STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075034	A. Building B. Wing	04/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Carolton Chronic & Convalescent Hospital Inc	400 Mill Plain Rd Fairfield, CT 06824

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51756 Based on review of the clinical record, facility documentation, facility policy and interviews for 3 of 4 residents (Resident #45, 53 and 4) reviewed for abuse, the facility failed to report allegations of abuse to the Administrator, the State Agency and Police according to facility policy. The findings include: 1. Resident #45's diagnoses included cerebral palsy and adjustment disorder with anxiety. The quarterly MDS dated [DATE] identified Resident #45 had intact cognition, required the assistance of 2 via mechanical lift for transfers to the wheelchair, and was independent while in the wheelchair. a. Interview with Resident #45 on 3/31/25 at 11:50 AM identified that Resident #53 had grabbed Resident #45's neck and pushed the back of his/her wheelchair when exiting the dining room. Resident #45 stated that he/she in turn ran over Resident #53's feet three times with his/her wheelchair purposely. Resident #45 stated he/she sees Resident #53 in the hallway and Resident #53 is always looking in his/her (Resident #45's) room. The allegation of resident-to-resident abuse was reported by the surveyor to the DNS on 3/31/25 at 12:30 PM. The DNS indicated that she was not aware of any allegations of resident-to-resident abuse between Resident #45 and Resident #53. A review of Resident #45's care plan on 4/3/25 failed to reflect Resident #45's fear of Resident #53 or the alleged resident to resident allegation. b. Resident #53's diagnoses included Alzheimer's disease with agitation. The quarterly MDS dated [DATE] identified Resident #53 as being severely cognitively impaired and required a wheelchair for mobility. Physician's order for Resident #53 dated 3/5/25 directed to administer Trazadone (antidepressant) 50 mg every 6 hours as needed for anxiety. A review of Resident #53's nurse and social worker notes and care plan dated 2/1/25 through 4/3/25 failed to reflect the incident. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with Resident #53's representative on 4/1/25 indicated that he was not made aware that Resident #53 had grabbed Resident #45's neck and pushed the back of his/her wheelchair or that Resident #45 stated that he/she in turn ran over Resident #53's feet three times. Interview with LPN #6 on 4/2/25 at 10:50 AM, who was Resident #53's charge nurse during the 7:00 AM - 3:00 PM shift on 4/1/25 and 4/2/25 was unaware of any allegations made regarding Resident #45 and Resident #53. Interview with the DNS on 4/2/25 at 1:35 PM identified that the DNS reported the alleged allegation to the State Agency on 4/1/25 (a day after being notified) and had not reported the allegation to the police. The DNS indicated that the facility policy is to report alleged allegations to the State Agency immediately. The DNS indicated that she started the investigation first, which caused a delay in reporting and indicated that there was conflicting information regarding what occurred. The DNS also indicated that it is not normal practice to investigate first then report the allegation to the State Agency. The DNS indicated that the allegation happened a while ago, and SW #1 had addressed the issue. However, the first time the DNS was made aware of the alleged allegation was when it was reported to her by the surveyor on 3/31/25. The DNS identified the Social Worker had never made her aware of the incident. Interview with SW #1 on 4/3/25 at 10:22 AM identified that he was aware of the incident after it occurred as Resident #45 asked to speak to him. SW #1 indicated that Resident #45 never stated that Resident #53 grabbed his/her neck or that Resident #45 ran over Resident #53's feet. SW #1 stated that Resident #45 thinks that Resident #53 has pinpointed him/her but that Resident #53 has never been aggressive towards Resident #45 as far as he is aware. Resident #53 wheels independently by Resident #45's room frequently. Interview with PT #2 on 4/3/25 at 10:48 AM identified that Resident #45 had reported that he/she ran over Resident #53's feet purposely and that he/she is fearful of Resident #53. 2. Resident #4 diagnoses included dementia, depression and generalized anxiety disorder. Physician's order dated 3/3/25 directed to document behaviors once a shift and administer Citalopram 10 mg daily and Mirtazapine 30 mg daily for depression. The quarterly MDS dated [DATE] identified Resident #4 had severely impaired cognition and was independent with toileting, personal hygiene, and ambulation. Interview with Resident #4 on 3/31/25 at 11:30 AM identified that several weeks ago he/she believed that a nurse aide pushed him/her into the bathroom. Resident #4 was unable to identify the nurse aide by name but believed the nurse aide was white and worked during the day shift. Resident #4 stated that this nurse aide is around a lot and is mean and bossy. Resident #4 stated he/she does not want that nurse aide to care for him/her and that he/she had reported the incident to his/her resident representative when it occurred. The allegation was reported to the DNS on 3/31/25 at 12:30 PM by the surveyor. The DNS stated she was not aware of the allegation or concerns related to Resident #4 and it had not been reported. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Resident Representative on 4/2/25 at 10:25 AM identified that he/she was made aware of the allegation by Resident #4 but did not report the concern as he/she believed Resident #4 may have misinterpreted what occurred. Interview with LPN #6 on 4/2/25 at 10:50 AM identified she was Resident #4's charge nurse on the day shift on 4/1/25 and 4/2/25 and she is Resident #4's primary nurse every other week. LPN #6 indicated that Resident #4 frequently mentions that a nurse aide is mean but the resident is unable to identify the nurse aide. LPN #6 indicated that Resident #4 is consistent in saying the nurse aide is mean and bossy, however, Resident #4 has never indicated to her that she was pushed by the nurse aide. LPN #6 identified that Resident #4 is confused and cannot always express his/her concerns clearly. LPN #6 identified that she has never reported to the administration Resident #4's concerns regarding a nurse aide being mean and bossy. Interview with RN #6 on 4/4/25 at 10:30 AM identified she was made aware by Resident #4 that a nurse aide pushed the resident. RN #6 identified she investigated the situation when it was reported to her. RN #6 identified that a nurse aide had pushed Resident #4 in the wheelchair to obtain a weight and Resident #4 did not want to be weighed and was upset because he/she was being pushed in the wheelchair onto the scale. RN #6 indicated she does not think she reported the incident to the DNS at the time it occurred, she did not think she obtained any written statements from staff and was unsure if she documented the incident in the nursing notes. Interview with the DNS on 4/2/25 at 1:35 PM indicated that after the allegation was reported to her for the first time on 3/31/25 at 12:30 PM she started the investigation which caused a delay in reporting the incident to the State Agency. The DNS indicated that RN #6 had investigated the situation when it occurred, however, the DNS was not aware of the incident involving Resident #4 because RN #6 did not report it. Review of the nurses and social worker notes and the care plan dated 2/1/25 through 4/3/25 failed to reflect documentation of the allegation. Review of the Resident/Patient Abuse policy revised 2/8/23 identified that any alleged or witnessed incident of abuse is to be immediately reported to the nursing supervisor. This report shall be promptly reported to the appropriate department heads and the administrator. The DNS or designated representative shall promptly notify the Police, DPH, the attending physician, the medical director and Administrator within 2 hours of notification of abuse.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37721 51756 Based on review of the clinical record, facility documentation, facility policy and interviews for 3 of 4 residents (Resident #45, 53 and 4) reviewed for abuse, the facility failed to immediately initiate a thorough investigation after allegations of abuse were either witnessed or reported, identify and remove the staff member involved, and report the results of the investigation to the administrator and to the State Agency within 5 working days of the incident. The findings include: 1. Resident #45's diagnoses included cerebral palsy and adjustment disorder with anxiety. The quarterly MDS dated [DATE] identified Resident #45 had intact cognition, required the assistance of 2 via mechanical lift for transfers to the wheelchair, and was independent while in the wheelchair. a. Interview with Resident #45 on 3/31/25 at 11:50 AM identified that Resident #53 had grabbed Resident #45's neck and pushed the back of his/her wheelchair when exiting the dining room. Resident #45 stated that he/she in turn ran over Resident #53's feet three times with his/her wheelchair purposely. Resident #45 stated he/she sees Resident #53 in the hallway and Resident #53 is always looking in his/her (Resident #45's) room. The allegation of resident-to-resident abuse was reported by the surveyor to the DNS on 3/31/25 at 12:30 PM. The DNS indicated that she was not aware of any allegations of resident-to-resident abuse between Resident #45 and Resident #53. A review of Resident #45's care plan on 4/3/25 failed to reflect Resident #45's fear of Resident #53 or the alleged resident to resident allegation. b. Resident #53's diagnoses included Alzheimer's disease with agitation. The quarterly MDS dated [DATE] identified Resident #53 as being severely cognitively impaired and required a wheelchair for mobility. Physician's order for Resident #53 dated 3/5/25 directed to