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	05/29/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observations, facility documentation and interviews, the facility failed to ensure that building equipment was maintained to provide a clean, comfortable, home-like environment for the residents. The findings include: Interview with Resident #15 on 5/28/25 at 12:19 PM identified staff complain there is not enough washcloths for care, it has taken weeks to get personal laundry back and staff have told him/her the facility has only one (1) working washing machine. Interview with Resident #2 on 5/28/25 at 12:24 PM identified his/her personal laundry was sent to laundry eight (8) days ago, he/she had not received it back, and he/she had to wear dirty clothing because he/she had no clean clothing left to wear. Resident #2 identified he/she reported the laundry delay to the Administrator a few days prior and inquired with the laundry staff who reported the facility had only one working washing machine. Interview with Resident #3 on 5/28/25 at 12:38 PM identified the facility does not have enough washcloths or towels for bathing, he/she has had to use sheets as towels, and staff told him/her they do not have washcloths or towels to provide. Interview with NA #1 on 5/28/25 at 12:41 PM identified the facility always had a shortage of washcloths and towels and if she did not rush in the morning to get what she needed for residents prior to starting care, she would be unable to find linens later in the shift. She identified that, at times, she needed to use more washcloths and towels when providing care to residents, but could not, due to the linen shortage, despite staff reporting the shortage to the Administrator. Observation of the B-wing laundry cart on 5/28/25 at 12:42 PM identified no washcloths and five (5) towels. Interview with NA #2 on 5/28/25 at 12:50 PM identified that it is difficult to find enough washcloths and towels for resident care on every shift. She reported that if staff needed additional linens for a resident after morning care, there was none left on the carts, and they were difficult to obtain from laundry. (continued on next page)

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	05/29/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Interview with the Administrator on 5/28/25 at 12:46 PM identified there was only one reliable laundry equipment vendor in the area and at times it took months to get parts. She identified the equipment vendor was currently in the facility fixing a washer that was inoperable, after having looked at the washer a month ago. Further, she identified the facility had not sent any personal laundry to an outside facility to be washed while waiting on parts and was unable to explain why. She identified the facility could borrow linens from sister facilities if needed. Observation of the laundry area on 5/28/25 at 12:52 PM identified a vendor working on the leftmost washer, the middle washer was washing laundry, and the rightmost washer had an out of order sign on it. In the dryer area, dryer #2 had an out of order sign on it. Interview with Laundry Aide #1 on 5/28/25 at 12:53 PM identified the 3:00 PM to 8:00 PM shift stocked the linen carts for the following 7:00 AM to 3:00 PM shift, but due to shortages on washcloths and towels, staff were requesting more linens early into the shift. Laundry Aide #1 identified they frequently do not have more linens to provide and must launder before dispersing. She identified she reported the shortage to the Director of Housekeeping and the Administrator multiple times over the prior 6 months and they said they would order more but the supply never grew. She reported that personal laundry should have a 24-hour turnaround time but turnaround time was around 72-hours due to having only one consistently working washing machine. She identified that residents often asked where their personal laundry was and that she offered to work overtime and extended shifts to keep up with the dirty laundry but administration would not allow it. Subsequent to surveyor interview, an invoice was provided on 5/28/25 identifying 32 dozen bath towels and 32 dozen washcloths were ordered. Observation of the B-unit linen cart on 5/29/25 at 8:11 AM identified no washcloths or towels available. Observation with RN #2 (Regional) on 5/29/25 at 8:17 AM identified no available washcloths or towels in the C-unit linen closet. The D-unit linen closet identified 13 towels and twenty washcloths. She indicated staff reported they already took what they needed for morning care but was unable to identify when and if the empty linen closets would be restocked for care later in the shift or at mealtime. Re-interview with Laundry Aide #1 on 5/29/25 at 9:50 AM identified the middle washer was the only washer working for four (4) to five (5) months. She identified the units linen closets and carts were not restocked during the shifts unless staff specifically requested linens and restocking was contingent on clean linen availability. (continued on next page)

