

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075078	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/03/2025
NAME OF PROVIDER OR SUPPLIER Westview Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 150 Ware Rd Dayville, CT 06241	
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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50179 Based on observations, review of the clinical record, facility documentation, facility policy and interviews for 12 of 12 residents (Resident #5, Resident #7, Resident #8, Resident #15, Resident #22, Resident #25, Resident #46, Resident #55, Resident #73 Resident #75, Resident #83, Resident #89) reviewed for dining, the facility failed to provide a dignified dining experience. The findings include: 1. Resident #5 was admitted to the facility in January of 2022 with diagnoses that included Dementia with agitation, anxiety disorder, Parkinson's disease, and dysphagia. A Resident Face Sheet identified Resident #5's current diet order was a mechanical soft with moist chopped meat and thin liquids. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #5 was severely cognitively impaired (Brief Interview for Mental Status (BIMS) score of 2) and required supervision or touching assistance for eating, and total dependence with toileting, bed mobility, and transfer. The Resident Care Plan dated 1/2/25 identified Resident #5 with a focus on nutrition: no problems chewing or swallowing with current swallowing guidelines and staff encouraged self-feeding. Interventions included intermittent supervision with meals, encourage at mealtime. May eat lunch and dinner in recreation room, direct supervision for mealtime. 2. Resident #7 was admitted to the facility in January of 2020 with diagnoses that included generalized anxiety disorder, adult failure to thrive, Alzheimer's dementia, behavioral disturbance and dysphagia. A Resident Face Sheet identified Resident #7's diet order was mechanical soft with ground moist meat and thin liquids. The annual Minimum Data Set assessment dated [DATE] identified Resident #7 had short-term and long-term memory problems, was severely cognitively impaired and was dependent with eating, toileting, bed mobility and transfer. (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 075078	Facility ID: 075078 If continuation sheet Page 1 of 73

