STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075047	A. Building B. Wing	12/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hewitt Health & Rehabilitation Center, Inc	45 Maltby Street Shelton, CT 06484

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43184 Based on clinical record reviews, facility documentation, facility policy and interviews for one (1) of three (3) sampled residents (Resident #2) who were reviewed for an accident, the facility failed to ensure Resident #2 had Geri-leg sleeves applied per the physician's order to prevent a left leg laceration that required sutures and steri-strips. The findings include: Resident #2's diagnoses included Parkinson's Disease without dyskinesia, dementia, psychotic disorder, muscle weakness and history of falls. A physician order dated 9/2/24 directed to apply Geri-legs on Resident #2's legs in the morning and remove at night. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #2 had a Brief Interview for Mental Status (BIMS) score of seven (7) out of fifteen (15) indicting severe cognitive impairment and Resident #2 required extensive one (1) person assistance with transfers. The Resident Care Plan dated 9/4/24 identified risk for skin impairment. Interventions directed to apply Geri-legs in the morning and remove at night, and gentle handling during all transfers and care procedures. The hospital Emergency Department note dated 9/16/24 identified when Resident #2 was being transferred to bed Resident #2's left lower leg got caught on the rail causing a three (3) inch laceration, there was minimal bleeding and Resident #2 denied pain The nurse's note dated 9/17/24 at 2:12 AM identified the Nursing Supervisor, Registered Nurse (RN) #2, was notified by the charge nurse that Resident #2 had sustained a skin tear. The note identified Resident #2 was noted to have a laceration to the left lower leg that measured 12 centimeters (cm) by 5 cm. The note identified the nurse aide, Nurse Aide (NA) #1, reported that while transferring Resident #2 at 6:42 PM from the wheelchair to the bed, she noticed Resident #2's foot stuck to the side rail. The note indicated the Advanced Practice Registered Nurse (APRN) was notified, and an order was given to send Resident #2 to the emergency department for evaluation and Resident #2 was transferred at 7:30 PM. The note identified Resident #2 returned to the facility at 10:00 PM with three (3) sutures placed and the remainder of the wound was covered with ten (10) steri-strips. (continued on next page)

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

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the nurse, Licensed Practical Nurse (LPN) #2, on 12/5/24 at 11:57 AM identified on 9/16/24, NA #1 reported Resident #2 had sustained a laceration while transferring from the wheelchair to bed. LPN #2 identified the supervisor was called and the resident was sent to the ED. LPN #2 indicated she could not recall if Resident #2 was wearing Geri-legs at the time of the incident. Interview with NA #1 on 12/5/24 at 1:48 PM identified while she was transferring Resident #2 from the wheelchair to bed, she noticed the resident's leg was bleeding after removing his/her pants. NA #1 could not recall if Resident #2 was wearing Geri-legs at the time of the transfer. Interview with RN #2, the Director of Nursing (DON) at time of this incident, on 12/5/24 at 1:59 PM identified it was reported that during a transfer, Resident #2 sustained a laceration to the lower extremity. RN #2 identified this laceration was in an area of a previous opening that had reopened. RN #2 could not recall if Resident #2 was wearing Geri-legs at the time of the transfer. RN #2 further identified if there was an order for Geri-legs, Resident #2 should have had them on. Interview with the current DON identified if there is an order for Geri-legs, it is the expectation that the Geri-legs should be on.