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	05/29/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Interview with the Director of Housekeeping (also the Director of Maintenance) on 5/29/25 at 9:57 AM identified he was employed at the facility for three (3) months, and the leftmost washing machine had not consistently worked since he started. He identified he did not know how long the rightmost washing machine or dryer #2 had been out of order, but reported he was only directed to call about the leftmost washing machine by the Administrator. He identified he did not have the ability to view or approve invoices so was unsure exactly what needed to be repaired. He identified that he was unsure if the facility was short washcloths or towels, but was aware the facility could obtain extra linens from sister facilities. He identified that personal laundry had not been sent to a laundry facility to be laundered and identified that personal laundry should be laundered and returned within one (1) day. Interview with Laundry Aide #2 on 5/29/25 at 10:04 AM identified that prior to 5/28/25, the middle washing machine was the only consistently functioning washing machine for several months, and laundry staff were expected to do all facility linens and personal laundry in one machine. She further indicated it was not possible to return personal laundry to residents within one (1) day with only one washing machine in use. She reported there was a shortage of washcloths and towels, and facility staff were often upset about there not being enough linen to stock. Interview with Laundry Aide #3 on 5/29/25 identified the rightmost washing machine had not functioned for almost two (2) years, dryer #2 had not functioned for close to four (4) years, and administration said they are too expensive to fix. Observation of the laundry area with RN #2 (Regional) on 5/29/25 at 10:12 AM identified she was not aware of the out of order washing machine and dryer and that she would discuss the out-of-order machines with corporate staff. Review of the Residents Rights policy dated 6/2023 did not speak to ensuring residents the right to a clean, homelike environment. Although requested, a policy on resident laundry and facility environment were not provided.

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	05/29/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for one (1) of three (3) residents (Resident #1) reviewed for falls, the facility failed to ensure a fall intervention was implemented according to the plan of care and according to physician order, after a resident who was identified as a high fall risk, sustained a fall out of bed. The findings include: Resident #1's diagnoses included altered mental status, muscle weakness, atherosclerotic heart disease (the build-up of plaque in the arteries limiting blood flow to the heart) and congestive heart failure (the hearts inability to pump blood as efficiently as it should). The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had moderately impaired cognition (Brief Interview for Mental Status (BIMS) score of 10), required substantial assistance for bed mobility and was dependent on staff for personal hygiene and transfers. The Resident Care Plan (RCP) dated 10/26/22 identified Resident #1 was at high risk for falls due to deconditioning and on 10/26/22 had a fall out of bed. Interventions included anticipating and meeting needs, ensuring the call bell was within reach, encouraging use of the call bell for assistance as needed and placing a floor mat to the left side of Resident #1's bed. A nurse's note dated 10/26/22 at 5:50 AM identified Resident #1 was observed lying supine (on the backside) on the floor next to his/her bed, incontinent of a large amount of stool. The note identified abrasions (superficial injury to the skin caused by scraping or rubbing) were noted to both knees and that the provider and family were notified. A facility Accident and Investigation (A&I) dated 10/26/22 identified that at 5:45 AM Resident #1 was observed lying supine on the floor next to his/her bed and stated he/she fell out of bed. The A&I identified Resident #1 could move all extremities, denied pain, and neurological signs were within normal limits. The report identified the interventions to be implemented included ensuring the call bell was within reach, encouraging the use of the call bell and a floor mat was to be placed to the left side of the bed. Review of physician's orders dated 10/26/22 through 10/31/22 failed to identify an order for a fall mat to be in place to the left side of bed. Review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR) for October 2022 failed to identify that nursing was ensuring a floor mat was in place to the left side of the bed. A physician's order dated 11/1/22 (6-days after the fall) directed for a fall mat to be in place to the left side of the bed. Review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR) for November 2022 failed to identify that nursing was ensuring the floor mat was in place to left side of the resident's bed. (continued on next page)

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	05/29/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Interview with the DNS on 5/28/25 at 3:43 PM identified that following a resident fall, an intervention to prevent future falls should be initiated immediately which included obtaining and transcribing a physicians order for the intervention and ensuring the order displayed on the TAR each shift. He identified that obtaining a physician's order for the floor mat to the left side of Resident #1's bed six (6) days after the fall was not appropriate and reported that the intervention should have been on the TAR for the nurses to sign off every shift. Interview with RN #3 (Regional nurse) on 5/28/25 at 3:10 PM identified that a physician's order should have been obtained and transcribed for the floor mat to the left side of Resident #1's bed immediately after the provider was notified of the fall and should have been entered into the electronic medical record so that it displayed on the TAR for nursing staff to sign off every shift that it was in place. Interview with DNS #2 (previous DNS) on 5/28/25 at 3:28 PM identified she was responsible for checking all A & I's once completed by nursing staff and ensuring that all interventions were in place appropriately. She identified that for Resident #1, a physician's order should have been obtained and transcribed immediately after the fall and should have been on the TAR for nursing staff to sign off that the left floor mat was in place. Although attempted, an interview with RN #4 was not obtained. Review of the Accident and Incident Investigation policy dated 4/2016 directed, in part, that interventions to prevent further accidents/incidents have been identified and implemented and actions are initiated to prevent further accidents/incidents.