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Resident Care Plan dated 11/7/24 identified Resident #7 with a focus on nutrition: failure to thrive, dysphagia, cachexia (a syndrome causing muscle loss that cannot be reversed with improved nutrition) no difficulty chewing or swallowing with current swallow guidelines. May dine in the recreation room to assist with meals for lunch and supper. Interventions included swallow guidelines, assist with feeding, encourage at mealtime, may dine in recreation room in full upright position with bilateral lower extremity leg rests. 3.Resident #8 was admitted to the facility in April of 2018 with diagnoses that included adult failure to thrive, Alzheimer's dementia, and anxiety disorder. A Resident Face Sheet identified Resident #8's diet order was mechanical soft with moist chopped meats and thin liquids. The annual Minimum Data Set assessment dated [DATE] identified Resident #8 was severely cognitively impaired (Brief Interview for Mental Status (BIMS) score of 3) and required partial moderate assistance with toileting, and bed mobility, supervision with transfer and independent with eating. The Resident Care Plan dated 1/22/25 identified Resident #8 with a focus for nutrition: failure to thrive, 6.6% weight loss for 180 days, no problems with chewing or swallowing with current swallow guidelines, eating lunch and dinner meals in recreation room for feed assistance, required assistance and intermittent supervision at mealtimes. Interventions included attend recreation feeding room for lunch and patient room for dinner meal, encouraged to feed self with intermittent supervision, encourage at mealtimes, set up and assist to cut up food at mealtimes, explain what is on the tray and initiate feeding as needed to promote good intake assist as needed. 4. Resident #15 was admitted to the facility in April of 2023 with diagnoses that included neurocognitive disorder with Lewy bodies, adult failure to thrive, dysphagia, and Parkinson's disease. A Resident Face Sheet identified Resident #15's diet order was puree with thin liquids. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #15 was severely cognitively impaired (Brief interview for mental Status (BIMS) score of 2) and was dependent with eating, toileting, bed mobility and transfer. The Resident Care Plan dated 1/9/25 identified Resident #15 with a focus on nutrition: Parkinson's disease, failure to thrive, swallow guidelines, meals in recreation room for feeding assistance, increased difficulty with straw. Interventions included 1:1 close supervision for meals with feeding assistance, refer to functional program, assist with all meals, recreation dining program for lunch and dinner. 5.Resident #22 was admitted to the facility in June of 2023 with diagnoses that included Alzheimer's dementia with agitation, impulse and conduct disorder. A Resident Face Sheet identified Resident #22's diet order was puree with thin liquids. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #22 had short-term and long-term memory problems with severely impaired cognition and was dependent with eating, toileting, bed mobility and transfer. (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Resident Care Plan dated 12/26/24 identified Resident #22 with a focus on nutrition: regular with swallow guidelines, eats lunch and dinner meals in assisted dining room. No difficulty with chewing or swallowing with current swallowing guidelines. Intervention included swallow guidelines, 1:1 supervision for meals, encourage at mealtimes, may dine in the recreation room for lunch and dinner sitting in wheelchair, feet flat on floor. Requires cues, assistance and encouragement. 6. Resident #25 was admitted to the facility in August of 2022 with diagnoses that included dementia with behavioral disturbances, dysphagia, and age-related cognitive decline. A Resident Face Sheet identified Resident #25's diet order was minced and moist (mechanically soft with moist ground meat) and thin liquids. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #25 was severely cognitively impaired (Brief Interview for Mental Status (BIMS) score of 2) and was dependent with eating, toileting, and bed mobility. Transfer was not attempted due to medical condition. The Resident Care Plan dated 1/9/25 identified Resident # 25 with a focus on nutrition: no difficulty chewing or swallowing with current swallow guidelines. Interventions included swallow guidelines, needs assistance with feeding self and at times able to feed self, assist when needed, encourage intake at mealtimes. 7. Resident #46 was admitted to the facility in January of 2019 with diagnoses that included dementia, dysphagia, restlessness, agitation and generalized anxiety. A Resident Face Sheet identified Resident #46's diet order was puree with thin liquids. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #46 was severely cognitively impaired (Brief Interview for Mental Status (BIMS) score of 2) and was dependent with eating, toileting, bed mobility and transfer. The Resident Care Plan dated 1/22/25 identified Resident # 46 with a focus on nutrition: no problems with chewing or swallowing with current swallow guidelines, dine in feed assist room for lunch and dinner meals. Interventions included swallow guidelines, recreation feed assist room at lunch and dinner meals, requires cueing and assistance at mealtimes. 8. Resident #55 was admitted to the facility in May of 2022 with diagnoses that included protein calorie malnutrition, adult failure to thrive, Alzheimer's dementia and dysphagia. A Resident Face Sheet identified Resident #55's diet order was puree, mechanical soft solids for desserts only and thin liquids. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #55 was severely cognitively impaired (Brief Interview for Mental Status (BIMS) score of 2) and was dependent with toileting, bed mobility and transfer and required assistance for eating. (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Resident Care Plan dated 12/26/24 identified Resident #55 with a focus on nutrition: no problem chewing or swallowing on current swallow guidelines. Encouraged at mealtimes but getting upset at times when staff persist. Interventions included swallow guidelines, 1:1, provide cues and assistance, encourage at mealtimes, may dine in recreation assist feed room for lunch and/or dinner, push intake as able, required cueing, 1:1 supervision at mealtime, refer to swallow guidelines. 9. Resident #73 was admitted to the facility in July of 2022 with diagnoses that included Alzheimer's disease, and depression. A Resident Face Sheet identified Resident #73's diet order was mechanically soft with moist chopped meats and thin liquids. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #73 had short term and long-term memory problems and was moderately cognitively impaired. Resident #73 required assistance with toileting, supervision or touching assistance with eating and was independent with bed mobility and transfer. The Resident Care Plan dated 12/7/24 identified Resident #73 with a focus on nutrition: no difficulty chewing or swallowing. Resident #73 now eats meals in the recreation room for assistance at mealtimes. Interventions included swallow guidelines, 1:1 feed assist, encourage at mealtime. 10. Resident #75 was admitted to the facility in October of 2023 with diagnoses that included adult failure to thrive, dysphagia, and Alzheimer's disease. A Resident Face Sheet identified Resident #75's diet order was puree with thin liquids. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #75 had short term and long-term memory problems and was severely cognitively impaired. Resident #75 was dependent with eating, toileting, bed mobility and transfer was not attempted due to safety concerns. The Resident Care Plan dated 12/20/24 identified Resident # 75 with a focus on nutrition: dysphagia swallow guidelines, family members had been educated and signed a waiver to be able to assist Resident #75 with oral intake. Interventions included swallow guidelines, encourage at mealtime, may eat breakfast in bed with staff assist for feeding, recreation room for lunch and dinner meals to feed assist, family members may assist at mealtimes. 11. Resident #83 was admitted to the facility in November of 2024 with diagnoses that included restlessness and agitation, altered mental status and repeated falls. A Resident Face Sheet identified Resident #83's diet order was soft bite sized mechanical soft with chopped meats and thin liquids. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #83 was severely cognitively impaired (Brief Interview for Mental Status (BIMS) score of 3) and required partial moderate assistance with toileting, bed mobility and transfers and supervision touching assistance with eating. (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Resident Care Plan dated 12/12/24 identified Resident #83 with potential alteration in nutrition, no significant weight changes, no difficulty with chewing or swallowing with swallow guidelines. Interventions included may eat lunch in the feeding room and in room for dinner, swallow guidelines, may feed self, encourage at mealtime. 12. Resident #89 was admitted to the facility in March of 2024 with diagnoses that included Alzheimer's dementia, dysphagia, and anxiety. A Resident Face Sheet identified Resident #89's diet order was puree with thin liquids. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #89 was severely cognitively impaired (Brief Interview for Mental Status (BIMS) score of 3). Resident #89 was dependent with toileting, and bed mobility, transfer was not attempted due to safety concerns and supervision touching assistance with eating. The Resident Care Plan dated 12/7/24 identified Resident #89 with a focus on nutrition: swallow guidelines 1:1 assist at mealtime. Eat meals in the recreation room at lunch and dinner. Interventions included swallow guidelines, 1:1 assists at mealtime, encourage at mealtime, may eat in the recreation feed assist dining room at lunch and dinner. Observations on 1/23/25 at 6:02 PM, identified 12 residents (Resident #5, Resident #7, Resident #8, Resident #15, Resident #22, Resident #25, Resident #46, Resident #55, Resident #73, Resident #75, Resident #83, Resident #89) in the recreation room being assisted to eat by Nurse Aide (NA) #1 and NA #2. NA #1 and NA #2 were both standing above the residents they were assisting and moving from 1 resident to another to assist with taking bites of food. Interview with NA #1 on 1/23/25 at 6:05 PM identified there are normally 12 residents in the recreation room for dinner and they need to be assisted to eat. NA #1 identified some of the residents required 1:1 feeding assistance and some of the residents required cues and supervision. NA #1 identified there are only 2 NA's in the recreation room for dinner to assist the 12 residents. NA #1 identified that she usually sits at eye level to assist the residents but did not sit at eye level on this evening and indicated that she usually feeds multiple residents at the same time. Interview with NA #2 on 1/23/25 at 6:05 PM identified that there are normally 12 residents in the recreation room for dinner that need to be assisted to eat. NA #2 identified that some of the residents require 1:1 feeding assistance and some require cues and supervision. NA #2 identified that there are only 2 NA's in the recreation room for dinner to assist the 12 residents. NA #2 identified that she does not sit at eye level to feed the residents but indicated she would moving forward. NA #2 identified she usually feeds multiple residents at the same time. Interview with Licensed Practical Nurse (LPN) #1 on 1/23/25 at 6:11 PM identified that there are typically 2 NA's to assist 12 residents with eating in the recreation room at dinnertime. LPN #1 identified that the NA 's feed multiple residents at the same time. Interview with the Assistant Director of Nursing (ADNS) on 1/23/24 at 6:21 PM identified that there are 2 NA's assigned to assist 12 residents in the recreation room for dinner. The ADNS indicated the NA's should be sitting at eye level with the resident while assisting with their meal. (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the feeding helpless patient policy dated 1/9/20 directed, in part, assist the resident to a comfortable position and put on bib or napkin. Encourage residents to assist as much as able. Feed residents slowly with a fork or spoon, filled only half full. Never rush the residents through meals. Review of Formal Dining Room and Recreation Room policy directed, in part, to provide a dining experience in the formal dining room or recreation room that maintains and/or enhances each resident's dignity and ability to maximize their dining experience.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50250 Based on review of the clinical record, facility documentation, facility policy and interviews for 1 of 2 residents (Resident #16) reviewed for pressure injuries, the facility failed to provide wound assessments by a qualified clinician. The findings include: Resident #16 was admitted to the facility in August of 2024 with diagnoses that included adult failure to thrive, repeated falls, diabetes mellitus without complications and generalized muscle weakness. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #16 was cognitively intact (Brief Interview for Mental Status (BIMS) score of 15) and required set up assistance for personal hygiene, supervision or touching assistance for bed mobility and transfers and was occasionally incontinent of stool. The MDS identified Resident #16 as not at risk for developing pressure injuries and failed to identify the presence of pressure ulcers. The Resident Care Plan (RCP) dated 11/14/24 identified Resident #16 with an alteration in skin integrity. It further identified that Resident #16 was admitted with multiple skin tears from a fall and had a pressure injury to his/her upper back. The RCP further identified that Resident #16 had a skin tear on his/her wrist that required prior treatment and a form of debridement. Interventions included to reposition every 2 hours and as needed, to encourage optimal nutrition and hydration, to monitor skin integrity and notify the provider of any concerns or need of treatment and use of a pressure redistributing mattress to bed for skin integrity management. The RCP failed to identify a new pressure area that was identified on 11/21/24 and progressively got worse. An APRN note dated 11/26/2024 at 10:55 AM by APRN #1 identified Resident #16 reported right toe pain. The note further identified Resident #16 had a wound greater than 0.5 cm with a white moist open area surrounded by a ring of erythema which was tender to touch. The note identified that Resident #16 had not been wearing shoes and therefore the etiology/cause of the toe wound was unclear. The note further identified that Resident 16 ' s toe was not reflective of inadvertent flexion disorder (no hammer toes). APRN #1 diagnosed Resident #16 with cellulitis (bacterial skin infection) of the right second toe and directed warm Epsom salt soaks to the right foot twice a day for 10 days and Mupirocin 2% ointment (topical antibiotic) to the wound followed by a Band-Aid dressing twice a day for 10 days. A Nurse ' s note dated 11/21/24 at 9:45 PM by LPN #4 identified Resident #16 presented with a scab to the right second toe and the surrounding area was red. The note further identified that Resident #16 ' s physician was notified and instructed application of a Band-Aid dressing to be changed daily and to monitor. A Physician ' s order dated 12/16/24 directed to leave the right second toe open to air and let a scab form on the toe. The order further directed staff to monitor the toe closely every shift. (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Nurses note dated 1/1/25 by LPN #3 identified that Resident #16 ' s right second toe presented with redness surrounding the wound bed that had previously healed. The note further identified slough (non-viable tissue) in the wound bed. The note identified LPN #3 updated MD #2 who directed to obtain a wound culture of the right second toe, an x-ray, Santyl (topical enzymatic debriding agent) daily and to start Augmentin 875mg (oral antibiotic) twice a day for 10 days. Review of the clinical record, both electronic and paper, failed to identify an RN assessment of the newly identified right second toe wound on 11/21/24. The first wound assessment was documented by APRN #1 on 11/26/25, 5 days after the wound was discovered, and cellulitis was noted at that time. The first facility performed RN assessment of the wound was documented on 1/7/25 by RN #7. An APRN note on 1/23/25 by APRN #1 identified Resident #16 had a right second toe deformity consistent with hammer toe. The progress note identified that attempts to leave the right second toe open to air on 12/16/24 to form a well adhered crust over the top of the wound did not occur. APRN #1 identified that the wound was being cleansed daily. The note further identified that on 1/1/25 the wound was assessed to have thick yellow exudation with erythema/redness and increased skin temperature of intact surrounding tissue. Resident #16 was commenced on antibiotic treatment and wound treatment. Interview and observation of Resident #16 on 1/27/25 at 2:30 PM, identified Resident #16 ' s right second toe was covered with a wound dressing from a follow up appointment with a surgeon earlier that day. Resident #16 ' s right great toe was open to air and presented with an area of dark brown dried eschar (devitalized/dead tissue) on the upper surface of the toe. Resident #16 identified that he had just arrived back to the facility from a podiatric consultation appointment with MD #3. Resident #16 identified that the right second toe wound progressively worsened and currently presented with ruptured tendons and exposed bone. Resident #16 identified the toe would be amputated per MD #3 ' s recommendation. Review of Wound Consultation Patient Care Summary by MD #3 dated 1/27/25 identified a wound care order directing to apply skin prep to the right great toe and a wound care order directing a wet to damp dressing with Dakin ' s solution (antiseptic used to treat and prevent wound infections) to the right second toe. Interview with the facility Wound Care Certified Registered Nurse (RN #4) on 1/29/24 at 12:02 PM identified that she had not seen, assessed or treated Resident #16 ' s wound. RN #4 further identified that Resident #16 ' s initial wound assessment/evaluation should have been completed by an RN, not an LPN, and that weekly wound assessments should have been completed and documented. Interview with LPN #3 on 1/30/25 at 12:30 PM identified she discovered Resident #16 ' s open wound with slough on 1/1/25. LPN #3 indicated that staff were documenting in the Treatment Administration Record (TAR) that the wound was open to air but there was no documentation detailing wound assessment or progress. LPN #3 identified she took a picture of the wound and sent the picture to MD #2 via secure text message. LPN #3 identified that she notified the RN supervisor who looked at the picture but did not physically assess Resident #16 ' s wound. LPN #3 identified that she did not obtain wound measurements or complete a Pressure Ulcer Packet. LPN #3 identified that MD #2 gave wound management orders via secure text message based on the photo sent. (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LPN #4 on 2/5/2025 at 11:40 AM identified Resident #16 reported throbbing pain on his/her right second toe on 11/21/24. LPN #4 identified that she assessed Resident #16 ' s toe and faxed wound assessment details to MD #2. MD #2 gave a telephone order to cover Resident #16 ' s toe with a Band-Aid dressing daily until healed. LPN #4 further identified she reported the change in condition to an RN supervisor but could not identify which RN supervisor she reported the change to. She further identified the RN supervisor did not assess Resident #16 ' s wound. LPN #4 indicated that an initial RN assessment of Resident #16 ' s wound was not required since LPN ' s frequently assessed wounds at the facility, including initial wound assessments. LPN #4 further identified that it was not necessary to complete a Pressure Ulcer Packet (contents of packet included: rehab seating screen submitted to Physical Therapy, skin integrity dietary screen submitted to the Dietician, Braden Risk assessment submitted to the MDS nurse and nursing interventions for treatment and prevention implemented) since the wound surface was scabbed and did not impair Resident #16 ' s activities of daily living. LPN #4 identified that she did not complete wound measurements but indicated that wound measurements should have been completed to enable monitoring of wound progress. Although requested, a policy for RN assessment was not provided.		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47489 Based on review of the clinical record, facility documentation, facility policy/procedures and interviews for 3 of 3 sampled residents (Resident #35, Resident #65, and Resident #71) reviewed for Pre-Admission Screening and Resident Review (PASARR), the facility failed to ensure that residents with PASARR Level II recommendations were provided services to meet the resident's needs. The findings include: 1. Resident #35 was admitted to the facility in August of 2022 and had diagnoses that included generalized anxiety disorder, auditory hallucinations, delusional disorders and vascular dementia with behavioral disturbances. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #35 had intact cognition, did not exhibit inattention, disorganized thinking, or altered level of consciousness, did not exhibit hallucinations or delusions, indicated that antipsychotics were received on a routine basis and that a gradual dose reduction had not been attempted. The quarterly MDS assessment dated [DATE] identified Resident #35 had severely impaired cognition (Brief Interview for Mental Status (BIMS) score of 9), did not exhibit inattention, disorganized thinking or altered level of consciousness, hallucinations or delusions but did exhibit little interest or pleasure in doing things and feeling down, depressed or hopeless nearly every day of the 14 days reviewed. Additionally, the MDS indicated that Resident #35 exhibited behaviors of feeling tired or having little energy, poor appetite or overeating, and trouble concentrating on things, such as reading the newspaper or watching TV half or more of the days reviewed. The Resident Care Plan (RCP) dated 1/26/25 identified impaired cognition with episodes of paranoia and delusions with interventions to notify the provider with any change in cognition, abnormal finding or increased forgetfulness/confusion, and to provide reassurance and 1:1 when experiencing delusions/hallucinations as Resident #35 allows. Additionally, the RCP indicated that Resident #35 had problems with his/her mood state and identified Resident #35 always felt isolated from those around but preferred the comfort of his/her room and often declined group activities. The RCP identified that Resident #35 was seen by the provider on 1/23/25 and indicated that his/her psychosis was doing well and Resident #35 tolerated his/her anxiety and hallucinations and identified interventions of situational 1:1 with social services as needed with direction to encourage ventilation of feelings as indicated. Physician's orders dated January of 2025 directed to administer Lorazepam 0.5 mg tablet, three times daily (12pm, 5pm and 9pm) and Aripiprazole 20 mg tablet at bedtime. The PASARR II findings dated 12/2/2022 identified recommendations for mental health counseling, to obtain archive psychiatric records to clarify history, ongoing evaluation of the effectiveness for current psychotropic medications on target symptoms and supportive counseling from facility nursing staff. (continued on next page)		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Physician's progress notes dated 1/10/23 identified Resident #35 was seen for abnormal stools and indicated Resident #35 had sleep pattern changes when experiencing visual hallucinations, anxiety paranoia, sleep disturbance and memory loss. The note further indicated Resident #35 had variable judgment and insight and pleasant mood and affect. Physician's progress notes dated 2/10/23 identified Resident #35 was seen for a monthly medical assessment exhibited anxiety and received Ativan 0.5mg Q6 hours PRN and Scheduled BID, had sleep disturbance, memory loss, and hallucinations that were treated with Abilify 15 mg QHS as of 12/20/22. Review of a Social Services progress note dated 2/22/23 identified Resident #35 continued to have paranoid delusions and seemed to handle them better. Physician's progress notes dated 4/10/23 identified Resident #35 was seen for right hand pain and still had visual hallucinations but indicated the resident wasn't afraid of them and additionally indicated the resident's vascular dementia with behavioral disturbances was stable. Social services progress notes dated 5/16/23 identified Resident #35 was still having delusions and hallucinations although reported to have decreased by staff. Additionally, the note indicated Resident #35 was alert and oriented x2 and able to make needs known. Social services progress notes dated 8/7/23 identified the resident engaged in self-talk about hallucinations and identified the roommate was able to offer support and call for assistance. Social services progress notes dated 11/2/23 identified sleep disturbances with anxiety and hallucinations at times. Social services progress notes dated 12/13/23 identified the resident was a tough roommate who was disruptive and indicated the roommate requested a room change. Provider progress notes dated 2/6/24 identified Resident #35 was seen for the monthly medical assessment and for left leg pain and right arm pain and indicated Ativan was increased to 0.5 mg PO TID on 1/31/24. Provider progress notes dated 4/8/24 identified Resident #35 was seen for the monthly medical assessment and was found crying and identified vascular dementia, moderate, with psychotic disturbance was stable and to continue Ability 15 mg PO QHS and Ativan 0.5 mg PO TID. Social Services progress notes dated 5/2/24 identified Resident #35 can become anxious and had episodic hallucinations and paranoia. Provider progress notes dated 6/12/24 identified Resident #35 articulated what was seen when having hallucinations, and indicated Resident #35 was frightened by them and doesn't feel safe. Additionally, the note identified Abilify would be increased to 20mg from 15 mg at bedtime and Resident #35 would continue Ativan 0.5 mg PO TID. Provider's progress notes dated 8/5/24 identified Resident #35 was seen for a monthly medical assessment and Abilify was increased from 15mg PO QD to 20 mg PO QD due to Resident 35's complaints of visual hallucinations. (continued on next page)		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Physician's examination notes dated 10/15/24 identified Resident #35's vascular dementia and visual hallucinations were stable with Abilify 20 mg at bedtime and indicated Resident #35 was not panicked when having hallucinations. Social services progress notes dated 11/3/24 identified visual and auditory hallucinations as part of Resident #35's baseline behavior. Provider progress notes dated 12/2/24 identified Resident #35 exhibited confusion, anxiety, memory loss, paranoia, and hallucinations and indicated the vascular dementia with psychotic disturbance and general anxiety disorder was stable with Abilify 20 mg QHS and Ativan 0.5 mg PO TID. Pharmacy consultant report dated 12/20/24 recommended considering a gradual dose reduction of Lorazepam but it was indicated by the Medical Director that a lower dose would cause severe distress and psychotic instability. Review of Resident #35's Electronic Health Record and physical chart failed to identify any referral, follow up, or assessment by a behavioral health provider and failed to identify mental health counseling as recommended by the PASSAR II. 2. Resident #65 was admitted to the facility in July of 2022 with diagnoses that included generalized anxiety disorder, bipolar disorder, and unspecified dementia with agitation. The admission MDS assessment dated [DATE] identified Resident #65 had intact cognition, did not exhibit inattention, disorganized thinking, or altered level of consciousness, identified a mood assessment should be conducted but was not completed, did not exhibit hallucinations or delusions, physical or verbal behavioral symptoms, or rejection of care, wandering, or a change in behavior. Additionally, the MDS identified Resident #65 received antipsychotics on a routine basis, and that a gradual dose reduction had not been attempted nor documented as clinically contraindicated. The quarterly MDS assessment dated [DATE] identified Resident #65 had intact cognition, identified Resident #65 was feeling down, depressed, or hopeless several days, did not exhibit hallucinations or delusions and exhibited rejection of care behaviors. The Resident Care Plan (RCP) dated 11/29/24 identified Resident #65 had impaired cognition but indicated the resident had intact cognition (BIMS 15/15) with interventions to monitor cognition for level of orientation, forgetfulness and confusion. Additionally, the RCP identified problems with mood state related to diagnoses of dementia, bipolar disorder, and anxiety with interventions for 1:1 with social services situationally as needed, encourage ventilation of feelings and provide emotional support and reassurance and to monitor mood/behaviors and participation in ADLs, therapy and attendance in recreational activities. Physician's orders dated January 2025 directed to administer Trazodone HCL 50 mg tablet at bedtime, dicyclomine HCL 20 mg tablet every six hours as needed, Vilazodone NCL 40 mg table 1 tab once daily for depression. Although the orders identified Resident #65 may be seen by audiology, ortho as needed, eye doctor as needed, podiatry as needed and the dentist as needed, the orders failed to identify behavioral health services or follow up. (continued on next page)		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Preadmission Screening and Resident Review (PASSAR) II dated 5/31/22 identified recommendations to include ongoing evaluation of the effectiveness of current psychotropic medications on target symptoms and supportive counseling from staff and indicated Resident #65's need for behavioral health services and medication management to assess symptoms and monitor medications. Social Services progress notes dated 3/8/23 identified Resident #65 had fluctuating moods; notably very talkative and interactive to sullen with increased sleep and indicated the resident cycled with the mood state. Social Services progress notes dated 6/5/23 identified Resident #65 was continuing to feel sick and indicated it was questionable as to if Residents #65's mental health caused the stomach pain and identified when Resident #65 had these episodes, Resident #65 slept to avoid socialization for a few days and then reverted to baseline. The note identified no changes had been made to psychotropic medications. Review of Provider's orders dated 8/4/23 directed to Administer Trazodone 50mg every 6 hours as needed for anxiety for 14 days. Social Services progress notes dated 12/1/23 identified Resident #65's level of forgetfulness was deceiving until a deeper conversation was had and identified Resident #65 continued to need redirection from behavior not permitted by the facility. Review of Provider's orders dated 9/30/24 directed to discontinue Seroquel 25 mg by mouth at bedtime for mental status changes. Review of Provider's orders dated 10/8/24 directed to administer Ativan 0.5 mg by mouth one time now for acute anxiety. Social Services progress notes dated 11/26/24 identified Resident #65 was alert and oriented x3 and cycled regularly with staying in bed and refusing showers to being social and interactive. Review of Resident #65's electronic health record and paper clinical chart failed to identify any Psychiatric or mental health care or follow-up. 3. Resident #71 was admitted to the facility June of 2022 and had diagnoses that included bipolar disorder, benign paroxysmal vertigo, and myelodysplastic syndrome. The MDS assessment dated [DATE] identified Resident #71 was cognitively intact, did not exhibit inattention, disorganized thinking, or altered level of consciousness, did not exhibit physical or verbal behaviors towards self or others, did not exhibit psychosis, wandering, or rejection of care, indicated that antipsychotics were taken on a routine basis and that a gradual dose reduction had not been attempted, nor documented as contraindicated. The Resident Care Plan (RCP) identified Resident #71 had bipolar disorder and indicated no behaviors were monitored. Additionally the RCP indicated Resident #71 had an escalation in manic disorder, bipolar disorder and was seen in the community on 5/16/24 by a psych provider. Interventions included 1:1 visits with social services as needed, encourage ventilation of feelings, and monitor mood/behaviors and to update the provider as mood changes arise. (continued on next page)		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Physician's orders dated 6/5/2022 directed administration of Zyprexa (antipsychotic) tab 5mg at bedtime (QHS) for bipolar mood disorder and ordered orthostatic vital signs to be taken weekly for use of the Zyprexa. The Preadmission Screening and Resident Review (PASSAR) dated 7/20/22 identified Resident #71 had a mental health diagnosis of bipolar disorder and needed mental health services and medication management with a psychiatric provider while at the nursing facility to monitor symptoms and manage medications. Social services notes dated 3/8/23 identified Resident #71 had a diagnoses of bipolar disorder, and was noted to be attending less activities and programs in the facility and indicated no changes made to psychotropic medications. Social Services notes dated 6/6/23 identified Resident #71 participated in 1:1 conversation with the social worker, was diagnosed with bipolar disorder and was prescribed Zyprexa 5 mg at bedtime. Social Services notes dated 9/4/23 identified Resident #71 was cooperative, easily engaged, and noted to be anxious at times. The note indicated the social worker checked in with Resident #71 frequently while in the halls or common areas and that Resident #71 did well with 1:1 attention. Physician's progress notes dated 10/6/23 identified Resident's #71's bipolar disorder was stable with management to include Zyprexa 5mg QHS and monthly orthostatic BPS. Social Services notes dated 2/29/24 identified Resident #71 had inappropriate behavior with the family of the roommate that had passed away and additionally indicated Resident #71 was spending a lot of money and asking for money for things that Resident #71 was not responsible for and for other residents. Social Services notes dated 3/4/24 identified that Resident #71 had been removing large amounts of cash from the account and was refusing to identify how it was spent. Additionally, Resident #71's family member was spoken with regarding spending and discussed the diagnosis of bi-polar and the possible cycling of the mental illness that could cause the spending and Resident #71 being taken advantage of. Physician's orders dated 3/5/24 directed to discontinue Zyprexa 5mg PO QHS and start Zyprexa 7.5mg PO QHS. Provider's progress notes dated 3/6/24 by APRN #1 identified Resident #71 had been progressively experiencing irritable mood and an increase in rapid pressured speech over the past week. The note indicated Resident #71 identified recent behaviors as manic and agreed to an increase in the Zyprexa to 7.5 mg for a short time. Provider's progress note dated 3/21/24 identified APRN #1 would set up for Resident #71 to see a Psychiatrist. Physician's progress notes dated 3/24/24 identified Resident #71 was much improved on prescribed medication and indicated Resident #71 was escalating, manic and was being scheduled to see a psychiatrist. (continued on next page)		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Physician's progress notes dated 4/12/24 identified Resident #71 had pleasant mood and affect and that judgement and insight were intact. Psychiatric notes dated 5/16/24 recommended to decrease Zyprexa back to 5mg QHS and obtain labs and EKG in consideration of another agent due to mucous production. Physician's orders dated 5/16/24 directed to discontinue Zyprexa 7.5 mg PO QHS and change to Zyprexa 5mg PO QHS. Social services notes dated 5/30/24 identified that Resident #71 went into the community for therapy sessions. Physician's progress notes dated 9/24/24 identified the resident had anxiety but was stable and prone to obsess. Pharmacy recommendation dated 12/18/24 identified Resident #71 received Zyprexa but was not care planned for specific target behaviors or individualized interventions. Response from the physician indicated the prescription was not for behaviors but for mania and psychosis. Physician's progress notes dated 1/25/25 identified the resident had Bipolar and did well with the prescribed medication but needed dose escalation at times. Interview on 1/27/25 at 11:31 AM with the Director of Resident Services identified if a Preadmission Screening and Resident Review level II was recommended, the assessment agency would request additional resident information and would come into the facility to complete the assessment. She indicated the outcomes are emailed to herself (Director of Resident Services) and are then sent to the MDS coordinator and the social worker, who should review the recommendations. Interview on 1/27/25 at 11:42 AM with SW #1 identified her credentials as BSW, BA. SW #1 indicated she did not have any counseling certifications, nor an advanced, Master's level degree. SW #1 identified she shared an office with the Director of Resident Services and most PASSR Level II completions were talked about verbally. SW #1 identified she is on standby if residents need a counselor or mental health intervention. SW #1 identified that Resident #71 was seeing an outside psychiatrist at his/her request and facilitates his/her own transportation, but was unable to identify how often this occurred. SW #1 identified the medical director was providing medication management and indicated it was a group effort, by facility staff, to monitor medications because the facility is small. SW #1 identified that per Resident's #71's request, the facility did not have contact with the outpatient mental health provider treating him/her. SW #1 identified that the facility has not had contracted behavioral health services since 2020. SW #1 further identified she did not put much credence into the PASRR II recommendations due to the assessment being diagnoses driven. SW #1 indicated both Resident #35 and Resident #65 hallucinated and would not be able to engage in mental health counseling, nor participate in telehealth. SW #1 identified she would provide 1 to 1 support if resident's needed services. SW #1 indicated that she was qualified to determine which residents needed psychotherapy, and that the medical director was in agreement. (continued on next page)		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview on 1/27/25 at 12:49 PM with APRN #1 identified Social Services makes the decision to refer residents to further behavioral health services. APRN #1 indicated that all behavioral health medications were managed under the Medical Director, and had remained that way over the last 6 years. APRN #1 identified Resident #71 was referred for outside services by herself (APRN #1) when Resident #71 identified not wanting to speak with the facility social worker. APRN #1 indicated she did not know about the recommendations for beahvioral health follow ups for Resident #35, Resident #65, and Resident #71 and identified they would have been referred for services had she been aware. APRN #1 identified there was a difference between medical management and psychiatric management. Interview on 1/29/25 at 11:28 AM with the Medical Director identified he was aware the facility did not have a contracted behavioral health service for medication management or therapeutic counseling services. The Medical Director indicated he was a fell owship board certified geriatrician which qualified him to manage mental health medications. The Medical Director identified that social services staff and the APRN become involved with behavioral health management depending on the acuity. The Medical Director identified that SW #1 was responsible for making referrals to outpatient mental health services as indicated. The Medical Director was aware of SW #1's credentials (BSW, BA) and indicated the social worker was qualified to make decisions for day-to-day care. The Medical Director identified he considers himself the psychiatric practitioner for the facility based on his geriatrician certification and that he manages medications and orders monitoring for staff to follow through on. The Medical Director identified he does not provide ongoing therapeutic counseling services. Interview on 1/30/25 at 12:43 PM with the Lead Level II Assessor for Specialized services for the State of Connecticut (Assessor) identified that if facility staff provided behavioral health services to residents, the facility staff should have some type of behavioral health education to enable assisting residents with certain behavioral health issues. She indicated that some of the medications and counseling can be managed by primary care or facility staff, but specified that counseling services that are recommended, should be performed by someone with a Masters level of education or higher. The Assessor identified supportive counseling can be managed by facility staff for reassurance, redirection, or issues that arise day to day with mood and behavior but if a resident had a change in symptoms, hallucinations, paranoia, or any increase in symptoms, a new level II should be completed by re-evaluation of the resident. The state requirements for preadmission and resident review page 55 identified that for residents exhibiting active, or specialized treatment needs, the state authority was determined to be responsible for providing that treatment. Routine and ongoing rehabilitative treatment needs were determined to be the responsibility of facility staff following the identification of those service needs through PASSR.