| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 075085 | A. Building<br>B. Wing | 11/12/2024 |

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| Saint Mary Home | 2021 Albany Ave<br>West Hartford, CT 06117 |

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| F 0572<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Give residents a notice of rights, rules, services and charges.<br><br>47489<br><br>Based on review of facility documentation, review of facility policy/procedures and interviews, the facility failed to ensure that resident rights were reviewed on an ongoing basis. The findings include:<br><br>A review of the resident council's monthly meeting minutes for the period of May 2024 through October 2024 failed to identify that resident rights were reviewed at the resident council meetings and/or that resident rights information was disseminated to the resident council as a group or to the residents in general.<br><br>Interview on 11/04/24 at 2:07 PM with the resident council identified that the facility did not review resident rights during the resident council meetings and did not disseminate resident rights information to the residents on a routine basis.<br><br>Interview on 11/7/24 at 9:29 AM with the Therapeutic Recreation Director identified the residents received a Resident's [NAME] of Rights when admitted to the facility. She further noted that she is the designated person that assists the residents with the resident council meetings and noted that the meetings did not have a designated time to review resident rights. In addition, the facility did not have policies in place that addressed resident council.<br><br>Interview on 11/7/24 at 10:27 with the Administrator identified the recreation department is responsible for conducting the resident council meetings and that the expectation is that the recreation staff will review resident rights with the residents during the meetings. |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0603<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Protect each resident from separation (from other residents, his/her room, or confinement to his/her room).<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47489<br><br>Based on observations, review of clinical records, review of the facility assessment and interviews for six sampled residents (Residents #29, #55, #60, #142, #167, and #184) residing on the secured unit (West 1), the facility failed to assess, care plan, demonstrate the secured unit was the least restrictive setting, and obtain consents for residents who were selected to reside on the secured unit. The findings included:<br><br>Observations during all days of the survey October 31st, November 4, 5, 6, 7, and 8, 2024 identified the [NAME] 1 unit located on the first floor had entrance doors that were closed and secured. There was a key code pad adjacent to the doors that required a number code to be entered in order to gain access to the unit. All exterior doors and stairwell doors on the unit also required a key code to access the door. The staff was noted to input the code for visitors to exit the unit or enter the unit.<br><br>Review of the Facility Assessment on 11/4/24 identified the facility's capability of managing residents with dementia and/or behaviors and indicated that residents with wandering behaviors would be considered for placement on the secured unit. The facility assessment did not include the criteria or specific function for placement on the unit.<br><br>Interview on 11/4/24 at 12:47 PM with the Administrator identified the facility did not have a policy for the dementia unit (secured unit). She identified the unit was specifically a dementia unit and required a diagnosis of dementia for placement. She indicated she was unaware of other criteria for placement on the unit and that it would be an interdisciplinary decision for placement.<br><br>Interview on 11/5/24 at 11:19 AM with SW #2 identified that placement on the secured unit involved the whole team and indicated the MDS, RN, SW, rehabilitation staff and Administrator were part of the team. She further identified that the doctor was not included at morning report when placement is discussed, and that nursing is responsible for completing the wandering assessments. She further identified that placement on the unit is talked about sporadically, but SW#2 was unsure what is documented in the clinical chart for residents residing on the secured dementia unit. Additionally, SW #2 indicated that some families request placement on the unit, but that most placements would be for safety reasons.<br><br>Interview on 11/5/24 at 11:52 AM with the DNS identified placement on the secured unit depended on resident history. The DNS indicated the resident had to have a diagnosis of dementia, and if a resident was found wandering, they would be placed on the secured unit. If there was a placement on the unit, there were not consents, and the families, or conservators would be notified of the placement. The DNS identified the placements on the secured unit are discussed at the risk meetings which are run by the doctor. She indicated there are not re-assessments and the facility does not indicate whether the placement was the least restrictive. She indicated there was not an order placed for placement, nor a note regarding placement.<br><br>(continued on next page) |