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	05/29/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for one (1) of three (3) residents (Resident #1) reviewed for impaired skin integrity, the facility failed to ensure preventative interventions were initiated and implemented according to facility policy for a resident admitted to the facility with an active pressure injury and after the development of a facility acquired pressure injury. The findings include: Resident #1's diagnoses included altered mental status, muscle weakness, atherosclerotic heart disease (the build-up of plaque in the arteries limiting blood flow to the heart) and congestive heart failure (the heart's inability to pump blood as efficiently as it should). A nurse's note dated 9/29/22 at 1:01 PM identified that Resident #1 was admitted to the facility with a stage 2 pressure injury (partial thickness wound) to the coccyx measuring 2 centimeters (cm) by 1 cm. A Braden Scale assessment dated [DATE] identified that Resident #1 was at a high risk for the development of a pressure injury. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had moderately impaired cognition (Brief Interview for Mental Status (BIMS) score of 10), required substantial assistance for bed mobility and was dependent on staff for personal hygiene and transfers. The MDS identified Resident #1 was at risk of developing injuries and identified Resident #1 had one (1) stage 2 pressure injury. The Resident Care plan (RCP) first initiated on 10/5/25 (5 days after admission to the facility) identified Resident #1 had a community acquired (developed outside of a healthcare setting) stage 2 pressure injury related to impaired mobility with interventions that included to follow facility policy/protocols for the prevention/treatment of skin breakdown and assist the resident with turning and repositioning every 2 hours. Review of physician's orders dated 9/29/22 through 10/6/22 failed to identify orders for an air mattress or a turning and repositioning schedule. Review of nurse's notes dated 9/29/22 through 10/6/22 failed to identify documentation that an air mattress was in place to Resident #1's bed or that a turning and repositioning schedule was being followed. A wound physician note dated 10/6/22 identified Resident #1 was seen for an initial wound consultation and Resident #1 had an unstageable pressure injury to the sacrum (triangular bone located below the lumbar vertebrae) measuring 9.5 cm by 7 cm by 0.3 cm. The note identified the area was compromised of 50 percent (%) subcutaneous tissue (deepest layer of skin below the dermis and epidermis) and 50 % slough (dead tissue within a wound appearing yellow, tan or white in color) and directed for the treatment to include cleansing the area, applying Medihoney (a gel that creates a moist wound environment and helps to remove slough or necrotic tissue to aide in wound healing) to the affected area followed by a dry dressing twice daily and for a pressure redistribution mattress per facility protocol. (continued on next page)

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	05/29/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of physician's orders dated 10/7/22 through 10/24/22 failed to identify orders were in place for an air mattress or a turning and repositioning schedule. Review of nurse's notes dated 10/7/22 through 10/24/22 failed to identify documentation that an air mattress was in place to Resident #1's bed or that a turning and repositioning schedule was being followed. A Weekly Skin Observation Tool dated 10/12/22 identified no new skin areas were observed. Review of the clinical record failed to identify that a Weekly Skin Observation Tool was completed between 10/12/22 and 10/24/22. A nurse's note dated 10/24/22 at 3:55 PM indicated that therapy informed nursing of an area noted to Resident #1's left heel. The note identified that the left heel area measured 3.5 cm by 3.5 cm and contained 100 % eschar (dead tissue). Ther note further identified an area was noted to the right heel measuring 0.5 cm by 0.5 cm. The note identified both heels were offloaded, and the wound physician was notified. The RCP dated 10/26/22 identified Resident #1 was admitted to the facility with a stage 2 pressure injury that progressed to unstageable (when the base of the wound is obscured by dead tissue, making it impossible to determine the depth or stage) by 10/6/22 and Resident #1 had a facility acquired unstageable pressure injury to the left heel on 10/24/22 related to impaired mobility as a result of orthostatic hypotension (low blood pressure that happens when standing up from a sitting or lying down position). Interventions included following facility policy and protocol for the prevention of and treatment of skin breakdown, administering treatments as ordered and monitoring for effectiveness, monitoring/documenting/reporting any changes in skin status, assisting the resident with turning/repositioning at least every two (2) hours, completing weekly treatment documentation and providing an air mattress. Review of the clinical record identified no further pressure injury related revisions to the RCP after 10/26/22. A wound physician note dated 10/27/22 identified the sacral pressure injury remained unstageable and measured 7.4 cm by 4 cm by 1 cm with new undermining (a separation of the wound edges from the surrounding healthy tissue creating a pocket under the wound surface) from 10 o'clock to 2 o'clock measuring 2.1 cm with 50 % subcutaneous tissue, 20 % necrotic tissue and 30 % slough. The note identified the left heel as an unstageable pressure injury measuring 3 cm by 3.7 cm by 0.3 cm with 100 % slough. The note identified the right heel as erythema (redness) measuring 5 cm by 5 cm by 0 cm. It reported that both the sacrum and left heel areas were debrided (a procedure that removes dead or damaged tissue from a wound to promote healing). Wound treatments were ordered for all three (3) affected areas and directed for a pressure redistribution mattress to be put into place per facility protocol. Review of physician's orders dated 10/27/22 through 1/12/23 failed to identify that orders were in place for an air mattress or a turning and repositioning schedule. (continued on next page)

