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	03/04/2025

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46117 Based on review of the clinical records, review of facility documentation, review of facility policy/procedures and interviews for two of four sampled residents (Residents #12 and #311) reviewed resident to resident abuse and misappropriation of resident property, the facility failed to ensure the residents were free from physical mistreatment and misappropriation of property abuse. The findings include: 1. Resident #12 's diagnoses included cerebral infarction, aphasia, hemiplegia affecting right dominant side, and delusional disorder. The quarterly MDS assessment dated [DATE] identified Resident #12 had severe cognitive impairment, verbal behavioral symptoms directed toward others, was independent with transfers and independent with wheelchair mobility. The Resident Care Plan (RCP) dated 10/10/24 identified Resident #12 had disruptive behaviors that included yelling at staff, using profanities and refusals of care. Care plan Interventions included, establish boundaries and limits, and provide verbal feedback regarding his/her behavior. The nurse's note dated 11/12/24 at 1:58 PM identified Resident #12 reported that he/she was hit in the left eye by Resident #33 when he/she was attempting to leave Resident #33's room. The note further identified there was no swelling or redness noted to the eye and that the resident would be monitored for pain. Additionally, the note identified that the residents should be separated while the incident is investigated. The Social Worker's (SW#2) progress note dated 11/12/24 at 10:01 AM identified that she met with Resident #12 regarding the incident and noted Resident #12 reported that he/she felt safe. The note further identified Resident #12's story was inconsistent. The Psychiatric APRN's progress note dated 11/15/24 identified Resident #12 was evaluated for an altercation with another resident. Resident #12 identified that he/she visited Resident #33 in his/her room and when he/she was trying to get out of Resident #33 room, that Resident #33 hit him /her in the eye. Further, the note identified that Resident #12 thought Resident #33 was his/her friend. Resident #12 was advised to not visit Resident #33. (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #33's diagnoses included hemiplegia and hemiparesis affecting left non dominant side, type 2 diabetes mellitus and peripheral vascular disease. The annual MDS assessment dated [DATE] identified Resident #33 had intact cognition, was independent with bed mobility, transfers, and ambulation. The RCP dated 9/19/24 identified Resident #33 was at risk for distress and fluctuating mood symptoms relate to inability to return home and adjustment disorder. Care plan interventions directed to refer to behavioral health specialist as needed, determine the psychosocial cause of the resident sadness, mood, and persistent anger, social service to provide support. The nurse's note dated 11/12/24 at 7:30 PM identified Resident #33 reported Resident #12 entered his/her room uninvited and was told to leave. The note further identified that Resident #33 admitted to hitting Resident #12 in the face. The Psychiatric APRN's progress note dated 11/15/24 identified Resident #33 was evaluated following an altercation with another resident. The note identified Resident #33 hit Resident #12 because Resident #12 refused to leave his/her room after multiple requests. Interview with SW #2 on 2/26/25 at 12:15 PM identified that she spoke to Resident #12 and Resident #33 related to the altercation between the two residents. She identified that Resident #33 hit Resident #12 in the left eye because Resident #12 entered Resident #33's room without permission. She further identified Resident #33 identified that he/she accidentally hit Resident #12 in the face when he/she was aiming for Resident #12's lower body. An attempt to interview Resident #33 was made but Resident #33 refused to be interviewed. Review of the Abuse Prohibition policy identified that when resident to resident abuse is suspected/occurs, the resident who was threatened or attacked will be removed from the situation and an investigation will be completed. The facility identified that it provides adequate supervision when risk to resident-to-resident altercations are suspected and will identify residents with a history of disruptive or intrusive interactions because it makes them more likely to be involved in an altercation. 