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| F 0603<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Interview on 11/5/24 at 2:59 PM with the Administrator confirmed the facility did not have criteria outlined for placement on the secured unit. She identified the placements were discussed at the morning meetings daily and the risk meetings, weekly. She indicated that residents who exhibited behaviors in other areas of the facility would be placed on the secured unit. Additionally, she indicated that the secured unit was usually full because of requests for the residents to stay there, and there were rarely placements made.<br><br>Interview on 11/6/24 at 2:13 PM with RN#1(unit supervisor) identified that placement on the secured unit or transfer onto the unit involved a discussion with the doctor and the family. RN #1 indicated the resident would have a diagnosis of dementia and would have to have wandering behaviors or safety concerns.<br><br>Interview on 11/6/24 at 3:34 PM with the Medical Director identified there was a long process for placement on the secured unit, but if a resident was wandering or had a pattern of unsafe behaviors they would be placed on the secured unit. The Medical Director identified there were no guidelines for placement and that it was a medical assessment or a psychological assessment. He indicated that medical reasons for placement were ruled out and that he would expect a provider note indicating the resident resided on a secured unit but that the note might vary among different providers.<br><br>Resident #29's diagnoses included unspecified dementia severe with other behavioral disturbance, Dysthymic disorder, and dysphagia oral stage.<br><br>The wander/elopement risk assessments dated 4/15/24 and 7/23/24 identified the resident did not exhibit wandering behavior.<br><br>The care plan dated 8/13/24 identified the resident had self-care deficits, falls, and confusion related to dementia but failed to identify the resident was placed on the secured unit and failed to identify behaviors of wandering.<br><br>The quarterly MDS assessment dated [DATE] identified Resident #29 had severely impaired cognition, required substantial/maximal assistance for all transfers, and used a manual wheelchair for mobility, did not use physical restraints or alarms, and did not exhibit hallucinations, delusions, rejection of care or wandering behaviors.<br><br>Resident #55's diagnoses included senile degeneration of brain, spinal stenosis, and dementia.<br><br>The quarterly MDS assessment dated [DATE] identified the resident did not refuse care, did not exhibit wandering behavior, was dependent with toileting, shower/bathing, lower dressing, and required substantial/maximum assistance with upper body dressing and personal hygiene, sit to lying, lying to sitting on side of bed and all transfers. The assessment further noted the resident required a wheelchair and could not self-propel, thus was dependent on staff for movement around the unit.<br><br>The care plan dated 9/16/24 identified Resident #55 was an elopement risk with an intervention to remains on secured locked unit. Additionally, the resident was identified as receiving Hospice care with interventions that included collaborate with hospice when changes to plan of care are made, Hospice SW and nurse to visit as needed to provide support, maintain an environment that promotes comfort, modify environment based on wants/needs and monitor for signs of restlessness or agitation.<br><br>(continued on next page) |

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| F 0603<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | The wandering/elopement risk assessment dated [DATE] identified that wandering behavior was not exhibited. This was the only wandering/elopement risk assessment provided for this resident.<br><br>Resident #60 was admitted to the facility in October of 2023 and had diagnoses that included dementia, psychotic disorder, anxiety, and repeated falls.<br><br>The Wandering/Elopement Risk assessment dated [DATE] identified Resident #60 had not exhibited any wandering behavior and had no history of wandering behavior.<br><br>The Wandering/Elopement Risk assessment dated [DATE] identified Resident #60 had exhibited wandering behavior 1 to 3 days, was wandering to find family or pet, wandering aimlessly, and exhibiting exit-seeking behavior. The assessment indicated that an elopement prevention care plan was initiated or updated.