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	05/29/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of nurse's notes dated 10/27/22 through 1/12/23 failed to identify documentation that an air mattress was in place to Resident #1's bed or that a turning and repositioning schedule was being followed. A wound physician note dated 1/12/23 identified that the unstageable pressure ulcers remained unhealed to Resident #1's sacrum and left heel. Review of the facility census identified that Resident #1 was discharged home from the facility on 1/17/23. Interview with the DNS on 5/28/25 at 1:46 PM identified that an air mattress should have been placed to Resident #1's bed from admission when it was identified that a pressure injury was present and then a physician's order should have been obtained and entered so that nursing was signing off and ensuring the placement of the mattress, that the settings were correct and that it was functioning properly. The DNS identified that per facility policy, once the wound progressed to an unstageable pressure injury, a physician's order should have been obtained for an every one (1) hour turning and repositioning schedule, that nursing is responsible for signing off that turning and repositioning is occurring on the Treatment Administration Record (TAR). The DNS was unable to identify why the policy was not followed for both the air mattress and the every 1 hour turning and repositioning schedule. Additionally, he identified that all residents are to have a full body skin check weekly and nursing is to document the results on the Weekly Skin Observation Tool. Interview with MD #2 (wound physician) on 5/28/25 at 2:17 PM identified that for residents identified as at risk for developing pressure injuries, skin integrity will deteriorate rapidly leading to negative outcomes, if interventions are not initiated timely. He identified that if a resident was admitted with a stage 2 pressure ulcer, an air mattress and a turning and repositioning schedule should be initiated immediately, and the facility should follow their skin policy. Interview with RN #1 (wound nurse) on 5/28/25 at 3:20 PM identified that if the Braden Scale assessment identified Resident #1 was at a high risk for developing a pressure injury on 9/29/22, an air mattress should have been placed to Resident #1's bed immediately. She identified that it was her responsibility to ensure interventions were in place and followed for residents with wounds to include air mattress placement and an every 1 hour turning and repositioning schedule. RN #1 was unable to explain why physician's orders were not in place and why there was no mention of the air mattress or the hourly turning and repositioning schedule in the nurse's notes. Interview with DNS #2 (previous DNS) on 5/28/25 at 3:28 PM identified the interdisciplinary team reviewed all resident's with wounds daily during morning report and weekly during at-risk meetings. She identified that failing to initiate the air mattress and a turning and repositioning schedule was an oversight by her and RN #1 and both interventions should have been initiated immediately upon admission and after the identified deterioration of the community acquired pressure injury on 10/6/22. Although attempted, an interview with LPN #1 was not obtained. (continued on next page)

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	05/29/2025

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the Pressure Ulcer Prevention/Assessment Plan policy dated 4/2016 directed, in part, that for a resident with a stage 2 pressure ulcer, interventions are to include an air mattress to be placed to the bed and heels are to be elevated off the bed with pillows. For a resident with several stage 2's, and/or a stage 3 (a wound that extends through the skin into deeper tissue and fat) and/or a Deep Tissue Injury (DTI), interventions are to include an every one (1) hour turning and repositioning schedule and foot pillow boots to be worn in bed. Residents will have a weekly skin audit /evaluation completed by the charge nurse on the resident scheduled shower/bath day and document in the clinical record (Body Audit).