2. Resident #311's diagnoses included chronic pain due to trauma, generalized anxiety disorder, Major depressive disorder and heart failure. The Quarterly MDS assessment dated [DATE] identified Resident #311 had intact cognition, was independent with all mobility, utilized a wheelchair and received scheduled and as needed (prn) pain medications. The care plan dated 5/30/24 identified problems with substance abuse related to a history of alcohol dependence; risk for falls related to use of psychotropic drugs and pain medications and chronic alteration in comfort/pain related to chronic pain from scar tissue on back, buttocks, bilateral lower extremities as well as chronic and acute pain to left wrist with interventions to medicate resident as ordered for pain, monitor side effects, and monitor frequency of episodes of breakthrough pain. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The physician's order dated 6/2/24 directed to administer Oxycodone (narcotic medication)10 mg tablet four times per day as needed for pain. Review of the reportable event report dated 6/11/24 at 7:00 AM identified a blister pack (medication dispensing container/packaging) of Oxycodone with 30, 10 mg tablets for Resident # 311 was unaccounted for (missing). The report identified that the blister pack of Oxycodone was present at the 11:00 PM when the shift-to-shift count was completed. It noted that the former DNS worked the night shift and had removed some medication from the cart while orienting a new nursing supervisor. The 7:00AM narcotic medication count identified that two blister packs of the medication were missing. This was brought to the DNS's attention, and one blister pack was returned but one remained unaccounted for. Interview on 2/28/25 at 2:15 PM with the Administrator and the DNS identified they started working at the facility in November of 2024 and were unaware of missing narcotic medication. The DNS indicated that she and the ADNS are currently developing a narcotic requisition process because there had not been one in place prior to them starting. Review of the facility policy for management of controlled drugs identified all staff who administer medications will safeguard controlled substances, and that two licensed nurses and/or authorized nursing personnel, per state regulations are required to document placement of controlled substances into inventory. Additionally, a complete count of all Schedule II-IV controlled substances is required at the change of shifts per state regulation or at any time in which narcotic keys are surrendered from on licensed nursing staff to another, the count must be performed by two licensed nurses and /or authorized nursing personnel, per state regulations. The abuse prohibition policy identified the purpose of the policy was to prohibit misappropriation of resident/patient property and identified the misappropriation of patient property as the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a patient's belongings without the patients consent. 47489

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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** 46117 Based on clinical record review, facility policy and interviews for 1 of 5 sample residents (Resident #12 and Resident #33) reviewed for abuse, the facility failed to develop and implemented a comprehensive care plan after altercation between residents. The findings include: Resident #12 's diagnoses included cerebral infarction, aphasia, hemiplegia affecting right dominant side, and delusional disorder. The quarterly MDS assessment dated [DATE] identified Resident #12 had severe cognitive impairment, verbal behavioral symptoms directed toward others, was independent with transfers and independent with wheelchair mobility. The Resident Care Plan (RCP) dated 10/10/24 identified Resident #12 had disruptive behaviors that included yelling at staff, using profanities and refusals of care. Care plan Interventions included, establish boundaries and limits, and provide verbal feedback regarding his/her behavior. The nurse's note dated 11/12/24 at 1:58 PM identified Resident #12 reported that he/she was hit in the left eye by Resident #33 when he/she was attempting to leave Resident #33's room. The note further identified there was no swelling or redness noted to the eye and that the resident would be monitored for pain. Additionally, the note identified that the residents should be separated while the incident is investigated. The Social Worker's (SW#2) progress note dated 11/12/24 at 10:01 AM identified that she met with Resident #12 regarding the incident and noted Resident #12 reported that he/she felt safe. The note further identified Resident #12's story was inconsistent. The Psychiatric APRN's progress note dated 11/15/24 identified Resident #12 was evaluated for an altercation with another resident. Resident #12 identified that he/she visited Resident #33 in his/her room and when he/she was trying to get out of Resident #33 room, that Resident #33 hit him /her in the eye. Further, the note identified that Resident #12 thought Resident #33 was his/her friend. Resident #12 was advised to not visit Resident #33. The Revised RCP dated 11/12/24 identified Resident #12 got struck in the left eye by another resident. Care plan interventions directed to monitor and document pain and/or discomfort and monitor the left eye for redness, edema, bruising and report abnormal finding to the physician. Resident #33's diagnoses included hemiplegia and hemiparesis affecting left non dominant side, type 2 diabetes mellitus and peripheral vascular disease. The annual MDS assessment dated [DATE] identified Resident #33 had intact cognition, was independent with bed mobility, transfers, and ambulation. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The RCP dated 9/19/24 identified Resident #33 was at risk for distress and fluctuating mood symptoms relate to inability to return home and adjustment disorder. Care plan interventions directed to refer to behavioral health specialist as needed, determine the psychosocial cause of the resident sadness, mood, and persistent anger, social service to provide support. The nurse's note dated 11/12/24 at 7:30 PM identified Resident #33 reported Resident #12 entered his/her room uninvited and was told to leave. The note further identified that Resident #33 admitted to hitting Resident #12 in the face. The SW # 2 progress note dated 11/14/24 at 2:34 PM identified she spoke with Resident #33 and the resident reported that he/she accidentally hit Resident #12 in the eye after asking Resident #12 to leave his/her room multiple times. SW #2 identified that Resident #33 did not want Resident #12 to enter his/her room again. The Psychiatric APRN's progress note dated 11/15/24 identified Resident #33 was evaluated following an altercation with another resident. The note identified Resident #33 hit Resident #12 because Resident #12 refused to leave his/her room after multiple requests. The note further identified that the Psychiatric APRN recommended to the nursing staff to not allow Resident #12 to enter Resident #33's room. Interview with NA # 1 on 2/25/25 at 10:30 AM identified that she was permanent nursing aide in the uni. She identified that Resident #12 typically had a verbal outburst toward staff and Resident #33 usually just stayed in his/her room and had no known behaviors. She identified Resident #12 typically roamed around freely on the nursing unit. NA #1 further noted she was unaware of any restriction between the two residents. Interview with LPN #5 on 2/26/25 at 11:20 AM identified that she aware of the altercation between Resident #12 and Resident #33. She identified that Resident #12 had a short temper and is easily angered. She identified that Resident #33 got upset after Resident #12 went to his/her room. She identified that SW #2 told her to avoid close contact between the two residents; however, she could not identify how other nursing staff would know that Resident #12 and Resident #33 should not have close contact to prevent the altercation happening again. Review of the nurse aide cards and the care plans for both residents failed to identify that the two residents should be kept apart or how to redirect Resident #12 when he/she wanders into other resident's rooms. Interview with SW #2 on 2/26/25 at 12:15 PM identified that she spoke to Resident #12 and Resident #33 related to the altercation between the two residents. She identified that Resident #33 hit Resident #12 in the left eye because Resident #12 entered Resident #33's room without permission. She further identified Resident #33 identified that he/she accidentally hit Resident #12 in the face when he/she was aiming for Resident #12's lower body. SW #2 identified that she told the nursing staff to avoid Resident #12 and Resident #33 being close together. SW #2 identified that she was not sure who would be responsible for updating the resident care plan to ensure all nursing staff were aware of restrictions between the two residents. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with DNS on 3/4/25 at 10:30 AM identified she was not the DNS when the incident between Resident #12 and Resident #33 occurred. She noted that the altercation between the two residents should have been included on both residents' care plan. The DNS noted that the care plans should include measures to ensure that both residents are kept away from each other. In addition, she identified that all the nurses are responsible for updating the care plans when necessary. Review of the Abuse Prohibition policy identified that when resident to resident abuse is suspected/occurs, the resident who was threatened or attacked will be removed from the situation and an investigation will be completed. The facility identified that it provides adequate supervision when risk to resident-to-resident altercations are suspected and will identify residents with a history of disruptive or intrusive interactions because it makes them more likely to be involved in an altercation.