was dated 9/18/2024. The dressing was noted to have dry blood underneath it, the insertion site was unable to be viewed and bulging was noted under the dressing. The resident denied pain or discomfort and refused a dressing change when informed the dressing needed to be changed. Resident #1 was transferred to the hospital for further evaluation.</p> <p>Hospital emergency note dated 9/28/2024 at 7:41 AM identified there were no signs or concerns for infection and the PICC line dressing was changed.</p> <p>Nursing note dated 9/28/24 at 11:25 AM indicated the resident returned from the hospital with no new orders.</p> <p>Interview with LPN #1 on 10/21/2024 at 10:50 AM identified she did not change Resident #1's PICC line dressing as ordered on 9/25/2024 and she should not have documented the dressing was changed when it was not.</p> <p>Interview and record review with the DNS on 10/21/2024 at 1:43 PM identified Resident #1's PICC line dressing was last changed on 9/18 and it was due to be changed on 9/25/2024. The DNS stated the documentation was not accurate in the record, and LPN #1 should not have signed that the dressing was changed when it was not completed.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Resident #2 had a diagnosis of gangrene, type 2 diabetes, chronic kidney disease, and peripheral vascular disease. The quarterly Minimum Data Set (MDS) dated [DATE] identified Resident #2 had a Brief Interview for Mental Status (BIMS) score of 11 indicative of moderately impaired cognition and had one (1) Deep Tissue Injury (DTI) and three (3) venous and arterial ulcers. The Resident Care Plan (RCP) dated 7/24/2024 identified Resident #2 had an alteration in skin integrity, and was at risk for skin breakdown. Interventions directed to apply treatments as ordered and observe for signs of skin breakdown.</p> <p>Physician order dated 9/24/2024 directed staff to cleanse the left heel with wound cleanser and apply a foam dressing every evening shift.</p> <p>Review of the Treatment Administration Record (TAR) from 9/24 to 9/30/2024 identified documentation that Resident #2's wound treatment was completed as ordered. Addition review identified LPN #6 signed the TAR on 9/28 and 9/29 to indicate the dressing changed.</p> <p>Review of the facility incident report dated 10/1/2024 identified Resident #2 did not have her/his dressing changed from 9/24 to 9/30/2024 (7 days).</p> <p>Review of written statement by LPN #6 dated 10/2/2024 identified Resident #2 refused the dressing change on 9/28 and 9/29/2024, and she forgot to change her documentation to reflect the refusals.</p> <p>Although attempted, interview with LPN #6 was not obtained during the survey.</p> <p>Interview with LPN #4 on 10/21/2024 at 2:01 PM identified he did not change Resident #2's left heel dressing from 9/25 to 9/27/2024 and on 9/30/2024, because there was no calcium alginate available. LPN #4 identified he failed to call the pharmacy to order additional supplies and did not notify his supervisor that calcium alginate was not available. LPN #4 stated he should have followed up to obtain the supplies needed for the treatment, and should have notified the supervisor.</p> <p>Interview with RN #3/DNS #2 on 10/22/2024 at 11:50 AM identified Resident #2 did not receive wound care treatments per physician orders, and the TAR should not have been signed to indicate they were completed when they were not actually completed as ordered.</p> <p>3. Resident #3 had diagnoses that included venous insufficiency, muscle weakness, and Parkinson's. The quarterly MDS dated [DATE] identified Resident #3 had a BIMS of 15 indicating the resident was alert and oriented, and had no wounds.</p> <p>The RCP dated 8/27/2024 identified Resident #3 had a wound on the left dorsal (upper part) foot, and was at risk for skin breakdown. Interventions directed to observe for signs of skin breakdown, and to provide wound care per treatment order.</p> <p>Physician order dated 9/20/2024 directed staff to cleanse left dorsal foot wound with wound cleanser. Pat dry, apply calcium alginate and cover with dry dressing. every day shift.</p> <p>Record review of the Treatment Administration Record (TAR) identified on 9/30/2024 the treatment was signed to indicate it was completed.</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the facility incident report dated 10/1/2024 identified LPN #3 signed to indicate the treatment was completed on 9/30/2024, but the dressing was noted to be dated 9/29/2024. The facility investigation determined the wound care treatment was not completed.</p> <p>Interview with LPN #3 on 10/22/2024 at 9:34 AM identified she did not complete Resident #3's dressing treatment as ordered, but signed that the treatment was completed. LPN #3 stated she forgot to write a nursing note that it was not done, and should not have signed the treatment was completed when it was not done.</p> <p>Interview with RN #3/DNS #2 on 10/22/2024 at 11:50 AM identified the documentation was not accurate and should not have been signed to indicate the dressing was completed when it was not done.</p>		