<br><br>The Wandering/Elopement Risk assessment dated [DATE] identified wandering behavior had occurred 1 to 3 days since the last assessment. Additionally, this assessment indicated the resident was wandering to find family or pet, wandering aimlessly, and was actively exhibiting exit-seeking behavior and that an elopement prevention care plan had been initiated or updated.<br><br>The Wandering/Elopement Risk assessment dated [DATE] identified wandering behavior was not exhibited and the resident had previously attempted to leave a residence or other place unescorted and that the resident was cognitively impaired and independently ambulatory and had two previous wandering events. The assessment form indicated that an elopement prevention care plan was initiated or updated.<br><br>The Wandering/Elopement Risk assessment dated [DATE] identified wandering behavior was not exhibited and that the resident had not had a history of elopement but did indicate the resident was cognitively impaired and independently ambulatory. Directions on the assessment form identified initiating/updating a care plan or service plan for elopement risk.<br><br>The annual MDS assessment dated [DATE] identified Resident #60 had severely impaired cognition, required partial/moderate assistance with chair to bed, toilet, and tub transfers, required supervision or touching assistance with walking 10 feet and wheeling 150 feet in the wheelchair. Additionally, the MDS indicated the resident did not exhibit wandering, rejection of care, or physical or verbal behaviors.<br><br>The care plan reviewed for dates 10/17/2023 through 11/7/2024 identified Resident #60 had a chronic cognitive deficit and required ADL assistance related to dementia with interventions to provide cues/reminders during tasks, encourage involvement in activities and monitor baseline cognitive functions and monitor/record for changes. However, the care plan failed to identify any mention of wandering/elopement/or placement on the facility's secured unit.<br><br>Review of Physician's orders, including discontinued orders from 10/17/2023 through 11/7/2024 identified the resident continued to require a skilled level of care based on evaluation of the resident' medical status, the orders failed to direct placement on a secured unit and failed to direct monitoring for wandering/elopement.<br><br>Interview on 11/06/24 at 11:54 AM with resident's responsible party identified he/she was notified that the resident had a room change but was unaware that the resident was moved the secured unit.<br><br>(continued on next page) |

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| F 0603<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Resident #142's diagnoses included dementia, cerebral infarction unspecified, and peripheral vascular disease.<br><br>The wandering/elopement risk assessment dated [DATE] identified wandering behavior was not exhibited. This was the only wandering assessment provided from the facility.<br><br>The significant change MDS assessment dated [DATE] identified Resident #142 had severely impaired cognition, was dependent with toileting, showering, and personal hygiene, did not exhibit hallucinations, delusions, physical or behavioral symptoms, rejection of care, or wandering.<br><br>The care plan dated 7/15/24 identified the resident was admitted for short term rehabilitation post hospitalization for stercoral colitis and lived on memory care unit with a goal to return to assisted living facility and interventions to include social work to work collaboratively with patient, family, IDT, and assisted living community to determine post discharge needs.<br><br>Resident #167's diagnoses included Wernicke's encephalopathy, dementia, and difficulty in walking.<br><br>Physician's progress notes dated 9/29/23, 1/24/24, 5/22/24, 7/25/24, and 9/18/24 identified the resident was transferred to memory unit because of agitation, risk of flight and indicated an attempted elopement in June 2023 but failed to identify re-assessment of placement on the secured unit and failed to identify that this was the least restrictive placement for the resident.<br><br>The quarterly MDS assessment dated [DATE] identified Resident #167 had severely impaired cognition, did not exhibit hallucinations, delusions, physical or verbal behavioral symptoms, rejection of care or wandering behaviors, and required supervision or touching assistance with walking 10 and 50 feet with use of a walker.<br><br>The care plan dated 10/7/24 identified resident #167 was at risk for wandering due to dementia and impaired safety awareness with a goal to not wander unsafely on or off memory lane through the next review with intervention to assess elopement risk upon admission, quarterly, or with significant change of condition and update care plan accordingly.<br><br>Resident #184 was admitted to the facility in July of 2024 with diagnoses that included Alzheimer's disease, end stage renal disease, and diabetes mellitus without complications.