STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075060	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Salmon Brook Rehab and Nursing	72 Salmon Brook Drive Glastonbury, CT 06033

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** 44675 Based on review of the clinical record, facility documentation, facility policy, and interviews for one (1) of three (3) residents (Resident #1) reviewed for allegation of neglect, the facility failed to conduct a thorough investigation for a resident with an allegation of neglect. The findings include: Resident #1 was admitted to the facility with diagnoses that included spina bifida, neurogenic bladder and spinal stenosis. A physician's order dated 4/25/24 directed to ensure Resident #1 was turned and repositioned every two hours every shift for wound prevention. Braden scale dated 4/26/24 identified Resident #1 was at risk for developing pressure sores. The MDS dated [DATE] identified Resident #1 had no impairments in cognition, no behaviors, was incontinent of bowel and bladder and required extensive assistance of one staff for toilet use and bed mobility. The care plan dated 7/23/24 identified Resident #1 had an ADL self-care performance deficit related to spina bifida. Interventions included to offer Resident #1 early care on the 7:00 AM - 3:00 PM shift prior to breakfast. The care plan further identified Resident #1 had the had a pressure ulcer due to decreased mobility with interventions that included assistance to turn and reposition at least every two hours and more often as needed. Review of Resident #1's care card identified Resident #1 was non-ambulatory, incontinent of bladder, required assistance of one staff for bathing, toileting and dressing at bed level and offer to get Resident #1 out of bed at breakfast time. Review of Resident #1's grievance form dated 8/26/24 identified Resident #1 had his/her call bell on for almost one and a half hours and nobody ever came in. It identified the grievance was resolved but failed to identify the resolution. Resident #1's statement identified on 8/26/24 at 8:33 AM Resident #1 but his/her call bell on. Resident #1 identified LPN #1 answered and stated his/her NA would not be in until 9:00 AM. At 9:30 AM Resident #1 put the bed to the floor, crawled over to his/her wheelchair in the bathroom and got into his/her wheelchair. The grievance form contained an unnamed statement, statement from Resident #1 and statement from LPN #1. (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 grievance form failed to conduct a thorough investigation of Resident #1's concerns including staff statements and look back at the care provided for Resident #1 on 8/26/24. Review of Resident #1's care flowsheets dated 8/26/24 identified for the 7:00 AM - 3:00 PM shift there was no documentation of care provided. Interview with Resident #1 on 9/5/24 at 10:00 AM identified he/she is supposed to be out of bed before breakfast time per his request, which he/she identified was put into his/her care plan. Resident #1 had documentation of his/her concerns from 8/26/24 that identified he/she had his/her call bell on at 8:33 AM to receive incontinent care and to get out of bed, and Resident #1 was not provided care. Resident #1 identified he/she had to pull his/herself out of bed and drag him/herself to the bathroom. Interview with the Rehab Director on 9/5/24 at 12:32 PM identified that the resident would not capable of dragging his lower body to the bathroom and getting himself into a wheelchair as he/she does not feeling from the waist down. Interview with LPN #1 on 9/5/24 at 10:30 AM identified she was Resident #1's nurse on 8/26/24 on the A wing during the 7:00 AM - 3:00 PM shift. She identified she came into Resident #1's room after breakfast around 9:30 AM and Resident #1 was screaming that he/she wanted a NA right at that moment. LPN#1 further identified there was one NA on the floor for her wing, A wing. Interview with NA #2 on 9/5/24 at 2:00 PM identified she was the only NA on 8/26/24 on the floor for A wing during the 7:00 AM - 3:00 PM shift (for 22 residents). However, she identified she was not assigned to Resident #1 and did not provide care for Resident #1. She further identified she was not interviewed in regard to Resident #1's concerns from 8/26/24. Interview with NA #3 on 9/5/24 at 2:09 PM identified on 8/26/24 she came in around 9:00 AM. She identified she provided care for Resident #1 between 10:30 AM and 11:00 AM, and the resident was still in bed when she provided care. Interview with the Administrator on 9/5/24 at 3:00 PM identified at 9:00 AM Resident #1 called her with concerns and stating he/she had been waiting for assistance for a while. She identified she spoke with LPN #1 and NA #1 and identified they were trying to care for other residents. Subsequent to surveyor inquiry, she was not aware NA #1 was not assigned to Resident #1 and not providing care for him/her. She further identified she spoke with LPN #1 to ensure Resident #1 would be out of bed for breakfast (however, Resident #1 was not out of bed for breakfast). The administrator was not able to identify why an investigation was not conducted into Resident #1's concerns. Review of the abuse reporting policy directed the facility will not condone resident abuse by anyone, including staff members, other residents, family members, legal guardians, sponsors, friends or other individuals. Any alleged violations involving mistreatment, neglect, or abuse must be reported to the administrator. It further identified neglect is defined as the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. It identified a completed copy of the reportable event form and written statements from witnesses, if any, must be provided to the administrator within