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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 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** 43184 Based on clinical record reviews, facility documentation, facility policy and interviews for one (1) of three (3) sampled residents (Resident #1) who exhibited behavioral symptoms, the facility failed to ensure a change in the anti-anxiety medication, Ativan, order was sent to the pharmacy and a follow through with the pharmacy when the Ativan was not available to prevent missed doses which resulted in Resident #1 having increased anxiety and agitation. The findings include: Resident #1's diagnoses included Alzheimer's Disease and depression. The Resident Care Plan dated 11/1/24 identified Resident #1 was at risk for potential adverse effects of psychotropic drug use. Interventions directed to be aware of the resident's mood and behavior, be aware of mental status functioning on an ongoing basis, identify common behavioral expressions and expected responses to interventions, implement appropriate individualized, person centered interventions and document results. The admission Minimum Data Set assessment dated [DATE] identified Resident #1 was not able to complete the Brief Interview for Mental Status (BIMS) indicating severe cognitive impairment. A physician's order dated 11/7/24 directed to administer Ativan 0.5 milligrams (mg) by mouth every eight (8) hours as needed for anxiety. The psychiatric provider note dated 11/11/24 identified Resident #1 was seen due to increased anxiety and agitation. The note identified an order was in place for Ativan 0.5 mg by mouth every eight (8) hours as needed for anxiety and agitation. The provider note identified the plan was to discontinue the Ativan 0.5 mg as needed dose and start on Ativan 0.25 mg by mouth at 6:00 AM and 2:00 PM and Ativan 0.5 mg at hour of sleep. A physician's order dated 11/12/24 directed to give Ativan 0.25 mg twice a day by mouth at 6:00 AM and 2:00 PM. The nurse's note dated 11/11/24 at 3:31 PM identified the order for the Ativan 0.5 mg by mouth every eight hours as needed was discontinued and a new order was given which directed to start Ativan 0.25 mg by mouth twice a day at 6:00 AM and 2:00 PM and start Ativan 0.5 mg at hour of sleep (HS). The nurse's note dated 11/12/24 at 2:37 PM identified the Ativan 0.25 mg was not available. The nurse's note dated 11/12/24 at 2:43 PM identified Resident #1 became aggressive with another resident and when staff attempted to intervene, Resident #1 became aggressive with the staff. The note identified Resident #1 was redirected and was placed on one-to-one (1:1) observations for approximately thirty (30) minutes with no further aggressive episodes for the remainder of the shift. (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 nurse's notes from 11/12/24 at 2:43 PM through 11/14/24 identified Resident #1 continued to pace back and forth on the unit, was walking into other resident rooms and yelling at the other residents, displayed an agitated, anxious mood, made repetitive actions of calling out and yelling with no response to redirection. The note dated 11/13/24 at 6:08 AM identified Resident #1 was given a dose of the as needed medication for anxiety and Resident #1 appeared less anxious after the intervention. Upon further review, although the nurse's notes identified the physician or Advanced Practice Registered Nurse (APRN) were updated regarding Resident #1's behaviors, the notes failed to identify the provider was informed that the Ativan 0.25 mg was not available, and the notes did not indicate the pharmacy had been contacted. The Advanced Practice Registered Nurse progress note dated 11/14/24 at 4:13 PM identified Resident #1 had increased agitation. The note indicated the Ativan 0.25 mg had not been given at 2:00 PM on 11/12/24, at 6:00 AM and 2:00 PM on 11/13/24 and 11/14/24, and the 9:00 PM dose of Ativan 0.5 mg was not given on 11/12/24. The note identified a stat (immediate) order was given that directed to administer Ativan 0.5 mg now. The note identified prescriptions were written and faxed to the pharmacy for a stat refill of the medication. Review of the November 2024 Medication Administration Record (MAR) identified the scheduled Ativan 0.25 mg dose was not administered on 11/12/24 at 2:00 PM, on 11/13/24 at 6:00 AM and 2:00 PM, on 11/14/23 at 2:00 PM, and on 11/14/24 at 6:00 AM for a total of five (5) doses missed and the 9:00 PM dose of Ativan 0.5 mg was not given on 11/12/24. The nurse's note dated 11/14/24 at 5:27 PM identified Resident #1 demonstrated aggressive behaviors toward another resident, the APRN was notified, an order directed to send Resident #1 to the hospital, and Resident #1 was transported at 5:15 PM. The nurse's note dated 11/16/24 11:40 AM identified Resident #1 returned from the hospital at 11:00 AM. Interview with the Assistant Director of Nursing (ADON) on 12/5/24 at 12:07 PM identified it is facility policy when there was a new or changed controlled medication, the provider must send the prescription to the pharmacy, and this was communicated to the staff either verbally or by flagging it in the resident's electronic medical record (EMR). The ADON identified for Resident #1, the provider wrote the new prescription for the change in the Ativan order, one of the charge nurses, Licensed Practical Nurse (LPN) #1, entered the order and it was communicated to the supervisor, who asked the provider to send the prescription into the pharmacy. The ADON could not identify when the prescription was sent to the pharmacy or when it was communicated to the pharmacy. The ADON indicated if a medication was not available, the charge nurse should report this to the supervisor, see if the medication was available in the emergency box, and if necessary, contact the provider to get further instructions. The ADON identified there was no follow-up on the changed Ativan dose with the pharmacy. Interview with LPN #1 on 12/5/24 at 12:22 PM identified she was made aware of the new order for the Ativan via the report and on the orders. LPN #1 identified all nurses are responsible for ensuring the pharmacy receives the new or changed medication order and reports it to the supervisor. LPN #1 identified she did not notify the provider, and she was unsure if any other staff member notified the provider regarding the Ativan 0.25 mg tablet not being available for the scheduled doses. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Pharmacy Technician at Omnicare pharmacy on 12/5/24 at 12:39 PM identified the pharmacy did not receive a new script for the Ativan until 11/16/24. Interview with the former Director of Nursing, Registered Nurse (RN) #2, on 12/5/24 at 1:54 PM identified when the provider writes a new or changed prescription for a controlled medication, the provider will send the prescription to the pharmacy. RN #2 identified it is the responsibility of the provider as well as the staff nurses to ensure the new or changed prescription was sent to the pharmacy. RN #2 identified she would expect immediate follow up with the pharmacy if the medication was not received for the resident's next dose. RN #2 explained when the Ativan was not available and was not in the emergency box on 11/12/24, the charge nurse reported it to the supervisor, and this is where there should have been follow up with the pharmacy as well as the provider. RN #2 identified there was a miscommunication, no follow up and the prescription fell through the cracks. RN #2 indicated when Resident #1 behaviors escalated was the time when they followed up with the pharmacy and APRN. Interview and clinical record review with the current Director of Nursing (DON) on 12/5/24 at 2:08 PM identified when a resident has a new or changed medication, once the prescription is put into the EMR, it automatically goes to the pharmacy through an interface with the pharmacy. The DON identified that if a medication was a controlled medication, a written prescription must be sent to the pharmacy as well. The DON identified the Ativan prescription should have been followed-up with the pharmacy when there was an order in the system and the medication was not available. Review of the facility policy titled Reordering, Changing and Discontinuing Medication orders, last revised 7/1/24 directed, in part, facility staff should review the transmitted re-orders for status and potential issues and pharmacy response. Additionally, the policy directed, in part, any request to change an existing order should be treated by the facility as a new order with corresponding cancellation of the previous order. Although attempted, an interview with the APRN was unable to be obtained.