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50250 Based on observation(s), review of the clinical record, facility documentation, facility policy and interviews for 1 of 2 residents (Resident #16) reviewed for pressure injuries, and 2 of 2 residents (Resident #18 and Resident #87) reviewed for suicidal ideations, the facility failed to revise the resident care plan (RCP) for a resident who developed a facility acquired pressure injury and failed to revise the RCP for residents who made expressions of suicidal ideations (SI). The findings include: 1. Resident #16 was admitted to the facility in August of 2024 with diagnoses that included adult failure to thrive, repeated falls, diabetes mellitus without complications and generalized muscle weakness. The Admission assessment dated [DATE] identified a 1.5 centimeter (cm) by 1.5 cm pressure injury to the upper back, a debrided/open area to the right wrist measuring 4 cm by 2 cm by 0.5 cm, and a skin tear measuring 5 cm by 5 cm by 0.1 cm to the left upper arm. The admission assessment did not identify toe deformities. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #16 was cognitively intact (Brief Interview for Mental Status (BIMS) score of 15) and required set up assistance for personal hygiene, supervision or touching assistance for bed mobility and transfers and was occasionally incontinent of stool. The MDS identified Resident #16 as not at risk for developing pressure injuries and failed to identify the presence of pressure ulcers. The Resident Care Plan (RCP) dated 11/14/24 identified Resident #16 with an alteration in skin integrity and identified Resident #16 was admitted to the facility with multiple skin tears related to a fall and had a pressure injury to his/her upper back. The RCP further identified that Resident #16 had a skin tear on his/her wrist that required prior treatment and a form of debridement. Interventions included to reposition every 2 hours and as needed, to encourage optimal nutrition and hydration, to monitor skin integrity and notify the provider of any concerns or need of treatment and use of a pressure redistributing mattress to bed for skin integrity management. A Nurse ' s note dated 11/21/24 at 9:45 PM by LPN #4 identified Resident #16 presented with a scab to the right second toe and the surrounding area was red. The note further identified that Resident #16 ' s physician was notified and instructed application of a Band-Aid dressing to be changed daily and to monitor. (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An APRN note dated 11/26/2024 at 10:55 AM by APRN #1 identified Resident #16 reported right toe pain. The note further identified Resident #16 had a wound greater than 0.5 cm with a white moist open area surrounded by a ring of erythema which was tender to touch. The note identified that Resident #16 had not been wearing shoes and therefore the etiology/cause of the toe wound was unclear. The note further identified that Resident #16's toe was not reflective of inadvertent flexion disorder (no hammer toes). APRN #1 diagnosed Resident #16 with cellulitis (bacterial skin infection) of the right second toe and directed warm Epsom salt soaks to the right foot twice a day for 10 days and Mupirocin 2% ointment (topical antibiotic) to the wound followed by a Band-Aid dressing twice a day for 10 days. A Physician's order dated 12/16/24 directed to leave the right second toe open to air and let a scab form on the toe. The order further directed staff to monitor the toe closely every shift. A Nurses note dated 1/1/25 by LPN #3 identified that Resident #16's right second toe presented with redness surrounding the wound bed that had previously healed. The note further identified slough (non-viable tissue) in the wound bed. The note identified LPN #3 updated MD #2 who directed to obtain a wound culture of the right second toe, an x-ray, Santyl (topical enzymatic debriding agent) daily and to start Augmentin 875mg (oral antibiotic) twice a day for 10 days. An APRN note on 1/23/25 by APRN #1 identified Resident #16 had a right second toe deformity consistent with hammer toe. The progress note identified that attempts to leave the right second toe open to air on 12/16/24 to form a well adhered crust over the top of the wound did not occur. APRN #1 identified that the wound was being cleansed daily. The note further identified that on 1/1/25 the wound was assessed to have thick yellow exudation with erythema/redness and increased skin temperature of intact surrounding tissue. Resident #16 was commenced on antibiotic treatment and wound treatment. Interview and observation of Resident #16 on 1/27/25 at 2:30 PM, identified Resident #16's right second toe was covered with a wound dressing from a follow up appointment with a surgeon earlier that day. Resident #16's right great toe was open to air and presented with an area of dark brown dried eschar (devitalized/dead tissue) on the upper surface of the toe. Resident #16 identified that he had just arrived back to the facility from a podiatric consultation appointment with MD #3. Resident #16 identified that the right second toe wound progressively worsened and currently presented with ruptured tendons and exposed bone. Resident #16 identified the toe would be amputated per MD #3's recommendation. Review of Wound Consultation Patient Care Summary by MD #3 dated 1/27/25 identified a wound care order directing to apply skin prep to the right great toe and a wound care order directing a wet to damp dressing with Dakin's solution (antiseptic used to treat and prevent wound infections) to the right second toe. (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with RN #1 (MDS coordinator) on 1/29/25 at 10:32 AM identified that she was not aware of Resident #16 's new wound until sometime in mid-January of 2025. RN #1 identified that she discovered the new wound while reviewing Resident #16 's clinical record and identified a nurses note from 1/1/25 that identified slough in the wound. RN #1 identified she staged the wound as a stage III pressure injury based on wound documentation on 1/1/25 and indicated the wound progressed to a stage IV based on documentation provided by MD #3 on 1/27/25. RN #1 identified that she did not update the care plan since she was not notified of a new pressure ulcer development. RN #1 indicated that had she been made ware she would have updated Resident's #16's care plan with interventions to guide wound management. Review of the clinical record identified there were no revisions to the RCP related to the development of the right toe wound on 11/21/24 and subsequent documented declines in wound status thereafter. No new or preventative interventions were added to the RCP. Subsequent to surveyor inquiry, the RCP was updated to include the current pressure injury. 2. Resident #18 was admitted to the facility in September of 2017 and had diagnoses that included Alzheimer's disease, bipolar disorder, depression, and suicidal ideations. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #18 was severely cognitively impaired (Brief Interview for Mental Status (BIMS) score of 5), had moderate depression (PHQ-2 to 9 (resident mood interview) severity score of 11), required substantial/maximal assistance with eating, and was dependent for bed mobility and transfers. The Resident Care Plan (RCP) dated 10/4/2024 identified Resident #18 was at risk for alteration of mood/behaviors related to diagnoses of dementia, bipolar disorder and depression. Interventions included to monitor for psycho/social needs and update the provider with mood/behavior issues as needed. Review of the Inter-Agency Patient Referral Report dated 12/20/2024 identified Resident #18 was extremely agitated, was throwing objects, and was verbalizing self-harm statements of I want to kill myself. and I want to jump out the window. A progress note by APRN #1 on 12/23/2024 at 9:59 AM identified on 12/20/2024 Resident #18 was physically and verbally aggressive, hollered, threw objects at staff, was unable to be redirected and subsequently was sent to the hospital for lack of safety to his/herself and lack of safety to others. The note identified Resident #18 had a prior psychiatric hospitalization for depression. A progress note by SW #1 on 12/23/2024 at 10:56 AM identified SW #1 called Resident #18's family member to discuss Resident #18's recent hospitalization on [DATE] for aggressive behavior. SW #1 indicated that during the call, Resident #18's family member was notified that if Resident #18 was aggressive with staff or peers again or posed a risk to self or others, Resident #18 may require an inpatient psychiatric hospitalization . Review of clinical record failed to identify revisions to the RCP to include new interventions related to documented expressions of SI. 3. Resident #87 was admitted to the facility in February of 2024 with diagnoses that included unspecified dementia, anxiety disorder, chronic kidney disease and diabetes. (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #87 was severely cognitively impaired (Brief Interview for Mental Status (BIMS) score of 6) and required set up assistance for eating, was dependent for toileting and required partial/moderate assistance with bed mobility and transfers. Resident #87 had no limits on range of motion for upper and lower extremities and used a walker and wheelchair for mobility. The Resident Care Plan (RCP) dated 12/15/24, identified Resident #87 had an alteration in mood/behavior. Interventions included to update the provider with mood/behavior issues as they arise, monitor and document behaviors, encourage ventilation of feelings, provide emotional support and reassurance, speak slowly using short, simple statements and administer as needed medication for anxiety/agitation. A Nurse's note dated 1/20/25 at 8:39 PM by the RN Supervisor (RN #6) identified NA #7 reported that Resident #87 requested a rope to hang him/herself. The note identified Resident #87 made the request 3 times and that Resident #87 was, at that current time, in bed with eyes closed. The note identified the provider was notified and Resident #87 would continue to be monitored. The note failed to identify that the legal representative was notified. Review of the nursing 24-hour report logs dated 1/19/25 through 1/25/25 failed to identify documentation of Resident #87's expressions of SI on 1/20/25. Observation of Resident #87 on 1/27/25 at 10:25 AM identified Resident #87 lying in bed with a call bell attached with a cord clipped on bed linen beside him/her. The call bell cord was approximately 8-10 feet in length. Review of the clinical record failed to identify a provider order for monitoring, a frequency or duration for monitoring, specification for monitoring or documentation of monitoring to be performed. yh Review of Resident #87's clinical record on 1/27/25 at 2:10 PM identified Resident #87 had not been seen by a provider since his/her expressions of SI on 1/20/25. Review of the clinical record failed to identify revisions to the RCP to include further interventions related to the documented expressions of SI. Facility policy titled, Resident Care plan updates, identified that the resident care coordinator or designee will review the 24 hour written reports of each wing daily as well as interview nurses for any changes that would result in alterations on the care plan. The care plan will be adjusted if applicable within a reasonable length of time. Therapy programs are updated on the care plan as submitted to the resident care coordinator.		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50250 Based on observations, review of the clinical record, facility documentation, facility policy and interviews for 1 of 2 sampled residents (Resident #16) reviewed for pressure injuries, the facility failed to conduct a registered nurse (RN) assessment after the identification of a new wound and failed to complete weekly wound assessments to monitor the status of an existing wound and prevent infection and failed to initiate preventative skin integrity monitoring for a resident with a history of pressure injuries and with a current a current pressure injury and failed to initiate new preventative pressure injury interventions after the development a pressure injury to prevent worsening of the pressure injury and the development of a new pressure injury. The findings include: Resident #16 was admitted to the facility in August of 2024 with diagnoses that included adult failure to thrive, repeated falls, diabetes mellitus without complications and generalized muscle weakness. The Admission assessment on 8/10/24 identified a 1.5 centimeter (cm) by 1.5 cm pressure injury to the upper back, a debrided/open area to the right wrist measuring 4 cm by 2 cm by 0.5 cm, and a skin tear measuring 5 cm by 5 cm by 0.1 cm to the left upper arm. The Admission assessment did not identify toe deformities. Resident #16 ' s Admission Braden Risk Assessment Scale (tool used to assess a residents risk of developing pressure injuries) performed by LPN #3 on 8/10/24 was scored 18, indicating that Resident #16 was at mild risk for developing pressure injuries despite the admission assessment identifying a pressure injury present on admission. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #16 was cognitively intact (Brief Interview for Mental Status (BIMS) score of 15) and required set up assistance for personal hygiene, supervision or touching assistance for bed mobility and transfers and was occasionally incontinent of stool. The MDS identified Resident #16 as not at risk for developing pressure injuries and failed to identify the presence of The Resident Care Plan (RCP) dated 11/14/24 identified Resident #16 with an alteration in skin integrity. It further identified that Resident #16 was admitted with multiple skin tears from a fall and had a pressure injury to his/her upper back. The RCP further identified that Resident #16 had a skin tear on his/her wrist that required prior treatment and a form of debridement. Interventions included to reposition every 2 hours and as needed, to encourage optimal nutrition and hydration, to monitor skin integrity and notify the provider of any concerns or need of treatment and use of a pressure redistributing mattress to bed for skin integrity management. Review of the clinical record identified all facility diagnoses lists included type II diabetes as an active diagnosis. A Nurse ' s note dated 11/21/24 at 9:45 PM by LPN #4 identified Resident #16 presented with a scab to the right second toe and the surrounding area was red. The note further identified that Resident #16 ' s physician was notified and instructed application of a Band-Aid dressing to be changed daily and to monitor. (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An APRN note dated 11/26/2024 at 10:55 AM by APRN #1 identified Resident #16 reported right toe pain. The note further identified Resident #16 had a wound greater than 0.5 cm with a white moist open area surrounded by a ring of erythema which was tender to touch. The note identified that Resident #16 had not been wearing shoes and therefore the etiology/cause of the toe wound was unclear. The note further identified that Resident #16's toe was not reflective of inadvertent flexion disorder (no hammer toes). APRN #1 diagnosed Resident #16 with cellulitis (bacterial skin infection) of the right second toe and directed warm Epsom salt soaks to the right foot twice a day for 10 days and Mupirocin 2% ointment (topical antibiotic) to the wound followed by a Band-Aid dressing twice a day for 10 days. A Physician's order dated 12/16/24 directed to leave the right second toe open to air and let a scab form on the toe. The order further directed staff to monitor the toe closely every shift. A Nurses note dated 1/1/25 by LPN #3 identified that Resident #16's right second toe presented with redness surrounding the wound bed that had previously healed. The note further identified slough (non-viable tissue) in the wound bed. The note identified LPN #3 updated MD #2 who directed to obtain a wound culture of the right second toe, an x-ray, Santyl (topical enzymatic debriding agent) daily and to start Augmentin 875mg (oral antibiotic) twice a day for 10 days. An APRN note on 1/23/25 by APRN #1 identified Resident #16 had a right second toe deformity consistent with hammer toe. The progress note identified that attempts to leave the right second toe open to air on 12/16/24 to form a well adhered crust over the top of the wound did not occur. APRN #1 identified that the wound was being cleansed daily. The note further identified that on 1/1/25 the wound was assessed to have thick yellow exudation with erythema/redness and increased skin temperature of intact surrounding tissue. Resident #16 was commenced on antibiotic treatment and wound treatment. Review of the clinical record failed to identify an order to cleanse the right great to wound/scab daily. Interview and observation of Resident #16 on 1/27/25 at 2:30 PM, identified Resident #16's right second toe was covered with a wound dressing from a follow up appointment with a surgeon earlier that day. Resident #16's right great toe was open to air and presented with an area of dark brown dried eschar (devitalized/dead tissue) on the upper surface of the toe. Resident #16 identified that he had just arrived back to the facility from a podiatric consultation appointment with MD #3. Resident #16 identified that the right second toe wound progressively worsened and currently presented with ruptured tendons and exposed bone. Resident #16 identified the toe would be amputated per MD #3's recommendation. Review of Wound Consultation Patient Care Summary by MD #3 dated 1/27/25 identified a wound care order directing to apply skin prep to the right great toe and a wound care order directing a wet to damp dressing with Dakin's solution (antiseptic used to treat and prevent wound infections) to the right second toe. Interview with MD #3 on 1/30/25 at 1:08 PM identified that he first assessed Resident #16's wound on 1/27/24 after he/she was referred by the facility for a podiatric wound consultation. MD #3 identified that there was bone exposure to Resident #16's right second toe and the tendon was totally ruptured. MD #3 identified that amputation of the toe was the best option. (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. Review of the clinical record, both electronic and paper, failed to identify an RN assessment of the newly identified right second toe wound on 11/21/24. The first wound assessment was documented by APRN #1 on 11/26/25, 5 days after the wound was discovered, and cellulitis was noted at that time. The first facility performed RN assessment of the wound was documented on 1/7/25 by RN #7. Interview with LPN #4 on 2/5/2025 at 11:40 AM identified Resident #16 reported throbbing pain on his/her right second toe on 11/21/24. LPN #4 identified that she assessed Resident #16 's toe and faxed wound assessment details to MD #2. MD #2 gave a telephone order to cover Resident #16 's toe with a Band-Aid dressing daily until healed. LPN #4 further identified she reported the change in condition to an RN supervisor but could not identify which RN supervisor she reported the change to. She further identified the RN supervisor did not assess Resident #16 's wound. LPN #4 indicated that an initial RN assessment of Resident #16 's wound was not required since LPN 's frequently assessed wounds at the facility, including initial wound assessments. LPN #4 further identified that it was not necessary to complete a Pressure Ulcer Packet (contents of packet included: rehab seating screen submitted to Physical Therapy, skin integrity dietary screen submitted to the Dietician, Braden Risk assessment submitted to the MDS nurse and nursing interventions for treatment and prevention implemented) since the wound surface was scabbed and did not impair Resident #16 's activities of daily living. LPN #4 identified that she did not complete wound measurements but indicated that wound measurements should have been completed to enable monitoring of wound progress. Interview with the facility Wound Care Certified Registered Nurse (RN #4) on 1/29/24 at 12:02 PM identified that she had not seen, assessed or treated Resident #16 's wound. RN #4 further identified that Resident #16 's initial wound assessment/evaluation should have been completed by an RN, not an LPN, and that weekly wound assessments should have been completed and documented. Review of facility nursing staff education files on 1/30/25 failed to identify that LPN #3 and LPN #4 received education related to wound or skin conditions for the year 2024 or education for recognizing and reporting changes in a resident condition for the years of 2023 and 2024. Although requested, a policy for RN assessment was not provided. 2. Review of the clinical record, both electronic and paper, failed to identify weekly wound assessments and daily wound monitoring. Review of Nursing progress notes from 11/21/24 through 1/6/25 failed to identify documentation of weekly wound assessments or detailed daily monitoring of the wound. Review of the Wound Management Detail Report from 11/21/24 through 1/6/25 failed to identify weekly documentation of wound progress. Review of the clinical record identified the first detailed wound assessment was completed by RN #7 on 1/7/25 at 11:12 AM and included a wound measurement of 1.2 cm by 0.9 cm by 0.1 cm, seropurulent (yellow or tan, cloudy and thick drainage) with slough in the wound bed. Additional weekly wound assessments were completed subsequent to 1/7/25. Interview with APRN #1 on 1/29/25 at 10:30 AM identified that Resident #16 had an unstageable wound to the right second toe which progressively worsened, and a referral was made to MD #3 who recommended amputation of the right second toe. (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with RN #4 on 1/29/24 at 12:02 PM identified that weekly wound assessments for the right second toe wound should have been completed and documented since discovery on 11/21/24. Interview with Resident #16 on 1/29/25 at 12:30 PM identified he did not have any toe deformity when he was admitted to the facility. Interview with the ADNS on 1/29/24 at 2:20 PM identified that all wound assessments and documentation are recorded in the electronic medical record (EMR). Interview with LPN #3 on 1/30/25 at 12:30 PM identified she discovered Resident #16 's open wound with slough on 1/1/25. LPN #3 indicated that staff were documenting in the Treatment Administration Record (TAR) that the wound was open to air but there was no documentation detailing wound assessment or progress. LPN #3 identified she took a picture of the wound and sent the picture to MD #2 via secure text message. LPN #3 identified that she notified the RN supervisor who looked at the picture but did not physically assess Resident #16 's wound. LPN #3 identified that she did not obtain wound measurements or complete a Pressure Ulcer Packet. LPN #3 identified that MD #2 gave wound management orders via secure text message based on the photo sent. 3. Review of the clinical record identified there was no preventative weekly skin assessments performed before the development of the right second toe wound on 11/21/24, no preventative weekly skin assessments performed after the development of the right second toe wound on 11/21/24 and no preventative weekly skin assessments performed before the discovery of a 2nd wound (right great toe), on 1/27/25, by a consulting provider. Review of Nursing progress notes failed to identify documentation of a right great toe wound. Review of the Wound Management Detail Report failed to identify weekly documentation of a right great toe wound. Interview with the ADNS on 1/29/24 at 2:20 PM identified that there were no scheduled preventative weekly skin assessments completed for Resident #16 since he/she was admitted to the facility. The ADNS identified that weekly skin assessments were not completed for Resident #16 because his/her Braden Risk Assessment Scale scores did not indicate that he/she was at risk of developing pressure injuries. The ADNS identified that Resident #16 had a diagnosis of diabetes and should have been placed on weekly skin checks of the feet due to his/her diabetes diagnosis. The ADNS indicated that the diabetes diagnosis was not included in the hospital discharge summary therefore was not identified as a current problem during the current admission to the facility. The ADNS identified that if a Pressure Ulcer Packet were completed when the right second toe wounds were discovered, a new Braden Risk Assessment Scale would have been performed as part of the packet, which then would have triggered new interventions for the pressure injuries. Interview with RN #1 on 1/30/24 at 10:00 AM identified that Resident #16 had been diagnosed with diabetes in 2020, during a prior facility admission. RN #1 indicated that diabetes was not a current problem since Resident #16 's hemoglobin A1C was normal on admission, and he/she was not on diabetic treatment. RN #1 further identified that diabetes was not listed as one of diagnoses on Resident #16 's hospital discharge summary even though it was listed as an active diagnosis in the facility chart. (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and clinical record review with RN #4 on 1/30/25 at 2:45 PM, identified there was no documentation of the right great toe wound. Subsequent to surveyor inquiry on 1/30/25, Resident #16 ' s right great toe was assessed by RN #4 and a wound assessment was documented in Resident #16 ' s clinical record at 4:04 PM identifying the right great toe wound as a new wound with an intact eschar to the wound base and a measurement of 0.8 cm by 1 cm. 4. The Braden Risk Assessment Scale dated 8/31/24 by RN #1 identified a score of 19 indicating Resident #16 was not at risk for developing pressure injuries. The Braden Risk Assessment Scale dated 11/10/24 by LPN #7 identified a score of 20 indicating that Resident #16 was not at risk for developing pressure injuries. Review of the clinical record failed to identify a repeat Braden Risk Assessment Scale after the development of a new pressure injury 11/21/24. Review of the clinical record failed to identify updated interventions in the RCP to reflect the development of a new pressure injury and applicable treatment interventions and failed to identify preventative interventions for prevention of additional wounds. Review of the Physicians orders failed to identify new preventative interventions Interview with RN #1 (MDS coordinator) on 1/29/25 at 10:32 AM identified that was she was not aware of Resident #16 ' s new wound until sometime in mid-January of 2025. RN #1 identified that she discovered the new wound while reviewing Resident #16 ' s clinical record and identified a nurses note from 1/1/25 that identified slough in the wound. RN #1 identified she staged the wound as a stage III pressure injury based on wound documentation on 1/1/25 and indicated the wound progressed to a stage IV based on documentation provided by MD #3 on 1/27/25. RN #1 identified that no Pressure Ulcer Packet was completed on 11/21/24 when the wound was initially discovered or on 1/1/25 when the wound worsened, therefore, a new Braden Risk Assessment Scale was not performed and appropriate interventions were not triggered. The facility policy titled, Pressure Ulcers, identified that if a patient is identified at risk for the development of pressure ulcers or is noted to have a pressure area, the pressure ulcer packet is to be completed and nursing interventions for treatment and prevention based on Braden Risk Assessment score are implemented.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50250 Based on clinical record review, review of facility policy, and interviews for 1 of 5 residents (Resident #31) reviewed for nutrition, the facility failed to obtain weekly weights according to physician order. The findings include: Resident #31 was admitted to the facility in September of 2024 with diagnoses that included diabetes, congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD) and anxiety disorder. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #31 was cognitively intact (Brief Interview for Mental Status (BIMS) score of 15), required partial/moderate assistance for toileting hygiene and was dependent for personal hygiene, bed mobility and transfers. A Resident Care Plan dated 10/4/24 identified Resident #31 was at risk for nutritional deficit. Interventions included encourage Resident #31 with feeding, offer substitutes for dislikes, maintain intake and output and obtain weekly weights. A Physician's order dated 10/4/24 directed to obtain weekly weights. A Physician's order dated 10/4/24 directed to administer Bumetanide 2mg (diuretic) tablet by mouth three times every week on Monday, Wednesday, and Friday. A Physician's order dated 10/4/24 directed to administer Spironolactone 25 mg (diuretic) tablet by mouth once daily. Review of the Medication Administration Record (MAR), and Weights and Vitals Summary from 10/4/24 through 1/21/25, identified the following weights: 10/4/24: 167.4 Lbs., 10/18/24: 164.6 Lbs., 10/25/24: 160.8., 11/1/24: 162.2Lbs., 11/8/24: 162.6 Lbs., 11/15/24: 166 Lbs., 11/18/24: 162.4 Lbs., 11/22/24: 164.6 Lbs., 11/29/24: 162.4 Lbs., 12/6/24: 162.2 Lbs., 12/13/24: 161 Lbs., 1/7/25: 160.1Lbs., 1/14/25: 160.6 Lbs., 1/21/25: 167.2 Lbs. Weights were not obtained on 10/11/24., 12/20/24., 12/27/24., and 1/3/25. Clinical record review from 10/4/24 through 1/21/25 failed to identify a care plan for weight refusals or nursing progress notes identifying weight refusals. Interview with RN #2 on 1/26/25 at 2:00 PM identified that NA 's obtain residents weights on shower days and nurses document weights either in the MAR or (Electronic Medical Record) EMR. RN #2 identified that Resident #31 was not weighed on 12/20/24 because he/she refused to be weighed. RN #2 was unable to identify if there were attempts to reweigh Resident #2 on 12/20/24 or thereafter. In addition, RN #2 could not explain or provide documentation of why Resident #31 was not weighed on 12/27/24. RN #2 further identified that Resident #31's weight was not obtained on 1/3/25 because his/her shower day was adjusted to 1/7/25 and indicated that weights are obtained on shower days. (continued on next page)		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the ADNS on 1/26/25 at 3:00 PM, failed to identify if any further attempts to reweigh Resident #31 were made on 12/20/24 or thereafter. The ADNS could not explain why Resident #31 was not weighed on 12/27/24. The ADNS indicated that Resident # 31's weight was not obtained on 1/3/25 because his/her shower day was adjusted to 1/7/25 when Resident #31 was weighed. The ADNS identified that the Physician's order for weekly weights should have been followed due to Resident #31's CHF diagnosis. Review of facility policy titled, Weight Loss/Gain Policy, identified in part, that, all residents are weighed upon admission and subsequently consistent with physician orders.		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 51183 Based on review of the clinical record, facility documentation, facility policy and interviews the facility failed to provide trained and competent nursing staff for monitoring resident skin conditions and failed to provide trained and competent nursing staff for changing oxygen tubing and cleaning oxygen concentrator filters. 1. Review of Healthcare Academy (online education platform) Course Status Reports for all staff for 2023 and 2024 identified a course assigned to NA's titled Skin Care Basics for Nursing Assistants which included education on skin tears, pressure injuries and reporting of skin problems to the nurse. Review of the completion rate for the Skin Care Basics course identified 32 out of 75 (42.6%) actively employed NA's did not complete this assigned course for 2024. Interview with Registered Nurse (RN) #1 on 1/21/2025 at 11:00 AM identified the licensed nurses did not conduct preventative weekly skin assessments for facility residents, that residents skin was monitored by the NA's during care and if the NA observed a change in skin integrity they would notify a nurse. Interview with RN #4 on 1/28/2025 at 2:10 PM identified that education on reporting changes in skin condition should be done annually for NA's and that the education would be added to the 2025 Skills Fair. She further inidcated she had not conducted competencies on reporting changes in skin condition during 2024. Review of completed 2024 NA competencies for 16 out of 75 NA's failed to identify a competency related to monitoring of resident skin condition and when to notify the nurse of a concern. 2. Interview with Registered Nurse (RN) #4 on 1/24/2025 at 11:30 AM identified cleaning oxygen concentrator filters and changing oxygen nasal cannula tubing were tasks that could be delegated to NA's. RN #4 was unaware of a policy for cleaning oxygen concentrator filters or if this was a task was covered in the Healthcare Academy course assigned to NA's. RN #4 indicated that she did not have a written educational in-service for cleaning of the filters on the oxygen concentrators. Review of the Oxygen Use Basics course curriculum document from Healthcare Academy identified the course did not contain training related to changing, labeling, and dating nasal cannula oxygen tubing or cleaning oxygen concentrator filters. Interview with RN #4 on 1/28/2025 at 2:10 PM identified that changing of oxygen tubing can be performed by the NA's, but licensed nurses are responsible for ensuring the task was performed and for applying a date label. RN #4 indicated that she did not provide education to the nurses on delegating tasks to the NA's and could not identify how the nurses would know what instructions to provide to the NA's for the completion of delegated tasks. Review of completed 2024 NA competencies for 16 out of 75 NA's failed to identify a competency related to changing of nasal cannula oxygen tubing and cleaning of oxygen concentrator filters. (continued on next page)		