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32738 Based on review of the clinical record, facility documentation, facility policy, and interviews for one (1) of three (3) residents, (Resident #1), reviewed for activities of daily living, the facility failed to ensure a resident who required extensive assistance with activities of daily living was provided incontinent care and turning and repositioning in accordance with the plan of care and physician orders. The findings include: Resident #1 had diagnoses that included spina bifida, neurogenic bladder and spinal stenosis. A physician's order dated 4/25/24 directed to ensure Resident #1 was turned and repositioned every two hours, every shift for wound prevention. Braden scale dated 4/26/24 identified Resident #1 was at risk for developing pressure sores. The MDS dated [DATE] identified Resident #1 had no impairments in cognition, no behaviors, was incontinent of bowel and bladder and required extensive assistance of one staff for toilet use and bed mobility. The care plan dated 7/23/24 identified Resident #1 had an Activity of Daily Living (ADL) self-care performance deficit related to spina bifida with interventions that included to offer Resident #1 early care on the 7:00 AM to 3:00 PM shift prior to breakfast. The care plan further identified that the resident had stage 3 pressure ulcer on the sacrum and was at risk for further pressure ulcer development due immobility and incontinence with interventions that included assistance to turn and reposition at least every two hours and more often as needed and to keep skin clean and dry. Review of Resident #1's care card identified Resident #1 was non-ambulatory, incontinent of bladder, required assistance of one staff for bathing, toileting and dressing at bed level and offer to get Resident #1 out of bed at breakfast time. Review of Resident #1's grievance form dated 8/26/24 identified Resident #1 had his/her call bell on for almost one and a half hours and nobody ever came in. Resident #1's statement identified on 8/25/24 at 8:33 AM Resident #1 placed his/her call bell on to request incontinent care. Resident #1 identified LPN #1 answered and stated his/her NA would not be in until 9:00 AM. At 9:30 AM Resident #1 put the bed to the floor, crawled over to his/her wheelchair in the bathroom and got into his/her wheelchair. Review of Resident #1's care flowsheets dated 8/26/24 identified for the 7:00 AM to 3:00 PM shift there was no documentation of care provided. Review of a wound assessment dated [DATE] identified that the resident had a stage 3 pressure ulcer on his/her sacrum that measured 2.3 cm in length, 1 cm in width and 0.3 in depth. (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Resident #1 on 9/5/24 at 10:00 AM identified he/she is supposed to be out of bed before breakfast time per his request and his/her plan of care. Resident #1 had documentation of his/her concerns from 8/26/24 that identified he/she had his/her call bell on at 8:33 AM and Resident #1 was not provided care. Resident #1 identified he/she had to pull his/herself to the bathroom. Interview with the Rehab Director on 9/5/24 at 12:32 PM identified that the resident would not capable of dragging his lower body to the bathroom and getting himself into a wheelchair as he/she does not have feeling from the waist down. Interview with LPN #1 on 9/5/24 at 10:30 AM identified she was Resident #1's nurse on 8/26/24 on the A wing during the 7:00 AM to 3:00 PM shift. She identified she came into Resident #1's room after breakfast around 9:30 AM and Resident #1 was screaming that he/she wanted a NA right at that moment. She further identified there was one NA on the floor for her wing, A wing. Interview with NA #2 on 9/5/24 at 2:00 PM identified she was the only NA on 8/26/24 on the floor for A wing during the 7:00 AM to 3:00 PM shift (for 22 residents). She had not provided any care to the Resident #1 because that morning because she was not assigned to Resident #1. Interview with NA #3 on 9/5/24 at 2:09 PM identified on 8/26/24 she came in around 9:00 AM. She identified she provided care for Resident #1 while he/she was still in bed between 10:30 AM and 11:00 AM. She identified Resident #1 was incontinent of urine. (incontinent care was provided 2 hours after the resident initially rang the call bell for assistance). NA#3 further identified that Resident #1 was in bed when she provided care. The resident was not provided turning and repositioning or incontinent care from the start of the shift at 7:00 AM to 10:30 AM (3.5 hours) and when the resident requested incontinent care he/she was not provided incontinent care until 10:30 AM (2 hours after h/her request). Review of staffing on 8/26/24 identified the census was 100 and required 217 nursing and NA hours between 7:00 AM - 9:00 PM. The facility had 194 hours (a deficit of 23 hours). On A wing (Resident #1's unit), there was one NA for 22 patients, until 9 AM when NA #3 arrived to assist. On C wing, there was one NA for 26 patients, until 12:00 PM when a second NA arrived. Interview with the Administrator on 9/5/24 at 3:00 PM identified at 9:00 AM Resident #1 called her with concerns and stating he/she had been waiting for assistance for a while. She identified she spoke with LPN #1 and NA #1 and identified they were trying to care for other residents. She further identified she spoke with LPN #1 to ensure Resident #1 would be out of bed for breakfast (however, Resident #1 was not out of bed for breakfast). Review of the pressure ulcer treatment protocol directed the following interventions may be used for pressure areas; change position at least every two hours and render incontinence care as warranted.