<br><br>The Wandering/Elopement Risk assessment dated [DATE] identified wandering behavior was not exhibited. Additionally, the assessment indicated the resident had not previously attempted to leave a residence or other place unescorted, was not cognitively impaired and independently ambulatory, did not have a history of elopement, was not on medication to manage elopement behaviors, had not verbalized intent to leave the facility, was not wandering to find family or a pet, was not wandering aimlessly and was not actively exit-seeking.<br><br>Review of Nursing progress note from 7/22/24 through 11/6/24 identified the resident was placed on [NAME] 1 unit but failed to identify this was a secured unit, failed to identify consent for placement, assessment or reason for placement, or identification that this was the least restrictive placement for the resident. Additionally, nursing progress notes identified the resident was alert and oriented to self, was pleasant and cooperative with care, and did not have behavioral issues.<br><br>(continued on next page) |

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| F 0603<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of provider progress notes dated from 7/24/24 through 9/23/24 failed to identify assessment or reason for placement on a secured unit and failed to identify the placement on the secured unit as the least restrictive placement for the resident.<br><br>The admission MDS dated [DATE] identified Resident #184 had severely impaired cognition, was always incontinent of bowel and bladder, utilized a walker and a wheelchair, required substantial/maximal assistance with toileting hygiene, shower/bathing, and partial/moderate assistance with all transfers and position changes.<br><br>Psychiatric Evaluation and Consultation notes reviewed from 7/24/24 through 10/7/24 identified Resident #184 did not exhibit any behavioral or mood concerns and failed to identify resident was housed on a secured unit.<br><br>The care plan dated 11/6/24 failed to identify the resident resided on a secured unit.<br><br>Interview on 11/8/24 at 12:02 PM with the DNS and the Administrator identified placement on the unit would be for safety reasons, including wandering/elopement. Additionally, the Administrator indicated the residents were not re-evaluated for placement and that most placements remained in place based on requests from family members. Further, the Administrator could not identify whether or not consents for placement on the unit were obtained. |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47402<br><br>Based on review of the clinical record, review of facility documentation, review of facility policy/procedures and interviews for one of six sampled residents (Resident #60) residing on the secured unit, the facility failed to ensure the resident's care plan was comprehensive in regards to behaviors of wandering, elopement risk and placement on a secured unit. The findings included:<br><br>Resident #60 was admitted to the facility in October of 2023 with diagnoses that included dementia, personal history of disease of the nervous system and sensory organs, and unsteadiness on feet and repeated falls.<br><br>The annual MDS assessment dated [DATE] identified Resident #60 had severely impaired cognition, required partial/moderate assistance with chair to bed, toilet, and tub transfers, required supervision or touching assistance with walking 10 feet and wheeling 150 feet in the wheelchair. Additionally, the MDS indicated the resident did not exhibit wandering, rejection of care, or physical or verbal behaviors.<br><br>The care plan reviewed for dates 10/17/2023 through 11/7/2024 identified Resident #60 had a chronic cognitive deficit and required ADL assistance related to dementia with interventions to provide cues/reminders during tasks, encourage involvement in activities and monitor baseline cognitive functions and monitor/record for changes. However, the care plan failed to identify any mention of wandering/elopement/or placement on the facility's secured unit.<br><br>Review of Physician's orders, including discontinued orders from 10/17/2023 through 11/7/2024 identified the resident continued to require a skilled level of care based on evaluation of the resident' medical status, failed to direct placement on a secured unit and failed to direct monitoring for wandering/elopement.<br><br>The Wandering/Elopement Risk assessment dated [DATE] identified Resident #60 had not exhibited any wandering behavior and had no history of wandering behavior.<br><br>A Social Services note dated 11/3/2023 at 6:29 PM identified Resident #60's Brother was notified the resident was moved to the secured unit for wandering off of the current unit.