administer Trazadone (antidepressant) 50 mg every 6 hours as needed for anxiety. A review of Resident #53's nurse and social worker notes and care plan dated 2/1/25 through 4/3/25 failed to reflect the incident. Interview with Resident #53's representative on 4/1/25 indicated that he was not made aware that Resident #53 had grabbed Resident #45's neck and pushed the back of his/her wheelchair or that Resident #45 stated that he/she in turn ran over Resident #53's feet three times. (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with LPN #6 on 4/2/25 at 10:50 AM, who was Resident #53's charge nurse during the 7:00 AM - 3:00 PM shift on 4/1/25 and 4/2/25 was unaware of any allegations made regarding Resident #45 and Resident #53. Interview with the DNS on 4/2/25 at 1:35 PM identified that the DNS reported the alleged allegation to the State Agency on 4/1/25 (a day after being notified) and had not reported the allegation to the police. The DNS indicated that the facility policy is to report alleged allegations to the State Agency immediately. The DNS indicated that she started the investigation first, which caused a delay in reporting and indicated that there was conflicting information regarding what occurred. The DNS also indicated that it is not normal practice to investigate first then report the allegation to the State Agency. The DNS indicated that the allegation happened a while ago, and SW #1 had addressed the issue. However, the first time the DNS was made aware of the alleged allegation was when it was reported to her by the surveyor on 3/31/25. The DNS identified the Social Worker had never made her aware of the incident. Interview with SW #1 on 4/3/25 at 10:22 AM identified that he was aware of the incident after it occurred as Resident #45 asked to speak to him. SW #1 indicated that Resident #45 never stated that Resident #53 grabbed his/her neck or that Resident #45 ran over Resident #53's feet. SW #1 stated that Resident #45 thinks that Resident #53 has pinpointed him/her but that Resident #53 has never been aggressive towards Resident #45 as far as he is aware. Resident #53 wheels independently by Resident #45's room frequently. Interview with PT #2 on 4/3/25 at 10:48 AM identified that Resident #45 had reported that he/she ran over Resident #53's feet purposely and that he/she is fearful of Resident #53. Although PT #2 was aware of the incident, according to the DPH reportable events portal, the incident took place on 3/24/25, was not reported to DPH until 4/1/25, and the investigation summary was not submitted until 4/11/25. Review of the Resident/Patient Abuse policy revised 2/8/23, directed following the initial report of suspected or alleged abuse, the involved department supervisor(s)/department head(s) shall immediately initiate an investigation of the incident, this investigation shall include, but not limited to, interviewing of the resident and or family members and interviewing of all involved staff. 2. Resident #4 diagnoses included dementia, depression and generalized anxiety disorder. Physician's order dated 3/3/25 directed to document behaviors once a shift and administer Citalopram 10 mg daily and Mirtazapine 30 mg daily for depression. The quarterly MDS dated [DATE] identified Resident #4 had severely impaired cognition and was independent with toileting, personal hygiene, and ambulation. Interview with Resident #4 on 3/31/25 at 11:30 AM identified that several weeks ago he/she believed that a nurse aide pushed him/her into the bathroom. Resident #4 was unable to identify the nurse aide by name but believed the nurse aide was white and worked during the day shift. Resident #4 stated that this nurse aide is around a lot and is mean and bossy. Resident #4 stated he/she does not want that nurse aide to care for him/her and that he/she had reported the incident to his/her resident representative when it occurred. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The allegation was reported to the DNS on 3/31/25 at 12:30 PM by the surveyor. The DNS stated she was not aware of the allegation or concerns related to Resident #4 and it had not been reported. Interview with the Resident Representative on 4/2/25 at 10:25 AM identified that he/she was made aware of the allegation by Resident #4 but did not report the concern as he/she believed Resident #4 may have misinterpreted what occurred. Interview with LPN #6 on 4/2/25 at 10:50 AM identified she was Resident #4's charge nurse on the day shift on 4/1/25 and 4/2/25 and she is Resident #4's primary nurse every other week. LPN #6 indicated that Resident #4 frequently mentions that a nurse aide is mean but the resident is unable to identify the nurse aide. LPN #6 indicated that Resident #4 is consistent in saying the nurse aide is mean and bossy, however, Resident #4 has never indicated to her that she was pushed by the nurse aide. LPN #6 identified that Resident #4 is confused and cannot always express his/her concerns clearly. LPN #6 identified that she has never