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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075085 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 03/03/2026 |
| NAME OF PROVIDER OR SUPPLIER Saint Mary Home | | STREET ADDRESS, CITY, STATE, ZIP CODE 2021 Albany Ave West Hartford, CT 06117 | |
| 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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few | <p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, interviews, and facility documentation/policies for one (1) of three (3) residents (Resident #5) reviewed for Advanced Directives, the facility failed to honor a resident's Advanced Directive which specified Do Not Resuscitate and Do Not Intubate (DNR/DNI) when the resident was found unresponsive and without a pulse. The findings included: Resident #5 was admitted to the facility in November of 2025 with diagnoses that included peripheral vascular disease, cellulitis of left lower limb, and unspecified open wound of left lower limb. The Nursing admission assessment by RN #6 dated [DATE] at 4:51 PM identified Resident #5 arrived to the facility by stretcher, had reduced strength of the lower extremities, could ambulate with assistance, and utilized a four (4) wheel walker. The Current Consent for Life Sustaining Procedure dated [DATE] (located in the resident's paper chart and signed by both the resident and Medical Director) identified Resident #5 refused cardiopulmonary resuscitation (CPR), artificial respiration, and artificial nutrition. The Electronic Medical Record failed to identify Resident #5's Advanced Directive to not resuscitate or intubate (DNR/DNI). A Nurse's note by LPN #5 dated [DATE] at 4:17 PM identified at about 8:00 AM, NA #1 (assigned to Resident #5) went to his/her room to obtain vital signs, noticed blood on the carpet in front of the bathroom door, and found Resident #5 seated on the toilet, unresponsive. Resident #5 was unresponsive and pulseless on the toilet. CPR was initiated, the nursing supervisor was paged STAT (immediately) to the unit, which was followed by a code blue page and the resident was pronounced deceased by the nursing supervisor. Interview with LPN #5 on [DATE] at 11:53 AM identified that upon being informed Resident #5 was unresponsive, he/she found Resident #5 pulseless, called the code, and initiated CPR. LPN #5 identified that upon arrival to the unit, LPN #7 took over and continued to provide CPR to Resident #5. Interview with LPN #7 on [DATE] at 2:31 PM identified he/she was assigned to another unit on [DATE], responded to the code, and administered compressions after being informed Resident #5 was a Full Code. LPN #7 further indicated LPN #5 relieved him and continued CPR when Emergency Medical Services (EMS) arrived. However, after review of Resident #5's medical records, EMS informed staff Resident #5 had a Do Not Resuscitate/Do Not Intubate (DNR/DNI) order in his/her paper chart. Staff stopped performing CPR, and the resident was pronounced deceased. Interview with the Director of Nursing Services (DNS) on [DATE] at 2:09 PM identified Resident #5's Advanced Directives were not followed as LPN #5 failed to check Resident #5's paper chart (which contained the signed Current Consent for Life Sustaining Procedure) prior to assuming the resident was a Full Code and administering CPR. The DNS indicated that if the paper chart been checked, Resident #5's Advanced Directives would have been identified, and CPR would not have been administered. Although requested, the facility was unable to provide an Advanced Directive policy. The Heartsaver Cardiopulmonary Resuscitation (CPR) and Automatic External Defibrillator (AED) policy directed the American Heart Association had established evidenced-based decision-making guidelines for initiation CPR when cardiac arrest occurs. CPR was initiated unless one (1) of the three (3) conditions was present: a valid DNR order was in place, initiating CPR could cause injury or peril to the rescuer, and in the presence of obvious signs of (continued on next page)</p> | | |

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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few | clinical death (e.g. rigor mortis, dependent lividity, decapitation, transection, or decomposition). In all other instances, CPR is to be administered. | | |