<br><br>The Wandering/Elopement Risk assessment dated [DATE] identified the resident had exhibited wandering behavior 1 to 3 days, wandering aimlessly, and exhibiting exit-seeking behavior. The assessment indicated that elopement prevention care plan was initiated or updated.<br><br>Review of Nursing Progress notes from 11/4/24 through 11/7/24 identified the resident was adjusting well to the secured unit without elopement behavior noted.<br><br>The nursing progress note dated 11/8/24 at 12:28 PM identified the resident self-propelled in the wheelchair and was noted to be wandering on the East 1 unit and when interviewed Resident #60 indicated he/she was looking his/her daughter. Additionally, the note identified the resident was within staff site until able to move to [NAME] 1, the secured unit.<br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Physician's note dated 11/29/24 identified the resident required long term care and had had multiple falls. The note did not indicate the resident resided on a secured unit or had a problem with wandering/elopement.<br><br>The Wandering/Elopement Risk assessment dated [DATE] identified wandering behavior had occurred 1 to 3 days since the last assessment. Additionally, this assessment indicated the resident was wandering to find family or pet, wandering aimlessly, and was actively exhibiting exit-seeking behavior and that an elopement prevention care plan had been initiated or updated.<br><br>The Wandering/Elopement Risk assessment dated [DATE] identified wandering behavior was not exhibited and the resident had preciously attempted to leave a residence or other place unescorted and that the resident was cognitively impaired and independently ambulatory and had two previous wandering events while looking for his/her daughter. The assessment form indicated that an elopement prevention care plan was initiated or updated.<br><br>The Wandering/Elopement Risk assessment dated [DATE] identified wandering behavior was not exhibited and that the resident had not had a history of elopement but did indicate the resident was cognitively impaired and independently ambulatory. Directions on the assessment form identified initiating/updating a care plan or service plan for elopement risk.<br><br>Interview on 11/5/24 at 11:18 AM with SW #2 identified that care plans were completed by all disciplines, but the baseline care plan would be completed by nursing and whomever needed to add to the comprehensive could add to it. SW#2 indicated the nursing staff does the wandering/elopement assessment immediately if there was a concern and then quarterly.<br><br>Interview on 11/5/24 at 2:59 PM with the DNS identified behaviors such as wandering or elopement should be reflected in the care plan.<br><br>Interview on 11/5/24 at 3:30 PM with the Medical Director identified placement on the secured unit was a collaborative effort and discussed at risk meetings. The medical director indicated that wandering/elopement or transfer to the secured unit would be reflected in the resident's care plan.<br><br>The facility policy for comprehensive care planning identified residents would have a patient specific plan of care identifying services that would be in place to maintain the resident's well-being.<br><br>The wandering/elopement policy identified monitoring for wander guards, however, the facility did not utilize wander guards. |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48335<br><br>Based on observation, review of the clinical record, review of facility documentation, review of facility policy and interviews for one sampled resident (Resident #58) reviewed for Activities of Daily Living (ADL's), the facility failed to ensure the resident was provided nail care. The findings include:<br><br>Resident #58's diagnoses include dementia, disorientation and difficulty swallowing.<br><br>The quarterly MDS assessment dated [DATE] identified Resident #58 was severely cognitively impaired, was moderately visually impaired, required moderate assistance for personal hygiene and was dependent for toileting, showering, and transfers.<br><br>The Social Worker note dated 9/5/24 at 12:55 PM identified Resident #58 was very hard of hearing and had poor eyesight.<br><br>The care plan dated 9/24/24 identified Resident #58 was at risk for a self-care deficit, required assistance with activities of daily living related to a visual impairment with interventions that included providing assistance in completing ADL tasks, and assistance with meals.<br><br>Observation on 10/31/24 at 11:30 AM identified a brown like substance under the fingernails on Resident #58's left hand, the nails affected included the pointer, middle and ring finger nails.<br><br>Observation on 11/5/24 at 12:15 PM identified a brown/black colored substance under Resident #58's fingernails on both the left- and right-hand.<br><br>Observation on 11/7/24 at 10:40 AM with RN#3 (unit manager on East 2) and NA #1 identified Resident #58's nails on both hands had a brown, black colored substance underneath the nails, and a couple of the nails on the right hand, had jagged edges.