reported to the administration Resident #4's concerns regarding a nurse aide being mean and bossy. Interview with RN #6 on 4/4/25 at 10:30 AM identified she was made aware by Resident #4 that a nurse aide pushed the resident. RN #6 identified she investigated the situation when it was reported to her. RN #6 identified that a nurse aide had pushed Resident #4 in the wheelchair to obtain a weight and Resident #4 did not want to be weighed and was upset because he/she was being pushed in the wheelchair onto the scale. RN #6 indicated she does not think she reported the incident to the DNS at the time it occurred, she did not think she obtained any written statements from staff and was unsure if she documented the incident in the nursing notes. Interview with the DNS on 4/2/25 at 1:35 PM indicated that after the allegation was reported to her for the first time on 3/31/25 at 12:30 PM she started the investigation which caused a delay in reporting the incident to the State Agency. The DNS indicated that RN #6 had investigated the situation when it occurred, however, the DNS was not aware of the incident involving Resident #4 because RN #6 did not report it. Review of the nurses and social worker notes and the care plan dated 2/1/25 through 4/3/25 failed to reflect documentation of the allegation. Although the resident reported the incident to RN #6 when it happened, RN #6 did not report the incident to the DNS or Administrator, the staff member was not identified or removed, and an investigation was not initiated. According to the DPH reportable events portal, the incident took place at the end of February 2025, was not reported to DPH until 4/1/25, and the investigation summary was not submitted until 4/11/25. Further, when requested, a statement obtained from RN #6, who was the supervisor on the day of the allegation, was undated and there was no statement from the alleged nurse aide involved. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Resident/Patient Abuse policy revised 2/8/23 identified all incidents or events that constitute alleged, suspected or actual abuse will be thoroughly investigated, initially by the nursing supervisor to whom it was reported and a complete investigation by the department head. Following the initial report of alleged or suspected abuse, the involved department head shall immediately initiate an investigation of the incident that shall include, but not limited to interviewing of the resident and/or family, and interviewing all staff involved. As a first step, the employee shall be removed from the assignment and interviewed independently. The immediate and initial first response is suspension from duty pending final investigation outcome.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50249 Based on review of the clinical record, facility documentation, facility policy and interviews for 1 resident (Resident #420) reviewed for a significant medication error, the facility failed to ensure the correct dose of a controlled pain medication was administered per the physician's order. The findings include: Resident #420's diagnoses included displaced fracture of the left leg, spiral fracture of the left tibia and chronic pain. A physician's order dated 1/23/25 directed to administer Morphine Sulfate Oral Solution 10mg/5ml, give 2.5 ml by mouth every 4 hours as needed for moderate pain x 10 days. A pain evaluation and management record dated 1/23/25 identified Resident #418 had severe pain in his/her left leg and upper extremity and was being followed up by pain management. Review of the State of Connecticut Department of Public Health Reportable Events form dated 1/24/25 identified an unintentional overdose of Morphine Sulfate Oral Solution had occurred with Resident #418 at 10:00 AM. The form indicated that no adverse effects were noted, and the resident remained stable. A physician's order dated 1/24/25 at 12:30 PM directed to hold Morphine Sulfate Oral Solution 10mg/5ml by mouth until 6:00 PM this evening (1/24/25 at 6:00 PM) A nurse's note, written by the DNS dated 1/24/25 at 5:59 PM identified a medication error involving the administration of Morphine Sulfate Oral Solution had occurred at 10:14 AM. Resident #420 had been administered a 50mg dose of the medication instead of the 5mg dose that had been ordered (100mg/5ml solution was administered instead of the 10mg/5ml solution that was ordered). The resident, DNS, APRN and MD were all notified of the error, and the resident was ordered to be closely monitored with the Morphine Sulfate Oral Solution order put on hold for re-administration until 6:00 PM on 1/24/25. Resident #420 had exhibited no apparent adverse reactions at the time of the evaluation. A nurse's note dated 1/24/25 at 6:08 PM identified Resident #420 had been administered Morphine Sulfate Oral Solution 10mg/5ml, 2.5 ml by mouth as needed for moderate pain. The admission MDS dated [DATE] identified Resident #420 was cognitively intact and was dependent with bed mobility, toileting, and transfers. The MDS indicated Resident #420 frequently experienced pain and received scheduled and as needed pain medications. The care plan dated 2/3/25 identified an alteration in musculoskeletal status related to displaced spiral fracture of the shaft of the left tibia. Interventions included to administer analgesics as ordered by the physician and monitor and document for side effects and effectiveness. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and review of facility documents with the RN supervisor (RN #3) on 4/7/25 at 12:25 PM identified she did not have the Morphine Sulfate Oral Solution 100mg/5ml stored in the Omnicell because the bar code was not working, and she was unable to store the medication in the Omnicell. RN #3 identified the pharmacy, and the DNS were aware and while she awaited intervention by the pharmacy, she had the Morphine Sulfate stored in a locked cabinet in the nursing supervisor's office. RN #3 indicated on the morning of 1/24/25 she was contacted by LPN #8 who stated Resident #420's Morphine Sulfate Oral Solution had not yet arrived from the pharmacy and the resident was in a lot of pain. RN #3 identified that had the medication been in the Omnicell, that would have required two nurse witnesses, but since the medication was in the locked cabinet in the supervisor's office, she alone removed the Morphine Sulfate Oral Solution 100mg/5ml and brought it to LPN #8. RN #3 indicated that she should have compared Resident #420's physician's order to the medication before dispensing the Morphine Sulfate 100mg/5ml solution to LPN #8 but had made a mistake. RN #3 further identified that she was busy that day and when LPN #8 asked for the Morphine Sulfate Oral Solution she gave her what was in the locked cabinet and never checked the order in the computer. Interview with the DNS on 4/7/25 at 1:00 PM identified she was immediately notified of the medication error with the Morphine Sulfate Oral Solution on 1/24/25 and completed an assessment of Resident #420 after the incident. The DNS indicated that she was aware that the Morphine Sulfate Oral Solution 100mg/5ml was being kept in a locked cabinet in the supervisor's office and she identified she had emailed the pharmacy and informed them of the issue with the Omnicell/barcode. The DNS identified that if the Morphine Sulfate Oral Solution was secured in the Omnicell, it would have required 2 licensed nurses to remove the medication from the device. The DNS indicated that although RN #3 should have compared the Morphine Sulfate Oral Solution with Resident #420's physician's order before dispensing the medication to LPN #8, RN #3 did not, and LPN #8 assumed it was the correct medication and administered the incorrect dose to the resident. Per the DNS, when LPN #8 realized her medication administration error, she notified RN #3 and the DNS. The DNS identified that Resident #420 had no apparent ill effects after the medication error and both RN #3 and LPN #8 were disciplined and re-education was completed with the facility's licensed nursing staff after the incident. Although requested, the DNS was unable to provide her email to the pharmacy regarding the Omnicell/barcode issue. Interview with LPN #8 on 4/8/25 at 11:30 AM identified that although she read the medication order for Resident #420 from her computer when she called RN #3 to request the Morphine Sulfate Oral Solution on the morning of 1/24/25, she did not check the label on the Morphine Sulfate Oral Solution 100mg/5ml with the physician's order prior to administering the medication to Resident #420. LPN #8 identified after she administered the medication to Resident #420, she looked at the Morphine Sulfate oral solution box and realized she had made a mistake and administered the wrong concentration and dosage to the resident. LPN #8 indicated she immediately notified RN #3 and the DNS of her medication administration error and went and checked on Resident #420 and informed the resident about the error. LPN #8 further identified this was a serious error because she failed to complete the necessary checks before administering a controlled substance. Review of the facility policy, Medication Related Errors, dated 12/1/07, directed an example of an administration error would include when a facility administers to the resident a medication dose by the correct route but in a different dosage than was specified by the original order. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy, General Dose Preparation and Medication Administration, dated 12/1/07, directed the facility should take all measures required by facility policy and applicable law including using a 3 way check to compare the medication to the medication administration record (MAR) and to the prescription label. In addition, prior to administration of medication facility staff should verify each time a medication is administered that it is the correct medication, at the correct dose, and confirm that the MAR reflects the most recent medication order.