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Staff Development Corporate Compliance Policy identified records of educational training were maintained in the Staff Development Room, an individual training record for each employee would be maintained, and NAs are required by state regulations to obtain at least 12 hours of continuing education each year and the 12 hours must be completed prior to their respective anniversary.		

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that the facility has sufficient staff members who possess the competencies and skills to meet the behavioral health needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50250 Based on observation(s), review of the clinical record, facility documentation, facility policy and interviews for 1 of 3 residents (Resident #87) reviewed for mood/behavior, the facility failed to provide a behavioral health assessment by a qualified clinician for a resident with suicidal ideations. The findings include: Resident #87 was admitted to the facility in February of 2024 with diagnoses that included unspecified dementia, anxiety disorder, chronic kidney disease and diabetes. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #87 was severely cognitively impaired (Brief Interview for Mental Status (BIMS) score of 6) and required set up assistance for eating, was dependent for toileting and required partial/moderate assistance with bed mobility and transfers. Resident #87 had no limits on range of motion for upper and lower extremities and used a walker and wheelchair for mobility. A Clinical note dated 11/15/24 at 3:57 PM by Advanced Practice Registered Nurse (APRN) #1 identified Resident #87 was transferred to the emergency room (ER) due to striking out with objects, kicking, hitting staff and threatening to kill them or apply physical harm. The note further identified that Resident #87 was assessed by a provider, cleared and returned to the facility the same day. The Resident Care Plan (RCP) dated 12/15/24, identified Resident #87 had an alteration in mood/behavior. Interventions included to update the provider with mood/behavior issues as they arise, monitor and document behaviors, encourage ventilation of feelings, provide emotional support and reassurance, speak slowly using short, simple statements and administer as needed medication for anxiety/agitation. A Nurse's note dated 1/20/25 at 8:39 PM by the RN Supervisor (RN #6) identified NA #7 reported that Resident #87 requested a rope to hang him/herself. The note identified Resident #87 made the request 3 times and that Resident #87 was, at that current time, in bed with eyes closed. The note identified the provider was notified and Resident #87 would continue to be monitored. The note failed to identify that the legal representative was notified. Review of the clinical record failed to identify a provider order for monitoring, a frequency or duration for monitoring, specification for monitoring or documentation of monitoring to be performed. Review of the clinical record failed to identify revisions to the RCP to include further interventions related to the expressions of SI. Review of the clinical record failed to identify that Resident # 87 was assessed by a qualified clinician after he/she expressed SI. Observation of Resident #87 on 1/27/25 at 10:25 AM identified Resident #87 lying in bed with a call bell attached with a cord clipped on bed linen beside him/her. The call bell cord was approximately 8-10 feet in length. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075078	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/03/2025
NAME OF PROVIDER OR SUPPLIER Westview Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 150 Ware Rd Dayville, CT 06241	
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 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Observation on 1/27/25 at 11:25 AM identified Resident #87 was lying in bed with the bed in a low position, slightly turned on his/her right side, and a corded call bell was positioned beside him/her, in bed, on the right side. Review of Resident #87's clinical record on 1/27/25 at 2:10 PM identified Resident #87 had not been seen by a provider since his/her expressions of SI on 1/20/25. Interview with an RN supervisor (RN #6) on 1/27/25 at 1:58 PM identified NA #7 notified her of Resident #87's expressions of SI on 1/20/25. RN #6 identified that she assessed Resident #87, in his/her room, for SI, by asking Resident #87 how his/her day was going, which Resident #87 responded, not good, and then asked Resident #87 if he/she needed to use the bathroom or wanted a snack. RN #6 identified she did not conduct a comprehensive assessment to determine if Resident #87 had a plan and/or means to harm him/herself. RN #6 identified she did not ask Resident #87 any targeted questions related to wanting to die, wanting to hang him/herself, or telling another staff member he/she wanted to harm him/herself. RN #6 indicated Resident #87 was monitored, after MD #1 was notified, but could not provide the frequency, duration or type of monitoring performed and identified there was no documentation of the monitoring because MD #1 did not provide a monitoring order. RN #6 identified that her interpretation of MD #1 directing her to monitor Resident #87, was to monitor Resident #87 for the next few hours. RN #6 identified that there were no changes made to Resident #87's environment after the expressions of SI were reported including the corded call bell remaining in place at the bedside. RN #6 was unable to identify a facility protocol for SI. RN #6 indicated that performing risk assessments for residents with SI was within her scope of practice as a RN. RN #6 could not identify any specialized training received from the facility or by any other entity that would qualify her to perform risk assessments. Interview with MD #1 on 1/27/25 at 2:30 PM identified he was notified of Resident #87's expressions of SI by RN #6 on 1/20/25 at 8:38 PM and directed to monitor Resident #87. MD #1 identified he did not specify a frequency or duration for monitoring because the facility should have monitored Resident #87 according to facility protocol. MD #1 identified he based his decision for monitoring on the assessment performed by RN #6 and only 1 expression of SI made by Resident #87 versus persistent expressions of SI. MD #1 stated I was only called once; I was not aware of 3 statements. MD #1 further identified that persistent expressions of SI would have warranted a higher level of monitoring such as 1:1 monitoring or transfer to the ER. MD #1 then stated He/she should have been a 1:1 if he/she made 3 statements. MD #1 indicated the corded call bell should have been removed from Resident #87's bedside after the expressions of SI were made and indicated the need for removing the corded call bell should have been apparent. Re-interview and review of the secure text message (dated 1/20/25 at 8:38 PM) with MD #1 on 1/27/25 at 4:30 PM identified that he was notified of Resident #87's SI statements through secure text message once and confirmed that in that 1 message, he was made aware of 3 expressions of SI and responded with a secure text message directing staff to monitor Resident #87. MD #1 indicated that Resident #87 is demented and indicated he does not think Resident #87 would have acted on the statements. MD #1 further identified that the facility Social Worker should have followed up with Resident #87 after the expressions of SI were made. MD #1 identified that he inquired about Resident #87's status via secure text message on 1/21/25 and received a response from RN #6 indicating Resident #87 was back to baseline. MD #1 identified that he did not evaluate Resident #87 and could not identify if another facility provider had evaluated Resident #87 since the expressions of SI made on 1/20/25. (continued on next page)		

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F 0741 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of Resident #87's clinical record on 1/27/25 at 2:10 PM identified Resident #87 had not been seen by a provider since his/her expressions of SI on 1/20/25. Review of RN #6's facility education and personel files failed to identify specialized training related to perofrming risk assessments. Subsequent to surveyor inquiry Resident #87 was assessed by APRN #1 and later by MD #1 for SI. APRN #1 and MD #1 both cleared Resident #87 of SI and rendered him/her safe in the facility. The facility policy titled, Suicide, Early Warnings, did not include a protocol for SI but only included definitions/examples of SI. Although requested, the facility did not provide a policy related to behavioral health assessments for residents with suicidal ideations.		

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50250 Based on observations, review of the clinical record, review of facility documentation, and interviews for 1 of 2 residents (Resident #87) reviewed for mood/behavior, the facility failed to provide appropriate treatment and services to attain the highest practicable mental and psychosocial well-being for a resident who expressed suicidal ideation (SI). These failures resulted in the finding of Immediate Jeopardy. The findings include: Resident #87 was admitted to the facility in February of 2024 with diagnoses that included unspecified dementia, anxiety disorder, chronic kidney disease and diabetes. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #87 was severely cognitively impaired (Brief Interview for Mental Status (BIMS) score of 6) and required set up assistance for eating, was dependent for toileting and required partial/moderate assistance with bed mobility and transfers. Resident #87 had no limits on range of motion for upper and lower extremities and used a walker and wheelchair for mobility. A Clinical note dated 11/15/24 at 3:57 PM by Advanced Practice Registered Nurse (APRN) #1 identified Resident #87 was transferred to the emergency room (ER) due to striking out with objects, kicking, hitting staff and threatening to kill them or apply physical harm. The note further identified that Resident #87 was assessed by a provider, cleared and returned to the facility the same day. The Resident Care Plan (RCP) dated 12/15/24, identified Resident #87 had an alteration in mood/behavior. Interventions included to update the provider with mood/behavior issues as they arise, monitor and document behaviors, encourage ventilation of feelings, provide emotional support and reassurance, speak slowly using short, simple statements and administer as needed medication for anxiety/agitation. A Nurse's note dated 1/20/25 at 8:39 PM by the RN Supervisor (RN #6) identified NA #7 reported that Resident #87 requested a rope to hang him/herself. The note identified Resident #87 made the request 3 times and that Resident #87 was, at that current time, in bed with eyes closed. The note identified the provider was notified and Resident #87 would continue to be monitored. The note failed to identify that the legal representative was notified. Review of the clinical record failed to identify a provider order for monitoring, a frequency or duration for monitoring, specification for monitoring or documentation of monitoring to be performed. Review of the clinical record failed to identify revisions to the RCP to include further interventions related to the expressions of SI. (continued on next page)		

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Observation of Resident #87 on 1/27/25 at 10:25 AM identified Resident #87 lying in bed with a call bell attached with a cord clipped on bed linen beside him/her. The call bell cord was approximately 8-10 feet in length. Interview with Social Worker (SW) #1 on 1/27/25 at 10:35 AM identified she was not aware of the expressions of SI made by Resident #87 on 1/20/25 because no notification was made to her by any facility staff. Observation of the Social Services log on 1/27/25 at 10:35 AM with SW #1 failed to identify documentation of notification to SW #1, of the expressions of SI, made by Resident #87 on 1/20/25 or thereafter. Observation on 1/27/25 at 11:25 AM identified Resident #87 was lying in bed with the bed in a low position, slightly turned on his/her right side, and a corded call bell was positioned beside him/her, in bed, on the right side. Interview and record review with the Assistant Director of Nursing Services (ADNS) on 1/27/25 at 11:40 AM identified she was not aware of the expressions of SI on 1/20/25 by Resident #87. The ADNS identified MD #1 was notified on 1/20/25, through a secure text message, of Resident #87 's expressions of SI and the provider directed staff to monitor Resident #87. The ADNS could not identify the nursing interventions implemented or type of monitoring that was performed on 1/20/25 to keep Resident #87 safe following the expressions of SI. The ADNS was unable to identify a protocol for SI and was unable to identify documentation that an assessment was conducted to ensure that Resident #87 was not a danger to self or others. The ADNS was notified by the surveyor that Resident #87 still had access to a call bell attached with a cord. Interview with an RN supervisor (RN #7) on 1/27/25 at 11:50 AM identified she had not encountered a resident with SI in a long time, but stated, there's probably a policy somewhere for it . RN #7 could not explain or identify a facility protocol for SI. Interview with SW #1 on 1/27/25 at 12:00 PM identified the expressions of SI made by Resident #87 should have been assessed by RN #6 and notifications should have been made to her (SW #1) and the provider, and if she received notification of the incident, she would have assessed Resident #87 on the morning of 1/21/25 for a self-harm plan, identification of SI risks, access to ligature risks, and review of interventions implemented on 1/20/25 after the expressions of SI. SW #1 identified she would have removed the call bell attached with a cord and provided a push button call bell. SW #1 could not identify a protocol that should have been initiated during the evening shift of 1/20/25 to include whether the call bell cord should have been removed. SW #1 indicated that the facility had not had a behavioral health consulting service since 2020 but identified that the facility had recently contracted a new behavioral health service which would begin in February of 2025. SW #1 identified that Resident #87 had not received behavioral health services since the expressions of SI on 1/20/25 and was not aware of a facility protocol for SI. SW #1 identified that the facility does not have interdisciplinary team (IDT) meetings for a coordinated approach to care and indicated staff communicate with her via a written Social Services log and written 24-hour report logs. SW #1 was made aware by the surveyor that Resident #87 still had access to a call bell with a cord. Review of the nursing 24-hour report logs dated 1/19/25 through 1/25/25 failed to identify documentation of Resident #87's expressions of SI on 1/20/25. (continued on next page)		