<br><br>Interview on 11/7/24 at 10:45 AM with NA #1 indicated the resident does not always allow care to be provided. The resident yells and calls out at times during care. If the resident pulls away or says no to care, care including nail care, would not be provided. NA #1 noted the resident's nails should be cleaned.<br><br>Interview on 11/7/24 at 10:46 AM with RN #3 indicated the resident's nails should be cleaned and gently filed, and the substance under the resident's nails, appeared to be something other than feces. If NA#1 needed assistance to provide nail care for Resident #58, RN#3 identified she would provide support.<br><br>On 11/7/24 at 10:50 AM subsequent to surveyor inquiry, Resident #58's nails were cleaned by NA#1.<br><br>Although requested, the NA ADL flow sheets for the last 2 months were not provided.<br><br>Review of the Activities of Daily Living (ADL) policy directed to document and provide individualized ADL care to each resident. Individualized care needs will be documented as appropriate. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48950<br><br>Based on observation, interviews and review of facility policy for 3 of 4 medication rooms, the facility failed to ensure medication rooms had sanitary refrigerators, maintained at appropriate temperatures and expired medications were removed from the cabinets. Additionally, for 3 of 5 medication carts, the facility failed to ensure the carts were clean. The findings include:<br><br>Observation of the [NAME] Crossing medication storage room with LPN #4 on 10/31/24 at 10:30 AM noted expired medication contained in the overstock cabinet consisting of 1 full bottle of 325 milligrams(mg) of Aspirin (100 tablets) with an expiration date of 9/24, and the freezer had a heavy accumulation of frost/ice.<br><br>Interview with LPN #4 on 10/31/24 at 10:35 AM identified that she was unsure of who was responsible for cleaning out and restocking medication in the medication storage room. LPN #4 identified that the freezer needed to be defrosted and that the 11:00 PM to 7:00 AM shift was responsible for picking up discontinued medications.<br><br>Interview with RN #1 at 11:15 AM on 10/31/24 identified that everyone should be monitoring the refrigerators temperatures but usually it is 3PM-11PM and it should be done daily. Also, RN#1 identified that 11PM-7AM was responsible for cleaning out expired medications from the storage rooms, that the freezer needed to be defrosted, and the refrigerator was soiled.<br><br>Observation of the [NAME] medication storage room with LPN #5 on 10/31/24 at 11:00 AM on identified that the freezer had a heavy accumulation of frost/ice and needed to be defrosted, temperature logs were missing from 9/2/24, 9/3/24, 9/6/24, 9/7/24, 9/11/24, 9/12/24, 9/16,24, 9/17/24, 9/21/24, 9/22/24, 9/25/24, 9/26/24, 10/24/24, and 10/31/24. The refrigerator was found to be soiled with a tan, dried liquid type substance. The refrigerator contained 650 milligram Tylenol suppository (5 suppositories) with an expiration date of 4/24 (7 months past the expiration date). Also in the refrigerator was Bisacodyl suppository 10mg house stock 10 in a box, 12 boxes of Influenza vaccine, Ziopetan 0.0015% eye vials (3 boxes), Trulicity 1. 5mg/0.5ml-0.5ml, Formoterol Fumarate 40ml one unit dose, a bottle of Rocklaton 0.02-0.005% eye drops, a bottle of Dorzolamide HCL 2% eye drops, a bottle of Rhopressa 0.02%, a bottle of Brimonidine Tartrate , a bottle of Latanoprost 0.005%, 2 pens of Trulicity 0.75mg/0.5ml, 1 Insulin Glargine pen, and 2 vials of Lispro 100units/ml.<br><br>Also, observed in the over stock cabinet in the [NAME] medication room, a full bottle of Aspirin 325 milligrams(ml) (100 tablet) with an expiration date of 9/24 (2 months past the expiration date).<br><br>Interview on 10/31/24 at 11:00 AM with LPN #5 identified that the refrigerator was soiled, needed to be cleaned, and the freezer need to be defrosted. The temperature logs were missing numerous dates and that 11:00 PM-7:00 AM and 3:00 PM-11:00 PM nursing staff were responsible for tracking the temperatures.<br><br>Observation of the East 2 medication cart on 10/31/24 at 12:00 PM with LPN #1 noted loose medication pills in the second drawer from the bottom along with loose pieces of paper.<br><br>(continued on next page) |