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	05/29/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation and interviews for one (1) of three (3) residents (Resident #4) reviewed for dependent care, the facility failed to ensure complete and accurate Nurse Aide documentation. The findings include: Resident #4's diagnoses included dementia, altered mental status, anxiety disorder and malnutrition. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #4 had moderately impaired cognition (Brief Interview for Mental Status (BIMS) score of 8), required setup assistance for eating and was dependent on staff for personal care, bed mobility and transfers. The Resident Care Plan (RCP) dated 4/29/25 identified Resident #4 required assistance with Activities of Daily Living (ADLs). Interventions included staff providing all Resident #4's care if he/she was unable to participate in ADLs. Observation on 5/28/25 at 12:34 PM identified Resident #4 was dressed and sitting in his/her wheelchair at the bedside. Resident #4 appeared clean, well dressed and had a bedside table over him/her with water and a book on the table. Observations of Resident #4 on 5/29/25 at 12:15 PM, identified Resident #4 dressed and sitting in his/her wheelchair at the bedside reading a book. Resident #4 appeared clean and well dressed and had a bedside table over him/her with water within reach. Review of the April 2025 Documentation Survey Report (Nurse Aide Documentation) for Resident #4 identified that for 24 out of 30 days (80 percent), there was inconsistent documentation every shift for the following tasks: behavior symptoms, transferring, bed mobility, bowel movements, toileting hygiene, intake and output and toilet use. For 18 out of 30 days (60 percent), there was inconsistent documentation on the day or evening shifts for the following tasks: oral hygiene, personal hygiene, showering/bathing self, snacks, eating and amount eaten. Review of the May 2025 Documentation Survey Report (Nurse Aide Documentation) for Resident #4 identified that for 26 out of 28 days (92.8 percent), there was inconsistent documentation every shift for the following tasks: behavior symptoms, transferring, bed mobility, bowel movements, toileting hygiene, intake and output and toilet use. For 26 out of 28 days (92.8 percent), there was inconsistent documentation on the day or evening shifts for the following tasks: oral hygiene, personal hygiene, showering/bathing self, snacks, eating and amount eaten. Interview and clinical record review with the DNS on 5/29/25 at 12:44 PM identified he was unaware the Nurse Aides were inconsistently documenting care for Resident #4. He identified the Nurse Aides should be documenting on all tasks every shift and did not know why the documentation for April and May 2025 was incomplete. Although requested, a facility policy for Nurse Aide documentation was not provided.

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	05/29/2025

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Keep all essential equipment working safely. Based on observations, facility policy and interviews, the facility failed to ensure that laundry equipment within the facility was maintained timely and in proper working order. The findings include: Interview with Resident #15 on 5/28/25 at 12:19 PM identified staff complain there is not enough washcloths for care, it has taken weeks to get personal laundry back and staff have told him/her the facility has only one (1) working washing machine. Interview with Resident #2 on 5/28/25 at 12:24 PM identified his/her personal laundry was sent to laundry eight (8) days ago, he/she had not received it back, and he/she had to wear dirty clothing because he/she had no clean clothing left to wear. Resident #2 identified he/she reported the laundry delay to the Administrator a few days prior and inquired with the laundry staff who reported the facility had only one working washing machine. Interview with Resident #3 on 5/28/25 at 12:38 PM identified the facility does not have enough washcloths or towels for bathing, he/she has had to use sheets as towels, and staff told him/her they do not have washcloths or towels to provide. Interview with NA #1 on 5/28/25 at 12:41 PM identified the facility always had a shortage of washcloths and towels and if she did not rush in the morning to get what she needed for residents prior to starting care, she would be unable to find linens later in the shift. She identified that, at times, she needed to use more washcloths and towels when providing care to residents, but could not, due to the linen shortage, despite staff reporting the shortage to the Administrator. Observation of the B-wing laundry cart on 5/28/25 at 12:42 PM identified no washcloths and five (5) towels. Interview with NA #2 on 5/28/25 at 12:50 PM identified that it is a struggle every shift to find enough washcloths and towels for resident care. She reported that if they need additional linens for a resident after morning care, there is none left in the carts, and they are difficult to obtain from laundry. Interview with the Administrator on 5/28/25 at 12:46 PM identified there was only one reliable laundry equipment vendor in the area and at times it took months to get parts. She identified the equipment vendor was currently in the facility fixing a washer that was inoperable, after having looked at the washer a month ago. Further, she identified the facility had not sent any personal laundry to an outside facility to be washed while waiting on parts and was unable to explain why. She identified the facility could borrow linens from sister facilities if needed. She identified that the facility did not have audits for linen levels but reported audits would be started twice weekly. Observation of the laundry area on 5/28/25 at 12:52 PM identified a vendor working on the leftmost washer, the middle washer was washing laundry, and the rightmost washer had an out of order sign on it. In the dryer area, dryer #2 had an out of order sign on it. (continued on next page)