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Observation of Resident #87 on 1/27/25 at 12:55 PM, identified Resident #87 lying in bed with a call bell attached to a cord clipped on bed linen beside him/her. Interview with the Administrator on 1/27/25 at 1:01 PM identified he was not aware of the expressions of SI made by Resident #87 on 1/20/25 and could not explain or provide a protocol for SI. The Administrator identified Resident #87 should have been evaluated by a qualified clinician after expressions of SI were made and indicated he (himself) should have been notified and the ADNS should have been notified in the absence of the DNS. The Administrator was notified by the surveyor that Resident #87 still had not been assessed for SI by a qualified clinician and that Resident #87 still had access to a call bell attached with a cord. Observation on 1/27/25 at 1:35 PM identified Resident #87 lying in bed with a call bell attached to a cord clipped on bed linen beside him/her. Interview with an RN supervisor (RN #6) on 1/27/25 at 1:58 PM identified NA #7 notified her of Resident #87's expressions of SI on 1/20/25. RN #6 identified that she assessed Resident #87, in his/her room, for SI, by asking Resident #87 how his/her day was going, which Resident #87 responded, not good , and then asked Resident #87 if he/she needed to use the bathroom or wanted a snack. RN #6 identified she did not conduct a comprehensive assessment to determine if Resident #87 had a plan and/or means to harm him/herself. RN #6 identified she did not ask Resident #87 any targeted questions related to wanting to die, wanting to hang him/herself, or telling another staff member he/she wanted to harm him/herself. RN #6 indicated Resident #87 was monitored, after MD #1 was notified, but could not provide the frequency, duration or type of monitoring performed and identified there was no documentation of the monitoring because MD #1 did not provide a monitoring order. RN #6 identified that her interpretation of MD #1 directing her to monitor Resident #87, was to monitor Resident #87 for the next few hours. RN #6 identified that there were no changes made to Resident #87's environment after the expressions of SI were reported including the corded call bell remining in place at the bedside. RN #6 was unable to identify a facility protocol for SI. Review of Resident #87's clinical record on 1/27/25 at 2:10 PM identified Resident #87 had not been seen by a provider since his/her expressions of SI on 1/20/25. Interview with MD #1 on 1/27/25 at 2:30 PM identified he was notified of Resident #87's expressions of SI by RN #6 on 1/20/25 at 8:38 PM and directed to monitor Resident #87. MD #1 identified he did not specify a frequency or duration for monitoring because the facility should have monitored Resident #87 according to facility protocol. MD #1 identified he based his decision for monitoring on the assessment performed by RN #6 and only 1 expression of SI made by Resident #87 versus persistent expressions of SI. MD #1 stated I was only called once; I was not aware of 3 statements. MD #1 further identified that persistent expressions of SI would have warranted a higher level of monitoring such as 1:1 monitoring or transfer to the ER. MD #1 then stated He/she should have been a 1:1 if he/she made 3 statements . MD #1 indicated the corded call bell should have been removed from Resident #87's bedside after the expressions of SI were made and indicated the need for removing the corded call bell should have been apparent . (continued on next page)		

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F 0742 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Re-interview and review of the secure text message (dated 1/20/25 at 8:38 PM) with MD #1 on 1/27/25 at 4:30 PM identified that he was notified of Resident #87's SI statements through secure text message once and confirmed that in that 1 message, he was made aware of 3 expressions of SI and responded with a secure text message directing staff to monitor Resident #87. MD #1 indicated that Resident #87 is demented and indicated he does not think Resident #87 would have acted on the statements. MD #1 further identified that the facility Social Worker should have followed up with Resident #87 after the expressions of SI were made. MD #1 identified that he inquired about Resident #87's status via secure text message on 1/21/25 and received a response from RN #6 indicating Resident #87 was back to baseline. MD #1 identified that he did not evaluate Resident #87 and could not identify if another facility provider had evaluated Resident #87 since the expressions of SI made on 1/20/25. Interview with NA #7 on 1/29/25 at 11:45 AM identified that Resident #87 requested her to give him/her a rope to hang him/herself, 3 times, while she was in the bathroom with him/her. NA #7 identified that she stayed with Resident #87 in the bathroom until he/she was finished, provided personal care and assisted him/her back to the wheelchair. NA #7 identified she then wheeled Resident #87 to the nurse's station within view of the charge nurse and then reported the expressions of SI to RN #6 because she believed there was a safety issue. NA #7 identified that she left Resident #87 with RN #6 and continued her assignment. The facility policy titled, Suicide, Early Warnings, did not include a protocol for SI but only included definitions/examples of SI. The Administrator was provided with the Immediate Jeopardy Template by the State Agency (SA) on 1/27/25 at 5:25 PM. The facility immediately placed Resident #87 on 1:1 monitoring and removed the call bell attached with a cord from Resident #87's bedside and replaced it with a hand bell. Interview with the Administrator on 1/27/25 at 6:45 PM identified the current facility policy for SI was insufficient, had been in place for decades, and required revisions. The facility developed a removal plan on 1/27/25 which was approved by the SA and included: SI policy was revised and updated to include a protocol for SI, Resident #87 was evaluated for suicidality by both APRN #1 and MD #2 and deemed safe in the facility. Facility staff were educated on the new SI policy related to care of residents with SI and residents in the facility identified to have moderate-severe depression were screened for SI. During an onsite visit on 1/27/25 the SA verified the implementation of the removal plan and the Immediate Jeopardy was removed.		

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50250 Based on observations, review of the clinical record, facility documentation, facility policy and interviews for 2 of 2 residents (Resident #18 and Resident #87) reviewed for suicidal ideation, the facility failed to provide social services for residents who expressed suicidal ideations. The findings include: 1. Resident #18 was admitted to the facility in September of 2017 and had diagnoses that included Alzheimer's disease, bipolar disorder, depression, and suicidal ideations. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #18 was severely cognitively impaired (Brief Interview for Mental Status (BIMS) score of 5), had moderate depression (PHQ-2 to 9 (resident mood interview) severity score of 11), required substantial/maximal assistance with eating, and was dependent for bed mobility and transfers. The Resident Care Plan (RCP) dated 10/4/2024 identified Resident #18 was at risk for alteration of mood/behaviors related to diagnoses of dementia, bipolar disorder and depression. Interventions included to monitor for psycho/social needs and update the provider with mood/behavior issues as needed. Review of the Inter-Agency Patient Referral Report dated 12/20/2024 identified Resident #18 was extremely agitated, was throwing objects, and was verbalizing self-harm statements of I want to kill myself. and I want to jump out the window. A progress note by APRN #1 on 12/23/2024 at 9:59 AM identified on 12/20/2024 Resident #18 was physically and verbally aggressive, hollered, threw objects at staff, was unable to be redirected and subsequently was sent to the hospital for lack of safety to his/herself and lack of safety to others. The note identified Resident #18 had a prior psychiatric hospitalization for depression. A progress note by SW #1 on 12/23/2024 at 10:56 AM identified SW #1 called Resident #18's family member to discuss Resident #18's recent hospitalization on [DATE] for aggressive behavior. SW #1 indicated that during the call, Resident #18's family member was notified that if Resident #18 was aggressive with staff or peers again or posed a risk to self or others, Resident #18 may require an inpatient psychiatric hospitalization . The progress note failed to identify social services visits or social services support provided for Resident #18 following the hospitalization for aggressive behaviors and suicidal ideations. Interview with RN #6 on 1/27/2025 at 3:25 PM identified Resident #18 started behaving aggressively toward staff and other residents during the 3:00 PM to 11:00 PM shift on 12/20/24 and the provider ordered Resident #18 to be transferred to the hospital for evaluation. She further identified that while waiting for the ambulance, Resident #18 began to verbalize statements of self-harm. 2. Resident #87 was admitted to the facility in February of 2024 with diagnoses that included unspecified dementia, anxiety disorder, chronic kidney disease and diabetes. (continued on next page)		

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #87 was severely cognitively impaired (Brief Interview for Mental Status (BIMS) score of 6) and required set up assistance for eating, was dependent for toileting and required partial/moderate assistance with bed mobility and transfers. Resident #87 had no limits on range of motion for upper and lower extremities and used a walker and wheelchair for mobility. The Resident Care Plan (RCP) dated 12/15/24, identified Resident #87 had an alteration in mood/behavior. Interventions included to update the provider with mood/behavior issues as they arise, monitor and document behaviors, encourage ventilation of feelings, provide emotional support and reassurance, speak slowly using short, simple statements and administer as needed medication for anxiety/agitation. A Nurse's note dated 1/20/25 at 8:39 PM by the RN Supervisor (RN #6) identified NA #7 reported that Resident #87 requested a rope to hang him/herself. The note identified Resident #87 made the request 3 times and that Resident #87 was, at that current time, in bed with eyes closed. The note identified the provider was notified and Resident #87 would continue to be monitored. The note failed to identify that the legal representative was notified. Review of the clinical record failed to identify a provider order for monitoring, a frequency or duration for monitoring, specification for monitoring or documentation of monitoring to be performed. Review of the clinical record failed to identify revisions to the RCP to include further interventions related to the expressions of SI. Review of the clinical record failed to identify a social services visit or follow up following the documented expressions of SI. Observation of Resident #87 on 1/27/25 at 10:25 AM identified Resident #87 lying in bed with a call bell attached with a cord clipped on bed linen beside him/her. The call bell cord was approximately 8-10 feet in length. Interview with Social Worker (SW) #1 on 1/27/25 at 10:35 AM identified she was not aware of the expressions of SI made by Resident #87 on 1/20/25 because no notification was made to her by any facility staff. Observation of the Social Services log on 1/27/25 at 10:35 AM with SW #1 failed to identify documentation of notification to SW #1, of the expressions of SI, made by Resident #87 on 1/20/25 or thereafter. Observation on 1/27/25 at 11:25 AM identified Resident #87 was lying in bed with the bed in a low position, slightly turned on his/her right side, and a corded call bell was positioned beside him/her, in bed, on the right side. (continued on next page)		

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with SW #1 on 1/27/25 at 12:00 PM identified the expressions of SI made by Resident #87 should have been assessed by RN #6 and notifications should have been made to her (SW #1) and the provider, and if she received notification of the incident, she would have assessed Resident #87 on the morning of 1/21/25 for a self-harm plan, identification of SI risks, access to ligature risks, and review of interventions implemented on 1/20/25 after the expressions of SI. SW #1 identified she would have removed the call bell attached with a cord and provided a push button call bell. SW #1 could not identify a protocol that should have been initiated during the evening shift of 1/20/25 to include whether the call bell cord should have been removed. SW #1 indicated that the facility had not had a behavioral health consulting service since 2020 but identified that the facility had recently contracted a new behavioral health service which would begin in February of 2025. SW #1 identified that Resident #87 had not received behavioral health services since the expressions of SI on 1/20/25 and was not aware of a facility protocol for SI. SW #1 identified that the facility does not have interdisciplinary team (IDT) meetings for a coordinated approach to care and indicated staff communicate with her via a written Social Services log and written 24-hour report logs. SW #1 was made aware by the surveyor that Resident #87 still had access to a call bell with a cord. Review of the nursing 24-hour report logs dated 1/19/25 through 1/25/25 failed to identify documentation of Resident #87's expressions of SI on 1/20/25. Review of Resident #87's clinical record on 1/27/25 at 2:10 PM identified Resident #87 had not been seen by a provider since his/her expressions of SI on 1/20/25. Interview with MD #1 on 1/27/25 at 4:30 PM identified that the facility Social Worker should have followed up with Resident #87 after the expressions of SI were made. The facility policy titled, Suicide, Early Warnings, did not include a protocol for SI. Although requested, a policy related to medically related social services, social services assessments or social services visits was not provided. 51183		

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NAME OF PROVIDER OR SUPPLIER Westview Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 150 Ware Rd Dayville, CT 06241	
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 50167 Based on observations, staff interviews, and review of facility documentation, the facility failed to dispose of condiments and beverages with an open date greater than (3) three days in 2 of 3 nourishment room refrigerators and 2 of 3 medication room refrigerators. The findings include: Observation of the North/West medication room refrigerator on 1/24/25 at 11:43 AM identified: (1) 46- fluid ounce prune juice container 3/4 full with an open date of 1/20. (1) 60- fluid ounce cranberry juice container 50% full with no open date. Interview with RN #1 on 1/24/25 at 11:43 AM identified that the juices stored in the medication room refrigerator are used for the medication pass and that the kitchen stocks and cleans out the refrigerator. She indicated she would call the kitchen to confirm how long the juices could be stored in the refrigerator once opened. Interview with RN #1 on 1/24/25 at 11:45 AM identified that the kitchen has a 3-day rule for all open food and drinks and that both juices needed to be disposed of. Tour of the Nourishment room on the North/West Wing on 1/24/25 at 12:50 PM identified the refrigerator to contain the following: a. (2) 1/2 gallon 2% milk containers opened and 1/2 full with no open date. b. (1) 1/2 gallon whole milk container opened and 1/2 full with no open date. c. (1) 46- fluid ounce V8 vegetable juice container 3/4 full with an open date of 11/19. d. (1) 46- fluid ounce grape juice container 1/2 full with an open date of 1/20. e. (1) 46 -fluid ounce prune juice container 3/4 full with an open date of 1/20. Tour of the Nourishment room on the Annex Wing on 1/24/25 at 1:00 PM identified the refrigerator to contain the following: a. (1) 17.1-ounce grape jelly container 3/4 full with an open date of 1/9. b. (1) 19.5-ounce chocolate topping container with an open date of 1/9. c. (1) 24-ounce chocolate syrup container 3/4 empty with an open date of 1/12. d. (1) 46-fluid ounce V8 vegetable juice 1/2 full with an open date of 1/17. (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Dietary Director on 1/24/25 at 1:43 PM identified the kitchen staff and the unit/floor staff are responsible for checking open dates, and the floor staff are responsible for date labeling when they open an item. He indicated that only perishable items, such as items cooked or made, are discarded after (3) three days, but items such as beverages and condiments are discarded by expiration dates. Review of the Facility Policy titled Monitoring, Stocking, and Cleaning of Nourishment Rooms, directed that Dietary must date all perishable items. All perishables must be discarded within three days. Nursing will be responsible for dating all perishable food/beverages as they are opened so that they can be monitored by dietary.		

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51183 Based on facility documentation, facility policy and interviews, the facility failed to ensure the Administrator updated the facility assessment to identify the services the facility provided and failed to ensure the Administrator facilitated a method of communication between disciplines (coordinated interdisciplinary communication and approach to care) and failed to ensure the Administrator contracted the facility with behavioral health services and failed to ensure Administrator oversight of the facility staff education department to ensure compliance. The findings include: 1. Review of the Annual Facility assessment dated [DATE] through September 30, 2024, completed on 10/10/2024 (annual update due 10/1/2025) identified the Facility Assessment was not updated after the dissolution of the facility contracted behavioral health service in 2020. Review of facility staff education files identified a failure of compliance with the required staff training and competencies as stated in the Facility Assessment. 2. Interview with SW #1 on 1/27/25 at 12:00 PM identified the facility does not have interdisciplinary team (IDT) meetings for a coordinated approach to care and indicated staff communicate with her via a written Social Services log and written 24-hour report logs. Interview with the Administrator on 1/28/25 at 11:15 AM identified that the facility does not hold IDT meetings to communicate the status of the well-being of the residents, the needs of the facility or any current outbreaks or unusual occurrences in the facility. The Administrator identified that nursing meets weekly with rehabilitation services to discuss rehab progress, and further indicated he is not a part of that meeting. 3. Interview with Advanced Practice Registered Nurse (APRN) #1 on 1/25/25 at 11:20 AM identified there had not been contracted behavioral health services since 2020. APRN #1 indicated the Medical Director, who is a Geriatrician, and herself (APRN #1) managed the psychotropic medications, gradual dose reductions (GDR's) and Abnormal Involuntary Movement Screening (AIMS), but do not offer psychotherapy. APRN #1 further identified the Social Worker would determine the need for an outside referral for psychotherapy or services that were not available in the facility and the Social Worker would make the referral. APRN #1 indicated the need for a referral to behavioral health services was communicated through a communication book that the Social Worker checked daily and/or a census report document that is used for communication to each department. APRN #1 identified a new contract for behavioral health services would begin on 2/1/25. (continued on next page)		

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 1/29/25 at 11:28 AM with the Medical Director identified he was aware the facility did not have a contracted behavioral health service for medication management or therapeutic counseling services. The Medical Director indicated he was a fellow ship board certified geriatrician which qualified him to manage mental health medications. The Medical Director identified that social services staff and the APRN become involved with behavioral health management depending on the acuity. The Medical Director identified that SW #1 was responsible for making referrals to outpatient mental health services as indicated. The Medical Director was aware of SW #1's credentials (BSW, BA) and indicated the social worker was qualified to make decisions for day-to-day care. The Medical Director identified he considers himself the psychiatric practitioner for the facility based on his geriatrician certification and that he manages medications and orders monitoring for staff to follow through on. The Medical Director identified he does not provide ongoing therapeutic counseling services. Based on the deficiencies during the survey, immediate jeopardy and substandard care were identified in the area of Treatment and Services Mental/Psychological Concerns. The facility failed to utilize resources effectively to attain/maintain the resident's well-being. 4. Interview with the Director of Education Services (RN #4) on 2/3/2025 at 11:33 AM identified she assigned facility staff required in-service courses through Healthcare Academy and checked completion of courses monthly. RN #4 identified after checking course completion, she notified department heads of staff members within their department with incomplete courses. Interview with Director of Nursing Services (DNS) on 2/3/25 at 12:15 PM identified RN #4 notified her of nursing staff with outstanding Healthcare Academy courses. The DNS indicated that the goal for annual education was for each staff member to complete 75% of their assigned courses. For those staff members who had not completed any (0%) of their assigned courses, the DNS stated We are working on that. The DNS further identified she did not oversee RN #4 who was the Director of the Education Services department and that RN #4 worked autonomously. Review of Healthcare Academy reports dated 1/29/2025 through 1/30/2025 for 2023 and 2024 staff education course completions identified 64 out of 227 (28.1%) facility staff members completed less than 75% of their assigned mandatory annual courses for 2024. Review of Healthcare Academy reports dated 1/29/2025 through 1/30/2025 for 2023 and 2024 staff education course completions identified 53 out of 119 (44.5%) nursing staff members completed less than 75% of their assigned mandatory annual courses for 2024. Review of the facility Organizational Chart identified RN #4 reported directly to the Administrator. (continued on next page)		

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Administrator's job description identified the responsibility of the Administrator was to direct day-to-day operations of the facility in accordance with federal, state and local standards, guidelines and regulations that govern long-term care facilities to assure the highest degree of quality care can be provided to our residents at all times. Plan, develop, organize, implement, evaluate and direct the facility's programs and activities. Develop, maintain written policies and procedures that govern the operation of the facility. Review the facility's policies and procedures, at least annually, and make changes as necessary to ensure continued compliance with current regulations. Ensure the public information describing the services provided in the facility is accurate and descriptive. Ensure that all employees, residents, visitors, and the general public follow the established policies and procedures. Assume administrative authority, responsibility, and accountability of directing the activities and programs of the facility. Assist in recruitment and selection of competent department directors, supervisors, consultants and other auxiliary personnel. Assist in standardizing the methods in which work would be accomplished. Schedule and participate in department meetings. Assist department directors in the planning, conducting and scheduling of in-service training classes, on the job training and orientation programs to ensure that current material and programs are continuously provided. Meet with department directors on a regularly scheduled basis and conduct/participate in in-service classes and supervisory level training programs. Ensure that all personnel attend and participate in annual in-service training programs. Ensure that all residents receive care in a manner and in an environment that maintains or enhances their quality of life without abridging the safety and rights of other residents. Ensure that each resident receives the necessary nursing, medical and psychosocial services to attain and maintain the highest possible mental and physical functional status as defined by the comprehensive assessment and care plan. Assist the Director of Nursing Services in developing the Preadmission Screening and annual review of Mental Ill and Mentally Retarded Individuals (PASSARR) program as necessary. Cross reference: F550, F641, F644, F657, F686, F726, F741, F742, F745, F838, F 840, F841, F 940, F 941, F 942, F943, F944, F945, F946, F947, F 949		