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| | 075085 | A. Building<br>B. Wing | 11/12/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Saint Mary Home | 2021 Albany Ave<br>West Hartford, CT 06117 |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Interview with LPN #1 on 10/31/24 at 12:05 PM identified that that everyone was responsible for cleaning the medication cart and that she felt it was not clean.<br><br>Observation of the [NAME] 1 medication cart along with the [NAME] 1 medication storage room on 10/31/24 at 12:15 PM with LPN #2 identified that there were dropped pills inside of the medication cart on the bottom along with a brown liquid substance. The refrigerator temperature logs were missing dates from 10/22/24, 10/23/24, 10/24/24, 10/29/24, 10/30/24, and 10/31/24. Contents of the refrigerator included: 2 bottles of Lorazepam 2mg/ml, 4 Lantus pens of 100units/ml, 3 vials of Lispro 100units/ml, and 1 pen of Trulicity 0. 75mg/0.5ml-0.5ml.<br><br>Interview with LPN #2 on 10/31/24 at 12:20 PM identified that the medication cart was not clean and that the brown substance was sticky. LPN #2 identified that 11:00 PM -7:00 AM nursing staff oversaw cleaning the medication cart, and she was unsure of the policy.<br><br>Observation of the EAST 1 med cart on 10/31/24 at 12:30 PM with LPN #3 identified that the medication cart contained a Geria Lanta 325 Milliliter(ml)Full bottle with an expiration date of 9/24 (2 months past the expiration date). Inside the cart it was noted to have brown, substance with a bubble pack containing medication laying in the bottom of the med cart.<br><br>Interview with LPN #3 on 10/31/24 at 12:35 PM identified that everyone was responsible for going through the cart, but 11:00 PM-7:00 AM nursing staff were responsible. LPN #3 stated that the staff could do better at cleaning the cart and identified that the bubble packed medication belonged to a current resident. LPN #3 identified that she would contact maintenance to clean the cart.<br><br>An interview with the Infection Preventionist (RN #2) on 10/31/24 at 2:20 PM identified that she doesn't always have access to the medication storage rooms because the unit nurse has the keys. RN #2 also identified that she checks the refrigerators on her rounds but not the freezers. Both the Director of Housekeeping and RN #2 identified that the freezers on [NAME] and Fitsgerald both needed to be defrosted and that the refrigerator on [NAME] was soiled. Also, the Director of Housekeeping and RN #2 identified that [NAME] 1 and East 1 medication carts were soiled and needed to be cleaned stating that nursing staff was to communicate to housekeeping when the medication carts needed to be cleaned including the refrigerators/freezers.<br><br>Review of the facility policy for Cleaning of Refrigerators identified that all refrigerators and freezers should be cleaned by housekeeping on a regular basis and as necessary by nursing departments for spills. Also, identified the temperatures of any refrigerator or freezer that contains drugs, should be checked daily per the night shift and logged to ensure proper temperature control.<br><br>Review of the facility policy for Storage and Expiration of Medications identified that the facility should ensure that medications and biologicals that have an expired date on the label, have been retained longer than recommended by manufacturer or supplier guidelines or contaminated or deteriorated, are stored separate from other medications until destroyed or returned to the pharmacy or supplier. Also, identified the facility should ensure that medication and biologicals are stored at their appropriate temperatures according to the United States Pharmacopeia guidelines for temperature ranges. Facility staff should monitor the temperatures of vaccines twice a day. Refrigerators temperatures should be from 36 degree-46 degrees. |

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| F 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop and implement policies and procedures for flu and pneumonia vaccinations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47900<br><br>Based on review of clinical records, review of facility documentation, review of facility policy/procedures, and interviews for two of five sampled residents (Resident #83 and Resident #160), reviewed for immunizations, the facility failed to administer the pneumococcal vaccine as requested by the resident upon admission. The findings include:<br><br>1. Resident #83 was admitted to the facility in the month of June 2024 with diagnoses that included pneumonia, multiple rib fracture, and Alzheimer's disease.<br><br>The quarterly MDS assessment dated [DATE] identified Resident #83 had severely impaired cognition.<br><br>Review of the Vaccination Consent form for pneumovax identified Resident #83 gave the facility permission to administer the pneumovax vaccine on 6/26/2024.<br><br>Review of Resident #83 clinical records failed to identify that he/she had received the vaccination at the facility or had change his/her decision.<br><br>2. Resident #160 was admitted to the facility in the month of June 2024 with diagnoses that included schizoaffective disorder, fracture of the right femur and heart failure.<br><br>The quarterly MDS assessment dated [DATE] identified Resident #160 was cognitively intact.<br><br>Review of the Vaccination Consent form for pneumovax identified Resident #160 gave the facility permission to administer the pneumovax vaccine on 6/26/2024.