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	05/29/2025

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Interview with Laundry Aide #1 on 5/28/25 at 12:53 PM identified the 3:00 PM to 8:00 PM shift stocked the linen carts for the following 7:00 AM to 3:00 PM shift, but due to shortages on washcloths and towels, staff were requesting more linens early into the shift. Laundry Aide #1 identified they frequently do not have more linens to provide and must launder before dispersing. She identified she reported the shortage to the Director of Housekeeping and the Administrator multiple times over the prior 6 months and they said they would order more but the supply never grew. She reported that personal laundry should have a 24-hour turnaround time but turnaround time was around 72-hours due to having only one consistently working washing machine. She identified that residents often asked where their personal laundry was and that she offered to work overtime and extended shifts to keep up with the dirty laundry but administration would not allow it. Subsequent to surveyor interview, an invoice was provided on 5/28/25 identifying 32 dozen bath towels and 32 dozen washcloths were ordered. Observation of the B-unit linen cart on 5/29/25 at 8:11 AM identified no washcloths or towels available. Observation with RN #2 (Regional) on 5/29/25 at 8:17 AM identified no available washcloths or towels in the C-unit linen closet. The D-unit linen closet identified 13 towels and twenty washcloths. She indicated staff reported they already took what they needed for morning care but was unable to identify when and if the empty linen closets would be restocked for care later in the shift or at mealtime. Re-interview with Laundry Aide #1 on 5/29/25 at 9:50 AM identified the middle washer was the only washer working for four (4) to five (5) months. She identified the units linen closets and carts were not restocked during the shifts unless staff specifically requested linens and restocking was contingent on clean linen availability. Interview with the Director of Housekeeping (also the Director of Maintenance) on 5/29/25 at 9:57 AM identified he was employed at the facility for three (3) months, and the leftmost washing machine had not consistently worked since he started. He identified he did not know how long the rightmost washing machine or dryer #2 had been out of order, but reported he was only directed to call about the leftmost washing machine by the Administrator. He identified he did not have the ability to view or approve invoices so was unsure exactly what needed to be repaired. He identified that he was unsure if the facility was short washcloths or towels, but was aware the facility could obtain extra linens from sister facilities. He identified that personal laundry had not been sent to a laundry facility to be laundered and identified that personal laundry should be laundered and returned within one (1) day. Interview with Laundry Aide #2 on 5/29/25 at 10:04 AM identified that prior to 5/28/25, the middle washing machine was the only consistently functioning washing machine for several months, and laundry staff were expected to do all facility linens and personal laundry in one machine. She further indicated it was not possible to return personal laundry to residents within one (1) day with only one washing machine in use. She reported there was a shortage of washcloths and towels, and facility staff were often upset about there not being enough linen to stock. (continued on next page)

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	05/29/2025

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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many Note: The nursing home is disputing this citation.	Interview with Laundry Aide #3 on 5/29/25 identified the rightmost washing machine had not functioned for almost two (2) years and dryer #2 had not functioned for close to four (4) years. Additionally, he identified that the middle washing machine, the only consistently functioning washing machine, had a broken pressure line which is used for opening and closing the latch of the machine door. He reported that a pen is pushed into the mechanism to latch and unlatch the door which is hazardous to staff. He identified that the Director of Laundry was aware of the problem but that the washing machine had not been repaired. Observation of the middle washing machine door latch with RN #2 on 5/29/25 at 10:12 AM identified the only way to open and close the middle washing machine door was to forcefully push the back of a pen into the door latch to engage/disengage the latch. She identified she was not aware of the issue and it needed to be repaired. Additionally, she reported that she would discuss the out-of-order machines with corporate staff. Although repair invoices were requested, only one washing machine invoice, dated 4/28/25, was provided. Review of the Maintenance Department Infection Control policy dated 8/2023 directed, in part, that the Maintenance Supervisor is to maintain safe status of the physical plant systems and equipment.