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51183 Based on review of the Facility Assessment the facility failed to update the facility assessment after the dissolution of the facility contracted behavioral health service in 2020 and failed to ensure compliance of required staff training and competencies. The findings include: 1. Review of the Annual Facility assessment dated [DATE] through September 30, 2024, completed on 10/10/2024 (annual update due 10/1/2025) identified services and care offered based on Resident's needs included mental health and behavior services. Management of medical conditions and medication related issues causing psychiatric symptoms and behavior, identification and implementation of interventions to help support individuals with issues such as dealing with anxiety, care of someone with cognitive impairment, care of individuals with depression, trauma/PTSD, other psychiatric diagnosis, 1:1 visit with social services designee for the purpose of allowing verbalization of feelings and issues surrounding SNF placement, and coping with grief and loss. Additionally, Facility Resources needed to provide competent support and care for the resident population every day and during emergencies identified Behavioral and Mental Health Providers including Psychologist (Contract). Interview with Advanced Practice Registered Nurse (APRN) #1 on 1/25/25 at 11:20 AM identified there had not been contracted behavioral health services since 2020. APRN #1 indicated the Medical Director, who is a Geriatrician, and herself (APRN #1) managed the psychotropic medications, gradual dose reductions (GDR's) and Abnormal Involuntary Movement Screening (AIMS), but do not offer psychotherapy. APRN #1 further identified the Social Worker would determine the need for an outside referral for psychotherapy or services that were not available in the facility and the Social Worker would make the referral. APRN #1 indicated the need for a referral to behavioral health services was communicated through a communication book that the Social Worker checked daily and/or a census report document that is used for communication to each department. APRN #1 identified a new contract for behavioral health services would begin on 2/1/25. Interview on 1/29/25 at 11:28 AM with the Medical Director identified he was aware the facility did not have a contracted behavioral health service for medication management or therapeutic counseling services. The Medical Director indicated he was a fellow ship board certified geriatrician which qualified him to manage mental health medications. The Medical Director identified that social services staff and the APRN become involved with behavioral health management depending on the acuity. The Medical Director identified that SW #1 was responsible for making referrals to outpatient mental health services as indicated. The Medical Director was aware of SW #1's credentials (BSW, BA) and indicated the social worker was qualified to make decisions for day-to-day care. The Medical Director identified he considers himself the psychiatric practitioner for the facility based on his geriatrician certification and that he manages medications and orders monitoring for staff to follow through on. The Medical Director identified he does not provide ongoing therapeutic counseling services. (continued on next page)		

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Review of the Annual Facility assessment dated [DATE] through September 30, 2024, completed on 10/10/2024 (annual update due 10/1/2025) identified staff training/education and competencies are provided upon new hire orientation, annually, as well as adding new training as needed. This emphasis on education maintains and ensures the staff competencies needed to care for the needs of the current and changing resident populations served. Such education is provided through mixed media forms which include online coursework, written coursework, video education, off site seminars, webinars, on site live education sessions, individual and group in-service training as well as daily quick reminder memos, read and sign important blasts and team report huddles on each wing before each shift and as needed throughout. The following training/education/review of facility specific Policies and Procedures are required for all employees of the facility upon hire and annually: Resident Rights, Assault and Abuse prevention and Reporting, Confidentiality/HIPPA, Emergency Preparedness and Fire safety, Infection Prevention and Control, Tuberculosis, Covid-19, Exposure Control, Bloodborne Pathogens, Hazardous Chemicals, Personal Protective Equipment/Transmission Based Precautions/Enhanced Barrier Precautions, Corporate Compliance, Ethics, Quality Assurance and Performance Improvement, Effective Communication , including dementia- specific strategies and Trauma Informed Care. Review of staff education documents identified that for 2024 69 staff members failed to complete communication-related education, 61 staff members failed to complete resident rights education, 61 staff members failed to complete abuse education, 61 staff members failed to complete QAPI education, 61 staff members failed to complete infection control education, 61 staff members failed to complete compliance and ethics education, 58 active NA ' s failed to complete competencies, 33 active NA ' s failed to complete all or most of their 12 hour education, 49 active NA ' s failed to complete any (0%) of their assigned 2024 education via Healthcare Academy (the primary source of education material), and 58 active NA ' s failed to complete competency training. The Administrator failed to complete any of the mandatory facility in servicing for 2024 and does not have an account in the Healthcare Academy for online for coursework. Cross reference F550, F644, F657, F726, F741, F742, F745, F840, F940, F941, F942, F943, F944, F945, F946, F947, F949		

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F 0840 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Employ or obtain outside professional resources to provide services in the nursing home when the facility does not employ a qualified professional to furnish a required service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50179 Based on observations, review of the clinical record, facility documentation, facility policy and interviews for the use of outside resources, the facility failed to provide behavioral health services including psychotherapy as identified in the facility assessment. The findings included: Review of the Annual Facility assessment dated [DATE] - September 30, 2024, completed on 10/10/2024 identified services and care offered based on Resident's needs included mental health and behavior services. Management of medical conditions and medication related issues causing psychiatric symptoms and behavior, identification and implementation of interventions to help support individuals with issues such as dealing with anxiety, care of someone with cognitive impairment, care of individuals with depression, trauma/PTSD, other psychiatric diagnosis, 1:1 visit with social services designee for the purpose of allowing verbalization of feelings and issues surrounding SNF placement, and coping with grief and loss. Additionally, Facility Resources needed to provide competent support and care for the resident population every day and during emergencies identified Behavioral and Mental Health Providers including Psychologist (Contract). Interview with Advanced Practice Registered Nurse (APRN) #1 on 1/25/25 at 11:20 AM identified there had not been contracted behavioral health services since 2020. APRN #1 indicated the Medical Director, who is a Geriatrician, and herself (APRN #1) managed the psychotropic medications, gradual dose reductions (GDR's) and Abnormal Involuntary Movement Screening (AIMS), but do not offer psychotherapy. APRN #1 further identified the Social Worker would determine the need for an outside referral for psychotherapy or services that were not available in the facility and the Social Worker would make the referral. APRN #1 indicated the need for a referral to behavioral health services was communicated through a communication book that the Social Worker checked daily and/or a census report document that is used for communication to each department. APRN #1 identified a new contract for behavioral health services would begin on 2/1/25. Interview on 1/29/25 at 11:28 AM with the Medical Director identified he was aware the facility did not have a contracted behavioral health service for medication management or therapeutic counseling services. The Medical Director indicated he was a fellow ship board certified geriatrician which qualified him to manage mental health medications. The Medical Director identified that social services staff and the APRN become involved with behavioral health management depending on the acuity. The Medical Director identified that SW #1 was responsible for making referrals to outpatient mental health services as indicated. The Medical Director was aware of SW #1's credentials (BSW, BA) and indicated the social worker was qualified to make decisions for day-to-day care. The Medical Director identified he considers himself the psychiatric practitioner for the facility based on his geriatrician certification and that he manages medications and orders monitoring for staff to follow through on. The Medical Director identified he does not provide ongoing therapeutic counseling services. Cross reference F 644, F 741, F 742, F 838		

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F 0841 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Designate a physician to serve as medical director responsible for implementation of resident care policies and coordination of medical care in the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50890 Based on review of facility documentation, facility policy and interviews the facility failed to ensure the Medical Director's responsibility in the coordination of behavioral health services for residents in need of behavioral health treatment and the oversight of a current and complete policy for management and treatment of residents with suicidal ideations. The findings include: Review of the Annual Facility assessment dated [DATE] through September 30, 2024, completed on 10/10/2024 (annual update due 10/1/2025) identified services and care offered based on Resident's needs included mental health and behavior services. Management of medical conditions and medication related issues causing psychiatric symptoms and behavior, identification and implementation of interventions to help support individuals with issues such as dealing with anxiety, care of someone with cognitive impairment, care of individuals with depression, trauma/PTSD, other psychiatric diagnosis, 1:1 visit with social services designee for the purpose of allowing verbalization of feelings and issues surrounding SNF placement, and coping with grief and loss. Additionally, Facility Resources needed to provide competent support and care for the resident population every day and during emergencies identified Behavioral and Mental Health Providers including Psychologist (Contract). Interview with Advanced Practice Registered Nurse (APRN) #1 on 1/25/25 at 11:20 AM identified there had not been contracted behavioral health services since 2020. APRN #1 indicated the Medical Director, who is a Geriatrician, and herself (APRN #1) managed the psychotropic medications, gradual dose reductions (GDR's) and Abnormal Involuntary Movement Screening (AIMS), but do not offer psychotherapy. APRN #1 further identified the Social Worker would determine the need for an outside referral for psychotherapy or services that were not available in the facility and the Social Worker would make the referral. APRN #1 indicated the need for a referral to behavioral health services was communicated through a communication book that the Social Worker checked daily and/or a census report document that is used for communication to each department. APRN #1 identified a new contract for behavioral health services would begin on 2/1/25. Interview with MD #1 on 1/27/25 at 2:30 PM identified he was notified of Resident #87's expressions of SI on 1/20/25 at 8:38 PM and directed facility staff to monitor Resident #87. MD #1 identified he did not specify a frequency or duration for monitoring because the facility should have monitored Resident #87 according to facility protocol. MD #1 was not aware the facility policy for SI did not include a protocol for SI. (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0841 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 1/29/25 at 11:28 AM with the Medical Director identified he was aware the facility did not have a contracted behavioral health service for medication management or therapeutic counseling services. The Medical Director indicated he was a fellowship board certified geriatrician which qualified him to manage mental health medications. The Medical Director identified that social services staff and the APRN become involved with behavioral health management depending on the acuity. The Medical Director identified that SW #1 was responsible for making referrals to outpatient mental health services as indicated. The Medical Director was aware of SW #1's credentials (BSW, BA) and indicated the social worker was qualified to make decisions for day-to-day care. The Medical Director identified he considers himself the psychiatric practitioner for the facility based on his geriatrician certification and that he manages medications and orders monitoring for staff to follow through on. The Medical Director identified he does not provide ongoing therapeutic counseling services. The facility policy titled, Suicide, Early Warnings, did not include a protocol for SI but only included definitions/examples of SI. Based on the deficiencies during the survey, immediate jeopardy and substandard care were identified in the area of Treatment and Services Mental/Psychological Concerns. The facility failed to utilize resources effectively to attain/maintain the resident's well-being. Cross reference F644, F657, F741, F742, F745, F835, F838, F840, F949		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50179 Based on observations, review of the clinical record, facility documentation, facility policy and interviews for 3 of 4 residents (Resident #4, Resident #94, and Resident #350) reviewed for oxygen therapy, 12 of 12 residents (Resident #5, Resident #7, Resident #8, Resident #15, Resident #22, Resident #25, Resident #46, Resident #55, Resident #73, Resident #75, Resident #83, Resident #89) reviewed for dining, and 1 of 2 residents (Resident #16) reviewed for pressure injuries, the facility failed to label and date oxygen tubing per facility policy, and failed to perform hand hygiene after feeding a resident and then before feeding a different resident, and failed to secure staff drinks in a nonresident care area, and failed to initiate enhanced barrier precautions for a resident with a pressure injury and failed to provide clear and accurate signage for transmission based precautions. The findings include: 1a. Resident #4 was admitted to the facility in November of 2024 and had diagnoses that included asthma, heart failure, and bipolar disorder. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #4 was severely cognitively impaired (Brief Interview for Mental Status (BIMS) score of 6), required setup or clean-up assistance with eating, partial/moderate assistance with personal hygiene, and was dependent for bed mobility. The Resident Care Plan (RCP) dated 1/9/2025 identified Resident #4 was at risk for impaired fluid maintenance related to diagnoses of asthma, chronic obstructive pulmonary disease (COPD), obstructive sleep apnea and Resident #4 had acute respiratory failure. Interventions included to monitor oxygen saturations, administer 3 liters per minute (LPM) of oxygen via nasal cannula (NC) to maintain oxygen saturation (blood oxygen levels) greater than 90 percent (%), and utilize the continuous positive airway pressure (CPAP) machine at bedtime and clean per facility policy. The RCP failed to identify changing and labeling of the nasal cannula oxygen tubing per facility policy. A provider order dated 1/9/2025 directed to administer oxygen via nasal cannula at 3 liters per minute to maintain oxygen saturation (blood oxygen level) greater than 90%. A provider order dated 1/9/2025 directed to change oxygen tubing and ensure a bag was available for storage every Wednesday on 11 PM to 7 AM shift, and treatment may be delegated to nurse aide (NA). Observation on 1/21/2025 at 2:35 PM identified Resident #4's oxygen concentrator set at 3 liters per minute with nasal cannula oxygen tubing unlabeled lacking the date of tubing change, and an unlabeled plastic bag tied to the handle of the concentrator. Observation on 1/23/2025 at 2:00 PM identified Resident #4's oxygen concentrator set at 3 liters per minute with nasal cannula oxygen tubing unlabeled lacking the date of tubing change, and an unlabeled plastic bag tied to the handle of the concentrator. Observation on 1/24/2025 at 10:15 AM identified Resident #4's oxygen concentrator set at 3 liters per minute with nasal cannula oxygen tubing unlabeled lacking the date of tubing change, and an unlabeled plastic bag tied to the handle of the concentrator. (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Westview Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 150 Ware Rd Dayville, CT 06241	
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Interview with Registered Nurse (RN) #4 on 1/28/2025 at 2:10 PM identified that the oxygen tubing should have been labeled and dated with the date of change per facility policy. RN #4 could not identify why the oxygen order set in the electronic medical record did not direct nursing staff to label and date the tubing but only directed to change tubing and ensure a bag was available for storage. Subsequent to surveyor inquiry, a provider order dated 1/28/2025 directed to change oxygen tubing, label and date tubing, ensure bag for storage available every Wednesday on 11PM to 7 AM shift, and treatment may be delegated to nurse aide (NA). 1b. Resident #94 was admitted to the facility in October of 2024 and had diagnoses that included chronic obstructive pulmonary disease (COPD), chronic respiratory failure, and anxiety. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #94 was severely cognitively impaired (Brief Interview for Mental Status (BIMS) score of 7), had shortness of breath (SOB) when lying flat, received oxygen therapy, required setup or clean-up assistance with personal hygiene and was independent with bed mobility and transfers. The Resident Care Plan (RCP) dated 1/10/2025 identified Resident #94 was at risk for alteration in fluid maintenance related to diagnoses of COPD and chronic respiratory failure. Interventions included keep head of bed elevated to facilitate breathing, monitor oxygen saturation (blood oxygen levels), administer 2 liters per minute (LPM) of oxygen via nasal cannula (NC) may titrate to 1 LPM continuous, and change oxygen tubing per facility policy/protocol. A provider order dated 1/16/2025 directed to administer oxygen continuously via nasal cannula at 2 liters per minute and may titrate to 1 liter per minute related to respiratory failure. A provider order dated 1/16/2025 directed to change oxygen tubing, ensure bag available for storage every Wednesday on 11 PM to 7 AM shift, and treatment may be delegated to nurse aide (NA). Observation on 1/22/25 at 9:30 AM identified Resident #94's oxygen concentrator set at 1.5 liters per minute with nasal cannula oxygen tubing unlabeled, lacking the date of tubing change, and an unlabeled plastic bag tied to the handle of the concentrator. Observation on 1/27/25 at 10:35 AM identified Resident #94's oxygen concentrator set at 1.5 liters per minute with nasal cannula oxygen tubing unlabeled, lacking the date of tubing change, and an unlabeled plastic bag tied to the handle of the concentrator. Interview with Registered Nurse (RN) #4 on 1/28/2025 at 2:10 PM identified that the oxygen tubing should have been labeled and dated with the date of change per facility policy. RN #4 could not identify why the oxygen order set in the electronic medical record did not direct nursing staff to label and date the tubing but only directed to change tubing and ensure a bag was available for storage. Subsequent to surveyor inquiry, a provider order dated 1/28/2025 directed to change oxygen tubing, label and date tubing, ensure bag for storage available every Wednesday on 11PM to 7 AM shift, and treatment may be delegated to nurse aide (NA). 1c. Resident #350 was admitted to the facility in January of 2025 and had diagnoses that included pulmonary embolism, atrial fibrillation, and asthma. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	The Comprehensive Admission Evaluation dated 1/19/2025 identified Resident #350 was alert, oriented to person, place, situation and had active range of motion to all extremities. The Resident Care Plan (RCP) dated 1/20/2025 identified Resident #350 was at risk for alteration in fluid maintenance related to pulmonary embolism and asthma. Interventions included administer 2 liters per minute (LPM) of oxygen via nasal cannula (NC) related to hypoxia to maintain oxygen saturation (blood oxygen levels) greater than 90 degrees (%), may titrate, and to change oxygen tubing per facility policy. A provider order signed 1/21/2025 directed to administer oxygen via nasal cannula at 2 liters per minute and may titrate to maintain oxygen saturation (blood oxygen level) greater than 90%. Observation on 1/21/25 at 2:30 PM identified Resident #350's oxygen concentrator set at 1.5 liters per minute with nasal cannula oxygen tubing unlabeled, lacking the date of tubing change, and an unlabeled plastic bag tied to the handle of the concentrator. Observation on 1/23/25 at 2:00 PM identified Resident #350's oxygen concentrator set at 2 liters per minute with nasal cannula oxygen tubing unlabeled, lacking the date of tubing change, and an unlabeled plastic bag tied to the handle of the concentrator. Observation on 1/24/25 at 10:15 AM identified Resident #350's oxygen concentrator off with nasal cannula oxygen tubing unlabeled, lacking the date of tubing change, and inside an unlabeled plastic bag tied to the handle of the concentrator. Interview with Registered Nurse (RN) #4 on 1/28/2025 at 2:10 PM identified that the oxygen tubing should have been labeled and dated with the date of change per facility policy. RN #4 could not identify why the oxygen order set in the electronic medical record did not direct nursing staff to label and date the tubing but only directed to change tubing and ensure a bag was available for storage. Review of the Policy, Use Of Oxygen, identified oxygen use required a provider order and to date and change nasal cannulas every week. 2. Observations on 1/23/25 at 6:02 PM, identified 12 residents (Resident #5, Resident #7, Resident #8, Resident #15, Resident #22, Resident #25, Resident #46, Resident #55, Resident #73, Resident #75, Resident #83, Resident #89) in the recreation room being assisted to eat by Nurse aides (NA) #1 and NA #2. NA #1 and NA #2 were both standing above the residents they were assisting and moving from 1 resident to another to assist with taking bites of food without the benefit of performing hand hygiene between residents. Interview with NA #1 on 1/23/25 at 6:05 PM identified that there are normally 12 residents in the recreation room for dinner and they need to be assisted to eat. NA #1 identified some of the residents required 1:1 feeding assistance and some of the residents required cues and supervision. NA #1 identified there are only 2 NA's in the recreation room for dinner to assist the 12 residents. NA #1 identified that she usually performs hand hygiene between residents but did not perform hand hygiene on this evening and indicated that she usually feeds multiple residents at the same time. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Interview with NA #2 on 1/23/25 at 6:07 PM identified that there are normally 12 residents in the recreation room for dinner that need to be assisted to eat. NA #2 identified that some of the residents require 1:1 feeding assistance and some require cues and supervision. NA #2 identified that there are only 2 NA's in the recreation room for dinner to assist the 12 residents. NA #2 identified that she did not perform hand hygiene between feeding residents, but indicated she would do so moving forward. Interview with Licensed Practical Nurse (LPN) #1 on 1/23/25 at 6:11 PM identified that there are usually 2 NA's to assist 12 residents with eating in the recreation room at dinnertime. LPN #1 identified that the NA 's feed multiple residents at the same time. LPN #1 identified that the NA 's are to perform hand hygiene between residents. Interview with the Assistant Director of Nursing (ADNS) on 1/23/24 at 6:21 PM identified that there are 2 NA's assigned to assist 12 residents in the recreation room for dinner. The ADNS identified that the NA 's should perform hand hygiene between residents. Review of NA #1 's employee education file identified that hand hygiene training/education was completed on 12/3/24. Review of the file identified no skills competencies were completed for 2024. Review of NA #2 's employee education file identified Feeding a Resident education was completed on 3/8/22, a skills checklist was completed for 2022, and handwashing education was completed on 3/28/22. The file failed to identify hand hygiene education for 2024. Review of the Hand Hygiene Technique policy directed, in part, hand hygiene is done before giving care to the resident and after giving care to the resident. 3. Observation on 1/24/25 at 12:33 PM identified 3 reusable beverage containers (1 closed, 1 open, and 1 containing a straw) belonging to nursing staff on the top of a documentation cart located at the corner of the hallway on the Annex unit. The beverage containers were in a resident care area without staff present. Interview with the Infection Preventionist (IP) on 1/24/25 at 12:34 PM identified that staff member beverages, left unattended and accessible in resident care areas, would pose a risk for residents prescribed thickened liquids. Observation on 1/24/25 at 12:42 PM identified 2 reusable beverage containers (1 open and 1 closed), and 2 open beverage cans (1 covered with a plastic cup and 1 uncovered) belonging to nursing staff on the top of a rolling cabinet at the entryway of the nursing station on the Northwest unit. The cabinet was approximately 3 feet tall and was located adjacent to the unit hallway in full view and within reach of residents passing by the nurse's station. Observations on 1/27/25 at 9:00 AM and 9:50 AM identified 3 reusable beverage containers (with straws) belonging to nursing staff on the top of a documentation cart located at the corner of the hallway on the Annex unit. Residents were observed ambulating and self-propelling their wheelchairs up and down the hallway past the documentation cart. The soiled utility room was located next to the documentation cart with soiled items observed transported in and out of the soiled utility rooms at various times throughout the day. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Review of policy and procedure on employee food and drinks directed, in part, employee food and drink may not be stored or consumed in patient areas where there is a reasonable likelihood of occupational exposure to hazards or infectious material. Additionally, food and drink may not be stored or consumed near resident food storage, and /or preparation areas, medication storage and /or preparation areas or where clean nursing supplies are stored. Employees may store and consume food and drinks in designated break areas and private office areas away from the clinical floor. Areas for employee food and drink consumption on the clinical floor may be approved based on a risk assessment. Occupational Safety and Health Administration (OSHA) 29 CFR 1910.1030(d)(2) (ix) Paragraph (d)(2)(ix) of this regulation prohibits the consumption of food and drink in areas in which work involving exposure or potential exposure to blood or other potentially infectious material exists, or where the potential for contamination of work surfaces exists. The prohibition against eating and drinking in such a work area is consistent with other OSHA standards and is good industrial hygiene practice. 4. Resident # 16 was admitted to the facility in August of 2024 with diagnosis that included adult failure to thrive, repeated falls, diabetes mellitus without complications and generalized muscle weakness. The Nursing Admission assessment dated [DATE] identified Resident #16 was admitted to the facility with multiple skin tears from a recent fall and had a pressure injury to his/her upper back. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #16 was cognitively intact (Brief Interview for Mental Status (BIMS score of 15) and required set up assistance for personal hygiene, and supervision or touching assistance for bed mobility and transfers. The Resident Care Plan dated 11/14/24 identified that Resident #16 had a skin tear on the wrist that required prior treatment in the form of debridement. Interventions included repositioning every 2 hours and as needed, to encourage optimal nutrition and hydration, to monitor skin integrity and notify the provider of any concerns or need of treatment and use of a pressure redistributing mattress to bed for skin integrity management. An Advanced Practice Registered Nurse (APRN)'s note dated 11/26/2024 at 10:55 AM by APRN #1 identified Resident #16 reported right toe pain. The note further identified Resident #16 with a wound greater than 0.5 centimeters (cm) with a white moist open area surrounded by ring of erythema which was tender to touch. The note identified that Resident # 16 had not been wearing shoes and therefore it was unclear as to the etiology/cause of the wound on the toe. A nurses note dated 1/1/25 by LPN #3 identified that Resident #16's right second toe wound with slough in the wound bed. LPN #3 updated MD #2 who gave orders to obtain wound culture of the right second toe, an x-ray, apply Santyl daily and start antibiotic treatment, Augmentin 875mg twice a day for 10 days. Review on 1/22/24 at 8:34 AM of the Transmission Based Precautions/Multiple Drug-Resistant Organisms/Enhanced Barrier Precautions (TBP/MDRO/EBP) list identified Resident #16 was not included on the list. On 1/24/25 at 12:27 PM an updated TBP/MDRO/EBP list was provided by the IP due to new gastrointestinal illness symptoms identified within the facility but failed to include Resident #16 for EBP. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Interview on 1/30/25 at 3:16 PM with the IP identified she reviewed Resident #16's clinical record and did not identify a wound classification therefore did not initiate EBP. The IP identified she would change her process of wound identification and classification from a clinical record review to visualizing the wounds to identify the need for EBP. The IP indicated Resident #16 would be placed on EBP. Center for Disease Control (CDC) guidelines identified April 1, 2024: Implementation of Enhanced Barrier Precautions (EBP) in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms. Multidrug-resistant Organism (MDRO): bacteria or fungi resistant to multiple antimicrobials and colonization identifies a germ is found on or in the body but is not causing infection. Many nursing home residents are unknowingly colonized with an MDRO, especially residents with risk factors like indwelling medical devices or wounds. Residents who have an MDRO can develop serious infections, remain colonized for long time periods, and spread MDROs to others. EBP are indicated for nursing home residents with any of the following: Infection or colonization with an MDRO when Contact Precautions do not otherwise apply, wounds and/or indwelling medical devices. EBP is not limited to outbreaks or specific MDROs. 5. Observation on 2/3/25 at 11 AM of signage outside of Resident #87 's room identified 3 separate signs: Contact Precautions sign directing: hand hygiene, dedicated patient equipment, gloves, and a gown; Droplet Precautions sign directing: hand hygiene, eye protection, procedure mask, dedicated patient equipment, gloves, and a gown; Airborne Respirator Precautions sign directing: hand hygiene, dedicated patient equipment, CAPR/PAPR or fitted N95 mask, keep door closed, and notify maintenance to add a fan to room. Interview with the IP on 2/3/25 at 12:49 PM identified that all 3 precautions signs are posted outside of resident rooms with potential or confirmed cases of Covid-19 because staff need to utilize a portion of each precaution to achieve Transmission Based Precautions for COVID-19 infections. The IP indicated that Airborne Respirator Precautions are modified as the facility is not equipped to provide rooms with negative pressure (ventilation requiring 6 air exchanges per hour and an exhaust directed outside through a HEPA filter). The IP indicated that having 3 different precautions signs with different instructions may be confusing to staff and visitors. The IP indicated facility staff were educated on the signage. Review of the Transmission Based Precautions education form identified no staff signatures to indicate which staff members, if any, were educated. Review of Transmission Based Precautions Policy dated (updated 8/2022) directed, in part, there are 3 categories of Transmission Based Precautions: Contact Precautions, Droplet Precautions and Airborne precautions. Transmission Based Precautions are used when the route of transmission is not completely interrupted using standard precautions alone. For some diseases that have multiple routes of transmission, more than 1 Transmission Based Precautions category may be used. When either singly or in combination, they are always used in addition to Standard Precautions. If a communicable disease or infection is suspected or confirmed in a resident, the resident shall be placed on the appropriate Transmission-Based Precaution immediately. The 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings: Appendix A will be used when determined appropriate transmission- based precautions. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	CDC guidelines identified Respiratory Infections Cough/fever/pulmonary infiltrate in any lung location in an HIV-infected patient or a patient at high risk for HIV infection, M. tuberculosis, Respiratory viruses, S. pneumoniae, S. aureus (MSSA or MRSA) use Airborne Precautions plus Contact Precautions, use eye/face protection if aerosol-generating procedure performed or contact with respiratory secretions anticipated. If tuberculosis is unlikely and there are no AIIRs and/or respirators available, use Droplet Precautions instead of Airborne Precautions. Respiratory Infections Cough/fever/pulmonary infiltrate in any lung location in a patient with a history of recent travel (10-21 days) to countries with active outbreaks of SARS, avian influenza, M. tuberculosis, severe acute respiratory syndrome virus (SARS- CoV), avian influenza use Airborne plus Contact Precautions plus eye protection. If SARS and tuberculosis are unlikely, use Droplet Precautions instead of Airborne Precautions. 51183		