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44675 Based on review of the clinical record, facility documentation, facility policy, and interviews for one (1) of three (3) residents (Resident #1) reviewed for neglect, the facility failed to ensure appropriate staffing to meet the needs of the resident. The findings include: Resident #1 had diagnoses that included spina bifida, neurogenic bladder and spinal stenosis. A physician's order dated 4/25/24 directed to ensure Resident #1 was turned and repositioned every two hours, every shift for wound prevention. Braden scale dated 4/26/24 identified Resident #1 was at risk for developing pressure sores. The MDS dated [DATE] identified Resident #1 had no impairments in cognition, no behaviors, was incontinent of bowel and bladder and required extensive assistance of one staff for toilet use and bed mobility. The care plan dated 7/23/24 identified Resident #1 had an Activity of Daily Living (ADL) self-care performance deficit related to spina bifida with interventions that included to offer Resident #1 early care on the 7:00 AM - 3:00 PM shift prior to breakfast. The care plan further identified Resident #1 had the potential for pressure ulcer development due immobility and incontinence with interventions that included assistance to turn and reposition at least every two hours and more often as needed and to keep skin clean and dry. Review of Resident #1's care card identified Resident #1 was non-ambulatory, incontinent of bladder, required assistance of one staff for bathing, toileting and dressing at bed level and offer to get Resident #1 out of bed at breakfast time. Review of Resident #1's grievance form dated 8/26/24 identified Resident #1 had his/her call bell on for almost one and a half hours and nobody ever came in. The grievance was resolved but failed to identify the resolution. Resident #1's statement identified on 8/25/24 at 8:33 AM Resident #1 but his/her call bell on. Resident #1 identified LPN #1 answered and stated his/her NA would not be in until 9:00 AM. At 8:20 AM Resident #1 was told by LPN #1 his/her NA called out and the replacement would not be in until 9:00 AM. At 9:30 AM Resident #1 put the bed to the floor, crawled over to his/her wheelchair in the bathroom and got into his/her wheelchair. Review of Resident #1's care flowsheets dated 8/26/24 identified for the 7:00 AM to 3:00 PM shift there was no documentation of care provided. Review of a wound assessment dated [DATE] identified that the resident had a stage 3 pressure ulcer on his/her sacrum that measured 2.3 cm in length, 1cm in width and 0.3 in depth. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Resident #1 on 9/5/24 at 10:00 AM identified he/she is supposed to be out of bed before breakfast time per his request and his/her plan of care. Resident #1 had documentation of his/her concerns from 8/26/24 that identified he/she had his/her call bell on at 8:33 AM and Resident #1 was not provided care. Resident #1 identified he/she had to pull his/herself to the bathroom. Interview with LPN #1 on 9/5/24 at 10:30 AM identified she was Resident #1's nurse on 8/26/24 on the A wing during the 7:00 AM to 3:00 PM shift. She identified she came into Resident #1's room after breakfast around 9:30 AM and Resident #1 was screaming that he/she wanted a NA right at that moment. She identified she was trying to get a NA and that Resident #1 did not want her. She further identified there was one NA on the floor for her wing, A wing. Interview with NA #2 on 9/5/24 at 2:00 PM identified she was the only NA on 8/26/24 on the floor for A wing during the 7:00 AM to 3:00 PM shift (for 22 residents). She had not provided any care to the resident because that morning becuase she was not assigned to Resident #1. Interview with NA #3 on 9/5/24 at 2:09 PM identified on 8/26/24 she came in around 9:00 AM. She identified she provided care for Resident #1 while still in bed between 10:30 AM and 11:00 AM. She identified Resident #1 was incontinent of urine. (incontinent care was provided 2 hours after the resident initially rang the call bell for assistance). The resident was not provided turning and repositioning or incontinent care from the start of the shift at 7:00 AM to 10:30 AM (3.5 hours) and when the resident requested incontinent care he/she was not provided incontinent care until 10:30 AM (2 hours after h/her request). Review of staffing on 8/26/24 identified the census was 100 and required 217 nursing and NA hours between 7:00 AM - 9:00 PM. The facility had 194 hours (a deficit of 23 hours). On A wing (Resident #1's unit), there was one NA for 22 patients, until 9 AM when NA #3 arrived to assist. On C wing, there was one NA for 26 patients, until 12:00 PM when a second NA arrived. Interview with the Administrator on 9/5/24 at 3:00 PM identified at 9:00 AM Resident #1 called her with concerns and stating he/she had been waiting for assistance for a while. She identified she spoke with LPN #1 and NA #1 and identified they were trying to care for other residents. She further identified she spoke with LPN #1 to ensure Resident #1 would be out of bed for breakfast (however, Resident #1 was not out of bed for breakfast). Review of the Connecticut Public Health Code Section 19a-563h directed that in no instance shall a chronic and convalescent nursing home have total nursing and nurse's aid staff below 1.6 hours per resident during 7:00 AM - 9:00 PM and .50 hours per resident during 9:00 PM - 7:00 AM. Review of the pressure ulcer treatment protocol directed the following interventions may be used for pressure areas; change position at least every two hours and render incontinence care as warranted.