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	02/04/2025

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

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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 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** 50059 Based on clinical record reviews, facility documentation, facility policy and interviews for one (1) of three (3) sampled residents (Resident #7) who were reviewed for an allegation of abuse, the facility failed to ensure a staff member did not video tape the resident and post the video on social [NAME]. The findings include: Resident #7's diagnoses included Alzheimer's, depression, and agitation. The annual Minimum Data Set assessment dated [DATE] identified Resident #7 had poor memory recall deficits, and was dependent on staff with transfers, personal hygiene, and dressing. The Resident Care Plan dated 11/5/24 identified Resident #7 had impaired thought processes related to Alzheimer's. Interventions directed to cue, anticipate needs, alleviate anxiety. The Facility Reported Incident report date1/14/25 at 12:00 PM identified a staff member reported that videos were recorded of a staff member interacting with residents in an unprofessional manner. The investigation identified in 1/14/25 a staff member brought to the Director of Nursing's attention that videos were posted online awhile back, the videos were shared with the Director of Nursing (DON) and then deleted from the staff member's phone. The report indicated the videos contained an unknown female being told they could not go into the dining room, a resident receiving care in which the resident's legs were in the video, and Resident #7 being spoken to inappropriately as Resident #7 was rummaging through things in the recreation room, and the staff member was saying to Resident #7 what are you thieving now. The psych progress note dated 1/14/25 identified Resident #7 was seen in a follow up visit and Resident #7 was unable to recall any details of the recent event and was doing perfectly fine. (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Director of Nursing (DON) on 2/4/25 at 1:45 PM identified a housekeeper reported to him the recreation aide had made videos of residents and posted them to social media. The DON stated he reviewed the videos and identified the following: Video #1 identified the recreation aide had video recorded asking Resident#7 if Resident #7 was thieving while rummaging through the bins in the recreation room. Video #2 identified the recreation aide in a resident room recording personal care, and the resident's lower legs had been visible on the video. Video #3 identified the recreation aide recording a resident in the dining area telling the resident he/she had been banned from the dining area and all recreational activities. The video recorded an exchange of words between the resident and the recreation aide. The DON stated the recreation aide was terminated at the conclusion of the investigation, and the social media posts had been deleted. Although attempted, interviews with the housekeeper and the recreation aide were unsuccessful. Review of the Residents Photographs or Recording Policy dated 10/1/16 identified each resident has a right to privacy and confidentiality for all aspects of care and services. Review of the Abuse Policy dated 6/23 identified abuse includes verbal, sexual, physical, and mantal abuse, including abuse facilitated or enabled through the use of technology.

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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** 51756 Based on record review, facility documentation and staff interviews for 1 of 3 sampled residents reviewed for accidents (Resident #2), the facility failed to conduct a thorough investigation for an injury of unknown origin. The findings include: Resident #2 was admitted to the facility in August 2024 with diagnoses that included dementia with behaviors, adjustment disorder with mixed anxiety and depression. A Resident Care Plan dated 11/6/24 identified a problem with behaviors, being physically aggressive, destructive in his/her room, and was noted to take the television off of the wall in his/her room. Interventions included to allow Resident #2 to make decisions regarding treatment regimen, encourage participation during care and activities and praise the resident when behavior was appropriate. Nursing notes dated 12/3/24 through 12/10/24 identified that Resident #2 did not exhibit any negative behaviors or anxiety. The quarterly Minimum Data Assessment (MDS) assessment dated [DATE] identified Resident #2 was severely cognitively impaired and required total dependence from staff for washing, dressing, toileting, moderate assistance for walking short distances, and independent with eating. The APRN progress noted dated 12/10/24 identified Resident #2 was examined due to increased pain to the right wrist, swelling and decreased range of motion. The APRN ordered a stat (immediate) x-ray of the right wrist. A facility Accident and Incident Report dated 12/11/24 at 10:00 AM identified that Resident #2 complained of discomfort to the right wrist. An x-ray was obtained on 12/11/24 at 12:26 PM and at 7:01 PM results indicated a fracture of the right ulnar styloid process (right wrist). The APRN was notified at that time and directed to stabilize the wrist and pain management. A review of the facility investigation failed to identify a complete and thorough investigation was conducted following the diagnosis of a right wrist fracture on 12/11/24. A 72-hour look back was not completed (per facility policy) and statements were obtained from only (5) 7:00 AM to 3:00 PM nursing staff that worked on 12/10/24 and no other staff on other shifts were interviewed. All 5 staff member statements identified that no one witnessed Resident #2 hitting his/her hand, but Resident #2 had history of attempting to get up from wheelchair unassisted and flails his/her hands frequently. A change of condition nursing note dated 12/12/24 at 1:15 PM was completed with recommendations from the APRN to stabilize Resident #2's right wrist. The physician assessed Resident #2's right wrist on 12/16/24 (5 days after the x-ray report identifying the fracture) with a new physician's order to send Resident #2 to the emergency room (ER) for an Orthopedic evaluation and treatment. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident # 2 was evaluated in theER on [DATE] (5 days after being diagnoses with a right wrist fracture). The ER physician in consultation with orthopedics determined that findings were consistent with chronic fractures and not acute. Recommendations for Resident #2 to have a cock-up splint to the right wrist for comfort and outpatient follow up with orthopedic services. Resident #2 returned to the facility with a splint to the right wrist. An interview and a review of facility documentation with the DNS on 1/30/25 at 1:37 PM identified that the facility policy was to conduct interviews/and statements for a 72 hour look back period related to injuries of unknown origin. The DNS indicated that a 72 hour look back was not conducted and that the facility should have conducted a 72 hour look back. The DNS concluded that Resident #2 must have hit his/her hand on the hallway rail when sitting in his/her wheelchair.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50094 Based on record review, facility documentation, and staff interviews for 2 of 3 residents (Resident #1 and Resident #3) reviewed for accidents, the facility failed to complete neurological assessments following an unwitnessed fall, and for 1 of 3 residents reviewed for accidents (Resident #2), the facility failed to provide documentation of wrist stabilization per APRN recommendations following a fracture. The findings include: 1. Resident #1 had a diagnosis of dementia, falls, osteoporosis, and adjustment disorder. Quarterly Minimum Data Set (MDS) dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of 3 indicating severely impaired cognition, no behaviors, required maximal assistance with toileting, and was independent with ambulation. Resident Care Plan (RCP) dated 1/18/2025 identified a risk for falls and required assist with ADLs. Interventions directed to offer assistance with ADL's and was assist of one (1) for transfers. Facility incident report dated 1/18/2025 at 2:35 PM identified Resident #1 got up from her/his wheelchair to walk, lost his/her balance and sustained an unwitnessed fall with left knee pain and bruising. The APRN was updated and ordered an x-ray of the left knee. X-ray of the left knee reported on 1/19/2025 at 3:51 AM identified no evidence of acute fracture or dislocation and mild osteoarthritis. Record review failed to identify neurological signs were monitored after the unwitnessed fall on 1/18/2025. Interview and record review with the DNS and Administrator on 1/30/2025 at 2:02 PM identified he was unable to provide documentation that neurological assessments were completed after the unwitnessed fall on 1/18/2025. The DNS stated neurological assessments should have been completed and was unable to explain why they were not completed. Facility Accident and Incident Investigation policy dated June of 2023 directed that any resident that had an unwitnessed fall will be observed for neurological abnormalities by performing neurological checks after the incident occurs. Facility Neurological Vital Signs policy dated July of 2023 directed staff in cases of possible head injury, neuro vital signs are to be obtained and documented every 15 minutes times 4, every 30 minutes times 4, every hour times 4, and then every shift for the duration of a 72-hour period. 2. Resident #2 was admitted to the facility in August 2024 with diagnoses that included dementia with behaviors, adjustment disorder with mixed anxiety and depression and legally blind. A Resident Care Plan dated 11/6/24 identified a problem with behaviors, physically aggressive, destructive in his/her room, and was noted to take the television off of the wall in his/her room. Interventions included to allow Resident #2 to make decisions regarding treatment regimen, encourage participation during care and activities and praise resident when behavior was appropriate. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nursing notes dated 12/3/24 through 12/10/24 identified that Resident #2 did not exhibit any negative behaviors or anxiety. The quarterly Minimum Data Assessment (MDS) assessment dated [DATE] identified Resident #2 was severely cognitively impaired and required total dependence from staff for washing, dressing, toileting, moderate assistance for walking short distances, and independent with eating. The APRN progress notes dated 12/10/24 identified Resident #2 was examined due to increased pain to the right wrist, swelling and decreased range of motion. The APRN ordered a stat (immediate) x-ray of the right wrist. A facility Accident and Incident Report dated 12/11/24 at 10:00 AM identified that Resident #2 complained of discomfort to the right wrist. An x-ray was obtained on 12/11/24 at 12:26 PM and at 7:01 PM results indicated a fracture of the right ulnar styloid process (right wrist). The APRN was notified at that time and directed to stabilize the wrist and pain management. A nursing note dated 12/12/24 at 1:15 PM was completed for a change in condition with recommendations from the APRN to stabilize Resident #2's right wrist. Review of the physician orders from 12/11/24 through 12/26/24 failed to identify the APRN's recommendation to stabilize Resident #2's right wrist was written. Although Resident #2 did not report increased pain, review of nursing notes, physician orders, and Treatment Administration Record from 12/11/24 through 12/16/24 failed to identify how Resident #2's right wrist was being stabilized or that stabilization occurred. The physician assessed Resident #2's right wrist on 12/16/24 (6 days after the x-ray report identifying the fracture) with a new physician's order to send Resident #2 to the emergency room (ER) for an Orthopedic evaluation and treatment. Resident #2 was evaluated in theER on [DATE]. The ER physician in consultation with orthopedics determined that findings were consistent with chronic fractures and not acute. Recommendations for Resident #2 to have a cock-up splint to the right wrist for comfort and outpatient follow up with orthopedic services. Resident #2 returned to the facility with a splint to the right wrist. Although the APRN directed to stabilize Resident #2's right wrist on 12/11/24, there was no documentation to indicate the manner Resident #2's right wrist was immobilized or that immobilization occurred. 