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop, implement, and/or maintain an effective training program for all new and existing staff members. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51183 Based on facility documentation, facility policy and interviews the facility failed to maintain an effective training program for all new and existing staff based on the facility assessment. Review of the Annual Facility assessment dated [DATE] through 9/30/2024 identified 19 areas of mandatory education for all staff upon hire and annually to include: resident rights, abuse prevention and reporting, confidentiality/Health Insurance Portability and Accountability Act (HIPAA), emergency preparedness, fire safety, infection prevention and control, tuberculosis, COVID-19, exposure control, bloodborne pathogens (BBP), hazardous chemicals, personal protective equipment (PPE), transmission based precautions (TBP), enhanced barrier precautions (EBP), corporate compliance/ethics, quality assurance and performance improvement (QAPI), effective communication, dementia-specific strategies (communication), and trauma informed care (TIC). The facility assessment failed to include annual mandatory education for workplace violence which is in the facility policy. Review of Healthcare Academy (online education platform) reports dated 1/29/2025 through 1/30/2025 for 2023 and 2024 staff education course completions identified 64 out of 227 (28.1%) facility staff members completed less than 75% of their assigned mandatory annual courses for 2024. Review of Healthcare Academy reports dated 1/29/2025 through 1/30/2025 for 2023 and 2024 staff education course completions identified 53 out of 119 (44.5%) nursing staff members completed less than 75% of their assigned mandatory annual courses for 2024 which included the communication training course. Review of the monthly schedule of course assignments for facility staff by department identified 19 courses assigned to all staff over 12 months. January-Communication Basics and Annual Federal Summary; February-Resident Rights and Workplace Violence; March-Infection Control for All Staff and Corporate Compliance; April-Abuse, Neglect and Exploitation and Trauma Informed Care; May-HIPAA; June-Fire Safety and Emergency Preparedness; July-Challenging Behaviors: Dementia; August-Bloodborne Pathogens and PPE; September-Hand Hygiene and Rules and Regulations of Nursing Homes; October-QAPI; November-Customer Service; and December-Sexual Harassment. Review of RN #4's monthly schedule of course assignments for facility staff by department identified 7 additional courses assigned to licensed nurses. March-Antibiotic Stewardship; April-Intravenous (IV) Therapy and Central Venous Access Device (CVAD) Therapy; July-Nursing Documentation for Long Term Care; September-Advanced Pain Management for Long Term Care; October-Recognizing Change of Condition; and December-Medication Administration. Review of the monthly schedule of course assignments for facility staff by department identified 7 additional courses assigned to nurse aides (NA). March-Skin Care Basics for nurse aides and Body Positioning Basics; April-Abuse Prevention in People with Dementia; May-NA Care of IV Patient; September-Pain Recognition for Non-nursing Staff; October-Recognizing and Reporting Change of Condition; and December-Death, Dying and Postmortem Care. (continued on next page)		

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Certified Nursing Assistant Orientation Packet identified new hire Nurse Aides (NA) were given an 80 hour orientation training schedule to start with additional hours as needed, and all assigned inservice education in Healthcare Academy must be completed by the end of the orientation period. Review of Healthcare Academy reports dated 1/30/2025 for 2024 staff education course completions identified 6 out of 21 actively employed NAs hired in 2024 lacked documentation of completed courses in Healthcare Academy for 2024. Review of Healthcare Academy reports dated 1/29/2025 through 1/30/2025 for 2023 and 2024 staff education, RN #4's monthly schedule of course assignments for facility staff by department, and nursing department orientation packets failed to identify education related to cultural competence, intellectual disability, person centered care, care planning, interdisciplinary collaboration, quality of life and care. Review of the Annual Facility assessment dated [DATE] through 9/30/2024 identified in addressing training/competencies the facility initiated Task Forces in 2024 for the following areas: Dietary Task Force, Support Services Task Force, Rehabilitation Task Force, and Nursing Task Force. Review of Healthcare Academy reports dated 1/29/2025 through 1/30/2025 for 2023 and 2024 staff education, RN #4's monthly schedule of course assignments for facility staff by department, read and sign education for 2024, and Staff Education Report for Year-to-Date 2024 by RN #4 failed to identify education related to Task Forces initiated in 2024 for training and competencies and failed to identify education related to QAPI initiatives and performance improvement projects related to mobility assessment program, feeding assistant program and increase of the vaccination rate in employees. Review of the Staff Development Corporate Compliance policy identified annual mandatory in-services each staff member was responsible for completing by the end of the month that their annual evaluation was due and an individual training record for each staff member was to be maintained by the Director of Staff Development. The Policy does not include department specific education topic requirements based on the resident needs identified within the facility assessment.		

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F 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop, implement, and/or maintain an effective training program that includes effective communications for direct care staff members. 51183 Based on facility documentation, facility policy and interviews the facility failed to ensure staff compliance with communication training. The findings include: Review of Healthcare Academy (online education platform) reports dated 1/29/2025 through 1/30/2025 for 2023 and 2024 staff education course completions identified 73 out of 227 (32.1%) facility staff members did not complete communication training in 2024. Review of Healthcare Academy reports dated 1/29/2025 through 1/30/2025 for 2023 and 2024 staff education course completions identified 32 out of 75 (42.6%) Nurse Aides did not complete communication training in 2024. Review of Healthcare Academy reports dated 1/29/2025 through 1/30/2025 for 2023 and 2024 staff education course completions identified 15 out of 44 (34%) Licensed Nurses did not complete communication training in 2024. Interview with the Director of Education Services (RN #4) on 2/3/2025 at 11:33 AM identified she assigned facility staff required in-service courses through Healthcare Academy and checked completion of courses monthly. RN #4 identified after checking course completion, she notified department heads of staff members within their department with incomplete courses. Interview with Director of Nursing Services (DNS) on 2/3/25 at 12:15 PM identified RN #4 notified her of nursing staff with outstanding Healthcare Academy courses. The DNS indicated that the goal for annual education was for each staff member to complete 75% of their assigned courses. For those staff members who had not completed any (0%) of their assigned courses, the DNS stated We are working on that. The DNS further identified she did not oversee RN #4 who was the Director of the Education Services department and that RN #4 worked autonomously. Review of the facility Organizational Chart identified RN #4 reported directly to the Administrator. Review of Healthcare Academy reports dated 1/29/2025 through 1/30/2025 for 2023 and 2024 staff education course completions identified 64 out of 227 (28.1%) facility staff members completed less than 75% of their assigned mandatory annual courses for 2024 which included the communication training course. Review of Healthcare Academy reports dated 1/29/2025 through 1/30/2025 for 2023 and 2024 staff education course completions identified 53 out of 119 nursing staff members completed less than 75% of their assigned mandatory annual courses for 2024 which included the communication training course. (continued on next page)		

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Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075078	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/03/2025
NAME OF PROVIDER OR SUPPLIER Westview Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 150 Ware Rd Dayville, CT 06241	
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 0941 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Staff Development Corporate Compliance policy identified, in part, a list of annual mandatory in-services, to include effective communication, that each staff member was responsible for completing, by the end of the month prior to their annual evaluation. The policy identified that an individual training record for each staff member was to be maintained by the Director of Staff Development.		

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F 0942 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that staff members are educated on resident rights and facility responsibilities to properly care for its residents. 51183 Based on facility documentation, facility policy and interviews the facility failed to ensure staff compliance with resident rights training. Review of Healthcare Academy (online education platform) reports dated 1/29/2025 through 1/30/2025 for 2023 and 2024 staff education course completions identified 44 out of 227 (19.3%) facility staff members did not complete resident rights training in 2024. Review of Healthcare Academy reports dated 1/29/2025 through 1/30/2025 for 2023 and 2024 staff education course completions identified 28 out of 75 (37.3%) Nurse Aides did not complete resident rights training in 2024. Review of Healthcare Academy reports dated 1/29/2025 through 1/30/2025 for 2023 and 2024 staff education course completions identified 9 out of 44 (20.4%) Licensed Nurses did not complete resident rights training in 2024. Interview with the Director of Education Services (RN #4) on 2/3/2025 at 11:33 AM identified she assigned facility staff required in-service courses through Healthcare Academy and checked completion of courses monthly. RN #4 identified after checking course completion, she notified department heads of staff members within their department with incomplete courses. Interview with the Director of Nursing Services (DNS) on 2/3/25 at 12:15 PM identified RN #4 notified her of nursing staff with outstanding Healthcare Academy courses. The DNS indicated that the goal for annual education was for each staff member to complete 75% of their assigned courses. For those staff members who had not completed any (0%) of their assigned courses, the DNS stated We are working on that. The DNS further identified she did not oversee RN #4 who was the Director of the Education Services department and that RN #4 worked autonomously. Review of the facility Organizational Chart identified RN #4 reported directly to the Administrator. Review of Healthcare Academy reports dated 1/29/2025 through 1/30/2025 for 2023 and 2024 staff education course completions identified 64 out of 227 (28.1%) facility staff members completed less than 75% of their assigned mandatory annual courses for 2024 which included the resident rights training course. Review of Healthcare Academy reports dated 1/29/2025 through 1/30/2025 for 2023 and 2024 staff education course completions identified 53 out of 119 (44.5%) nursing staff members completed less than 75% of their assigned mandatory annual courses for 2024 which included the resident rights training course. (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 0942 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Staff Development Corporate Compliance policy identified, in part, a list of annual mandatory in-services, to include resident rights, that each staff member was responsible for completing, by the end of the month prior to their annual evaluation. The policy identified that an individual training record for each staff member was to be maintained by the Director of Staff Development.		

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation. 51183 Based on facility documentation, facility policy and interviews the facility failed to ensure staff compliance with abuse, neglect, and exploitation training and the facility failed to ensure staff compliance with dementia management training. 1. Review of Healthcare Academy (online education platform) reports dated 1/29/2025 through 1/30/2025 for 2023 and 2024 staff education course completions identified 35 out of 227 (15.4%) facility staff members did not complete abuse, neglect, and exploitation training in 2024. Review of Healthcare Academy reports dated 1/29/2025 through 1/30/2025 for 2023 and 2024 staff education course completions identified 22 out of 75 (29.3%) Nurse Aides did not complete abuse, neglect, and exploitation training in 2024. Review of Healthcare Academy reports dated 1/29/2025 through 1/30/2025 for 2023 and 2024 staff education course completions identified 7 out of 44 (15.9%) Licensed Nurses did not complete abuse, neglect, and exploitation training in 2024. 2. Review of Healthcare Academy (online education platform) reports dated 1/29/2025 through 1/30/2025 for 2023 and 2024 staff education course completions identified 34 out of 227 (14.9%) facility staff members did not complete dementia management training in 2024. Review of Healthcare Academy reports dated 1/29/2025 through 1/30/2025 for 2023 and 2024 staff education course completions identified 23 out of 75 (30.6%) Nurse Aides did not complete dementia management training in 2024. Review of Healthcare Academy reports dated 1/29/2025 through 1/30/2025 for 2023 and 2024 staff education course completions identified 5 out of 44 (11.3%) Licensed Nurses did not complete dementia management training in 2024. Interview with the Director of Education Services (RN #4) on 2/3/2025 at 11:33 AM identified she assigned facility staff required in-service courses through Healthcare Academy and checked completion of courses monthly. RN #4 identified after checking course completion, she notified department heads of staff members within their department with incomplete courses. Interview with the Director of Nursing Services (DNS) on 2/3/25 at 12:15 PM identified RN #4 notified her of nursing staff with outstanding Healthcare Academy courses. The DNS indicated that the goal for annual education was for each staff member to complete 75% of their assigned courses. For those staff members who had not completed any (0%) of their assigned courses, the DNS stated We are working on that. The DNS further identified she did not oversee RN #4 who was the Director of the Education Services department and that RN #4 worked autonomously. Review of the facility Organizational Chart identified RN #4 reported directly to the Administrator. (continued on next page)		

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F 0943 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Healthcare Academy reports dated 1/29/2025 through 1/30/2025 for 2023 and 2024 staff education course completions identified 64 out of 227 (28.1%) facility staff members completed less than 75% of their assigned mandatory annual courses for 2024 which included the abuse, neglect, and exploitation training and dementia management training courses. Review of Healthcare Academy reports dated 1/29/2025 through 1/30/2025 for 2023 and 2024 staff education course completions identified 53 out of 119 (44.5%) nursing staff members completed less than 75% of their assigned mandatory annual courses for 2024 which included the abuse, neglect, and exploitation training and dementia management training courses. Review of the Staff Development Corporate Compliance policy identified, in part, a list of annual mandatory in-services, to include abuse prevention and reporting and dementia strategies, that each staff member was responsible for completing, by the end of the month prior to their annual evaluation. The policy identified that an individual training record for each staff member was to be maintained by the Director of Staff Development.		

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct mandatory training, for all staff, on the facility's Quality Assurance and Performance Improvement Program. 51183 Based on facility documentation, facility policy and interviews the facility failed to ensure staff compliance with Quality Assurance and Performance Improvement (QAPI) (framework used to improve resident safety and the quality of their services) training. Review of Healthcare Academy (online education platform) reports dated 1/29/2025 through 1/30/2025 for 2023 and 2024 staff education course completions identified 60 out of 227 (26.4%) facility staff members did not complete QAPI training in 2024. Review of Healthcare Academy reports dated 1/29/2025 through 1/30/2025 for 2023 and 2024 staff education course completions identified 33 out of 75 (44%) Nurse Aides did not complete QAPI training in 2024. Review of Healthcare Academy reports dated 1/29/2025 through 1/30/2025 for 2023 and 2024 staff education course completions identified 13 out of 44 (29.5%) Licensed Nurses did not complete QAPI training in 2024. Interview with the Director of Education Services (RN #4) on 2/3/2025 at 11:33 AM identified she assigned facility staff required in-service courses through Healthcare Academy and checked completion of courses monthly. RN #4 identified after checking course completion, she notified department heads of staff members within their department with incomplete courses. Interview with the Director of Nursing Services (DNS) on 2/3/25 at 12:15 PM identified RN #4 notified her of nursing staff with outstanding Healthcare Academy courses. The DNS indicated that the goal for annual education was for each staff member to complete 75% of their assigned courses. For those staff members who had not completed any (0%) of their assigned courses, the DNS stated We are working on that. The DNS further identified she did not oversee RN #4 who was the Director of the Education Services department and that RN #4 worked autonomously. Review of the facility Organizational Chart identified RN #4 reported directly to the Administrator. Review of Healthcare Academy reports dated 1/29/2025 through 1/30/2025 for 2023 and 2024 staff education course completions identified 64 out of 227 (28.1%) facility staff members completed less than 75% of their assigned mandatory annual courses for 2024 which included the QAPI training course. Review of Healthcare Academy reports dated 1/29/2025 through 1/30/2025 for 2023 and 2024 staff education course completions identified 53 out of 119 (44.5%) nursing staff members completed less than 75% of their assigned mandatory annual courses for 2024 which included the QAPI training course. Review of the Staff Development Corporate Compliance policy identified, in part, a list of annual mandatory in-services, to include QAPI training, that each staff member was responsible for completing, by the end of the month prior to their annual evaluation. The policy identified that an individual training record for each staff member was to be maintained by the Director of Staff Development.		

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program. 51183 Based on facility documentation, facility policy and interviews the facility failed to ensure staff compliance with their infection control program (infection prevention and control, tuberculosis, COVID-19, bloodborne pathogens, personal protective equipment, transmission based precautions, and enhanced barrier precautions) training. A. Review of Healthcare Academy (online education platform) reports dated 1/29/2025 through 1/30/2025 for 2023 and 2024 staff education course completions identified 53 out of 227 (23.3%) facility staff members did not complete infection prevention and control training in 2024. Review of Healthcare Academy reports dated 1/29/2025 through 1/30/2025 for 2023 and 2024 staff education course completions identified 30 out of 75 (40%) Nurse Aides did not complete infection prevention and control training in 2024. Review of Healthcare Academy reports dated 1/29/2025 through 1/30/2025 for 2023 and 2024 staff education course completions identified 11 out of 44 (25.0%) Licensed Nurses did not complete infection prevention and control training in 2024. B. Documentation of staff completion of tuberculosis education for 2024 was not provided. Review of Healthcare Academy reports dated 1/29/2025 through 1/30/2025 for 2023 and 2024 staff education course completions failed to identify education on tuberculosis was assigned to facility staff in 2023 or 2024. C. Documentation of staff completion of COVID-19 education for 2024 was not provided. Review of Healthcare Academy reports dated 1/29/2025 through 1/30/2025 for 2023 and 2024 staff education course completions failed to identify education on COVID-19 was assigned to facility staff in 2023 or 2024. D. Review of Healthcare Academy reports dated 1/29/2025 through 1/30/2025 for 2023 and 2024 staff education course completions identified 51 out of 227 (22.4%) facility staff members did not complete bloodborne pathogens (BBP) training in 2024. Review of Healthcare Academy reports dated 1/29/2025 through 1/30/2025 for 2023 and 2024 staff education course completions identified 30 out of 75 (40%) Nurse Aides did not complete BBP training in 2024. Review of Healthcare Academy reports dated 1/29/2025 through 1/30/2025 for 2023 and 2024 staff education course completions identified 12 out of 44 (27.2%) Licensed Nurses did not complete BBP training in 2024. (continued on next page)		

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	E. Review of Healthcare Academy reports dated 1/29/2025 through 1/30/2025 for 2023 and 2024 staff education course completions identified 59 out of 227 (25.9%) facility staff members did not complete personal protective equipment (PPE) training in 2024. Review of Healthcare Academy reports dated 1/29/2025 through 1/30/2025 for 2023 and 2024 staff education course completions identified 31 out of 75 (41.3%) Nurse Aides did not complete PPE training in 2024. Review of Healthcare Academy reports dated 1/29/2025 through 1/30/2025 for 2023 and 2024 staff education course completions identified 13 out of 44 (29.5%) Licensed Nurses did not complete PPE training in 2024. F. Documentation of staff completion of transmission-based precautions education for 2024 was not provided. Review of Healthcare Academy reports dated 1/29/2025 through 1/30/2025 for 2023 and 2024 staff education course completions failed to identify education on transmission-based precautions was assigned to facility staff in 2023 or 2024. G. Review of Healthcare Academy reports dated 1/29/2025 through 1/30/2025 for 2023 and 2024 staff education course completions identified 66 out of 227 (29.0%) facility staff members did not complete enhanced barrier precautions training in 2024. Review of Healthcare Academy reports dated 1/29/2025 through 1/30/2025 for 2023 and 2024 staff education course completions identified 35 out of 75 (46.6%) Nurse Aides did not complete enhanced barrier precautions training in 2024. Review of Healthcare Academy reports dated 1/29/2025 through 1/30/2025 for 2023 and 2024 staff education course completions identified 15 out of 44 (34.0%) Licensed Nurses did not complete enhanced barrier precautions training in 2024. Interview with the Director of Education Services (RN #4) on 2/3/2025 at 11:33 AM identified she assigned facility staff required in-service courses through Healthcare Academy and checked completion of courses monthly. RN #4 identified after checking course completion, she notified department heads of staff members within their department with incomplete courses. Interview with the Director of Nursing Services (DNS) on 2/3/25 at 12:15 PM identified RN #4 notifies her of nursing staff with outstanding Healthcare Academy courses. The DNS indicated that the goal for annual education was for each staff member to complete 75% of their assigned courses. For those staff members who had not completed any (0%) of their assigned courses, the DNS stated We are working on that. The DNS further identified she did not oversee RN #4 who was the Director of the Education Services department and that RN #4 worked autonomously. Review of the facility Organizational Chart identified RN #4 reported directly to the Administrator. (continued on next page)		

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Healthcare Academy reports dated 1/29/2025 through 1/30/2025 for 2023 and 2024 staff education course completions identified 64 out of 227 (28.1%) facility staff members completed less than 75% of their assigned mandatory annual courses for 2024 which included the infection prevention and control training, BBP training, PPE training, and enhanced barrier precautions training courses. Review failed to identify tuberculosis education, COVID-19 education, and transmission-based precautions education. Review of Healthcare Academy reports dated 1/29/2025 through 1/30/2025 for 2023 and 2024 staff education course completions identified 53 out of 119 (44.5%) nursing staff members completed less than 75% of their assigned mandatory annual courses for 2024 which included the infection prevention and control training, BBP training, PPE training, and enhanced barrier precautions training courses. Review failed to identify tuberculosis education, COVID-19 education, and transmission-based precautions education. Review of the Staff Development Corporate Compliance policy identified, in part, a list of annual mandatory in-services, to include infection prevention and control, tuberculosis, COVID-19, bloodborne pathogens, personal protective equipment, transmission based precautions, and enhanced barrier precautions, that each staff member was responsible for completing, by the end of the month prior to their annual evaluation. The policy identified that an individual training record for each staff member was to be maintained by the Director of Staff Development.		

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F 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide training in compliance and ethics. 51183 Based on facility documentation, facility policy and interviews the facility failed to ensure staff compliance with corporate compliance and ethics training. Review of Healthcare Academy (online education platform) reports dated 1/29/2025 through 1/30/2025 for 2023 and 2024 staff education course completions identified 52 out of 227 (22.9%) facility staff members did not complete corporate compliance and ethics training in 2024. Review of Healthcare Academy reports dated 1/29/2025 through 1/30/2025 for 2023 and 2024 staff education course completions identified 29 out of 75 (38.6%) Nurse Aides did not complete corporate compliance and ethics training in 2024. Review of Healthcare Academy reports dated 1/29/2025 through 1/30/2025 for 2023 and 2024 staff education course completions identified 10 out of 44 (22.7%) Licensed Nurses did not complete corporate compliance and ethics training in 2024. Interview with the Director of Education Services (RN #4) on 2/3/2025 at 11:33 AM identified she assigned facility staff required in-service courses through Healthcare Academy and checked completion of courses monthly. RN #4 identified after checking course completion, she notified department heads of staff members within their department with incomplete courses. Interview with Director of Nursing Services (DNS) on 2/3/25 at 12:15 PM identified RN #4 notified her of nursing staff with outstanding Healthcare Academy courses. The DNS indicated that the goal for annual education was for each staff member to complete 75% of their assigned courses. For those staff members who had not completed any (0%) of their assigned courses, the DNS stated We are working on that. The DNS further identified she did not oversee RN #4 who was the Director of the Education Services department and that RN #4 worked autonomously. Review of the facility Organizational Chart identified RN #4 reported directly to the Administrator. Review of Healthcare Academy reports dated 1/29/2025 through 1/30/2025 for 2023 and 2024 staff education course completions identified 64 out of 227 (28.1%) facility staff members completed less than 75% of their assigned mandatory annual courses for 2024 which included the corporate compliance and ethics training course. Review of Healthcare Academy reports dated 1/29/2025 through 1/30/2025 for 2023 and 2024 staff education course completions identified 53 out of 119 (44.5%) nursing staff members completed less than 75% of their assigned mandatory annual courses for 2024 which included the corporate compliance and ethics training course. (continued on next page)		

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F 0946 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Review of the Staff Development Corporate Compliance policy identified, in part, a list of annual mandatory in-services, to include corporate compliance and ethics training, that each staff member was responsible for completing, by the end of the month prior to their annual evaluation. The policy identified that an individual training record for each staff member was to be maintained by the Director of Staff Development.		

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. 51183 Based on facility documentation, facility policy and interviews the facility failed to ensure Nurse Aides (NA) completed at least 12 hours of education for 2024. Review of Healthcare Academy (online education platform) reports dated 1/29/2025 through 1/30/2025 for 2023 and 2024 staff education course completions identified 37 out of 75 (49.3%) nurse aides did not complete at least 12 hours of education in 2024. Facility handwritten read and sign inservices for 2023 and 2024 were additionally reviewed, and with the addition of read and sign inservices, 12 hours of education was not met. Interview with RN #4 on 2/3/2025 at 11:33 AM identified that she was responsible for assigning education courses to all staff in Healthcare Academy, that she monitored their completion monthly, and notified facility department heads of any staff within their department who did not complete their courses. RN #4 indicated that she notified the DNS of nursing staff who had not completed their courses. Interview with the Director of Nursing Services (DNS) on 2/3/25 at 12:15 PM identified RN #4 notified her of nursing staff with outstanding Healthcare Academy courses. The DNS indicated that the goal for annual education was for each staff member to complete 75% of their assigned courses. For those staff members who had not completed any (0%) of their assigned courses, the DNS stated We are working on that. The DNS further identified she did not oversee RN #4 who was the Director of the Education Services department and that RN #4 worked autonomously. Review of the Staff Development Corporate Compliance Policy identified records of educational training were to be maintained in the Staff Development Room, an individual training record for each employee would be maintained, and NA's are required by state regulations to obtain at least 12 hours of continuing education each year and the 12 hours must be completed prior to their respective anniversary.		

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NAME OF PROVIDER OR SUPPLIER Westview Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 150 Ware Rd Dayville, CT 06241	
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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 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide behavior health training consistent with the requirements and as determined by a facility assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51183 Based on facility documentation, facility policy and interviews the facility failed to ensure staff compliance with behavioral health training. A. Review of Healthcare Academy reports dated 1/29/2025 through 1/30/2025 for 2023 and 2024 staff education course completions identified 96 out of 227 (42.2%) facility staff members did not complete behavioral health-trauma informed care (TIC) training in 2024. Review of Healthcare Academy reports dated 1/29/2025 through 1/30/2025 for 2023 and 2024 staff education course completions identified 47 out of 75 (62.6%) Nurse Aides did not complete behavioral health-TIC training in 2024. Review of Healthcare Academy reports dated 1/29/2025 through 1/30/2025 for 2023 and 2024 staff education course completions identified 20 out of 44 (45.4%) Licensed Nurses did not complete behavioral health-TIC training in 2024. B. Review of Healthcare Academy reports dated 1/29/2025 through 1/30/2025 for 2023 and 2024 staff education course completions identified 34 out of 227 (14.9%) facility staff members did not complete dementia management training in 2024. Review of Healthcare Academy reports dated 1/29/2025 through 1/30/2025 for 2023 and 2024 staff education course completions identified 23 out of 75 (30.6%) Nurse Aides did not complete dementia management training in 2024. Review of Healthcare Academy reports dated 1/29/2025 through 1/30/2025 for 2023 and 2024 staff education course completions identified 5 out of 44 (11.3%) Licensed Nurses did not complete dementia management training in 2024. C. Review of the Westview Health Care Center Annual Facility assessment dated [DATE] identified the facility provides care for residents admitted with or who develop the following diagnoses: psychosis (hallucinations/delusions), impaired cognition, mental disorder, depression, bipolar disorder, schizophrenia, post-traumatic stress disorder, anxiety, and behaviors requiring interventions. Review of Healthcare Academy reports dated 1/29/2025 through 1/30/2025 for 2023 and 2024 staff education course completions failed to identify facility staff education for 2024 related to psychosis (hallucinations/delusions), impaired cognition, depression, bipolar disorder, schizophrenia, and anxiety, as determined by the facility assessment. Interview with the Director of Education Services (RN #4) on 2/3/2025 at 11:33 AM identified she assigned facility staff required in-service courses through Healthcare Academy and checked completion of courses monthly. RN #4 identified after checking course completion, she notified department heads of staff members within their department with incomplete courses. (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075078	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/03/2025
NAME OF PROVIDER OR SUPPLIER Westview Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 150 Ware Rd Dayville, CT 06241	
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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 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Director of Nursing Services (DNS) on 2/3/25 at 12:15 PM identified RN #4 notifies her of nursing staff with outstanding Healthcare Academy courses. The DNS indicated that the goal for annual education was for each staff member to complete 75% of their assigned courses. For those staff members who had not completed any (0%) of their assigned courses, the DNS stated We are working on that. The DNS further identified she did not oversee RN #4 who was the Director of the Education Services department and that RN #4 worked autonomously. Review of the facility Organizational Chart identified RN #4 reported directly to the Administrator. Review of Healthcare Academy reports dated 1/29/2025 through 1/30/2025 for 2023 and 2024 staff education course completions identified 64 out of 227 (28.1%) facility staff members completed less than 75% of their assigned mandatory annual courses for 2024 which included the behavioral health-TIC training and dementia management training courses. Review failed to identify facility staff education for 2024 related to psychosis (hallucinations/delusions), impaired cognition, depression, bipolar disorder, schizophrenia, and anxiety, as determined by the facility assessment. Review of Healthcare Academy reports dated 1/29/2025 through 1/30/2025 for 2023 and 2024 staff education course completions identified 53 out of 119 (44.5%) nursing staff members completed less than 75% of their assigned mandatory annual courses for 2024 which included the behavioral health-TIC training and dementia management training courses. Review failed to identify facility staff education for 2024 related to psychosis (hallucinations/delusions), impaired cognition, depression, bipolar disorder, schizophrenia, and anxiety, as determined by the facility assessment. Review of the Staff Development Corporate Compliance policy identified, in part, a list of annual mandatory in-services, to include behavioral health training, that each staff member was responsible for completing, by the end of the month prior to their annual evaluation. The policy identified that an individual training record for each staff member was to be maintained by the Director of Staff Development.		