3. Resident #3 was admitted to the facility in February 2022 with diagnoses that included Parkinson's, syncope and collapse, psychotic disorder with delusions and atrial fibrillation (irregular heartbeat). The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #3 had intact cognition and required set up from staff for washing, dressing, toileting, and was independent for walking short distances and eating. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Physician orders dated 11/14/24 directed to administer Eliquis (a blood thinner) 5 milligrams (mg) twice a day and to monitor for any signs and symptoms of bleeding or bruising once a shift as Resident #3 was on a blood thinner. The Resident Care Plan dated 12/1/24 through 1/30/25 identified a concern of being at risk for falls related to unsteadiness on feet, history of falls and Parkinson's disease. Interventions included to anticipate needs, respond promptly for all requests for assistance, keep area around the bed and wheelchair clutter and spill free. A facility Accident and Incident report dated 12/2/24 at 5:30 PM identified Resident #3 was found on the floor with his/her feet stretched out, and Resident #3 was sitting next to the wheelchair and bed with no injuries (an unwitnessed fall). Review of the neurological assessment documentation and nursing notes identified neurological assessments were not completed for 2 of 18 shifts (not completed on 12/4/24 on the 3:00 PM to 11:00 PM shift and on 12/5/24 on the 7:00 AM to 3:00 PM shift). A facility Accident and Incident report dated 1/23/25 at 6:30 PM identified Resident #3 attempted to transfer him/herself from the wheelchair without assistance and the wheelchair rolled away causing Resident #3 to sit on the floor (an unwitnessed fall). Review of the nursing notes (there was no neurological assessment form in the clinical record) failed to identify any neurological assessment had been completed after the unwitnessed fall on 1/23/25. A facility Accident and Incident report dated 1/24/25 at 2:10 PM identified that Resident #3 was found sitting on floor next to his/her wheelchair. Resident #3 verbalized he/she was leaning forward in the wheelchair getting dressed and slid off the wheelchair. Review of the neurological assessment documentation and nursing notes identified neurological assessments were not completed for 3 of 21 shifts (not completed on 1/26/25 for the 11:00 PM to 7:00 AM shift and 3:00 PM to 11:00 PM shift. Also not completed on 1/27/25 for the 11:00 PM to 7:00 AM shift). Interview with the DNS and review of facility documentation on 1/30/25 at 1:28 PM identified that neurological assessment for the fall on 12/2/24 were incomplete. The DNS indicated that medical records could not locate neurological assessment for the fall on 1/23/25. In addition, neurological assessments for the fall on 1/24/25 were incomplete. The DNS indicated that it was the facility policy to complete neurological checks on all unwitnessed falls. Review of the Accident and Incident Investigation policy revised in July 2023 directed, in part, the Administrator, DON or designee will review all accidents/incidents to determine if: 1. Required documentation is completed; and 2. Interventions to prevent further accidents/incidents have been identified and implemented (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Make every effort to ascertain the cause of the accident/incident In addition, the policy directed that any resident that had an unwitnessed fall will be observed for neurological abnormalities by performing neurological checks after the incident occurs. Facility Neurological Vital Signs policy dated July 2023 directed staff in cases of possible head injury, neuro vital signs are to be obtained every 15 minutes times 4, every 30 minutes time 4, every hour times 4, and then every shift for the duration of a 72-hour period. 51756

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F 0730 Level of Harm - Potential for minimal harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 50059 Based on review of personnel files and interviews for two (2) of four (4) personnel (Nurse Aide #2 and Nurse Aide #3) the facility failed to conduct annual performance evaluations. The findings include: Review of Nurse Aide (NA) #2's employee file identified the last performance evaluation was completed in 2/23. Review of NA #3's employee file identified the last performance evaluation was completed in 2/23. Interview with the Regional Clinical Nurse, RN #2, on 2/4/25 at 2:30 PM identified performance evaluations should be completed annually. RN #2 stated there had been several changes within administration, and the facility was in the process of reviewing overdue performance evaluations. Interview with the Administrator on 2/4/25 at 2:40 PM identified performance evaluations should be conducted yearly, and she had not been made aware that they had not been completed as expected by the former Director of Nursing (DON). Although requested an employee performance evaluation policy was not provided.