<br><br>Review of Resident #160 clinical records failed to identify that he/she had received the vaccination at the facility or had change his/her decision.<br><br>Interview with the Infection Preventionist nurse (RN #2) on 11/7/24 at 9:45 AM identified the charge nurses and/or supervisors are responsible to obtain the consent, obtain a physician's order, order the vaccine, administer the vaccine and document in the resident's immunization records. RN #2 further identified that she was not informed that the vaccine was not administer nor the charge nurse or supervisor notified her of any issues as to why the resident did not receive the vaccine as if the consent was signed the expectation was that it would be administered.<br><br>Interview with the Nursing Supervisor/Unit Manager (RN #3) on 11/7/24 at 10:11 AM identified that the vaccine consents were obtained by the charge nurse and the nursing supervisor for resident who were responsible for themselves and cognitively intact, but it was primarily the responsibility of the charge nurse. RN #3 further identified the procedure after a vaccine consent was obtained from the resident or resident representative, that a physician's order would be obtained, the vaccine would be ordered from pharmacy then administered to the resident followed by updating the resident's immunization records.<br><br>(continued on next page) |

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| F 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Review of the Immunization of Patients/Residents policy in effect up until of September 2024 identified all new patients/residents will be assessed for pneumococcal and Prevnar 13 vaccine status upon admission and permission obtained from the patient/resident (or representative) to administer the pneumococcal vaccine. The policy further identified that the pneumococcal vaccine should be administered one time only per physician's order. |

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| F 0887<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47900<br><br>Based on review of the clinical records, review of facility documentation, facility policy/procedures, and interviews for 5 of 5 residents (Resident #83, Resident #97, Resident #120, Resident #160 and Resident #187), reviewed for immunizations, the facility failed to ensure that the COVID-19 vaccination were offered and/or assessed to residents. The findings include:<br><br>1. Resident #83 was admitted to the facility in the month of June 2024 with diagnoses that included pneumonia, multiple rib fracture, and Alzheimer's disease.<br><br>The quarterly MDS assessment dated [DATE] identified Resident #83 had severely impaired cognition. The assessment further identified that Resident #83 COVID-19 vaccination was not up to date.<br><br>Review of Resident #83's immunization consents and/records, along with the new admission vaccine audit documentation for June 2024 with the Infection Preventionist (RN #2) on 11/7/24 at 9:45 AM failed to identify that the COVID-19 booster vaccine was offered to the resident.<br><br>2. Resident #97 was admitted to the facility in the month of November 2023 with diagnoses that included type 2 diabetes mellitus, spinal stenosis and chronic obstructive pulmonary disease (COPD).<br><br>The quarterly MDS assessment dated [DATE] identified Resident #97 was cognitively intact.<br><br>Review of Resident #97's immunization consents and/records, along with the new admission vaccine audit documentation for November 2023 with the Infection Preventionist (RN #2) on 11/7/24 at 9:45 AM failed to identify that the COVID-19 vaccine was offered and/or assessed for past immunization.<br><br>3. Resident #120 was admitted to the facility in the month of October 2022 with diagnoses that included end stage renal disease, anemia and dementia.<br><br>The annual MDS assessment dated [DATE] identified Resident #120 had severely impaired cognition.<br><br>Review of Resident #120's immunization consent and/records with the Infection Preventionist (RN #2) on 11/7/24 at 9:45 AM failed to identify that the COVID-19 booster vaccine was offered to the resident.<br><br>4. Resident #160 was admitted to the facility in the month of June 2024 with diagnoses that included schizoaffective disorder, fracture of the right femur and heart failure.<br><br>The quarterly MDS assessment dated [DATE] identified Resident #160 was cognitively intact. The assessment further identified that Resident #160 COVID-19 vaccination was not up to date.<br><br>Review of Resident #160 immunization consents and/records, along with the new admission vaccine audit documentation for June 2024 with the Infection Preventionist (RN #2) on 11/7/24 at 9:45 AM failed to identify that the COVID-19 booster vaccine was offered to the resident.<br><br>(continued on next page) |

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| F 0887<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | 5. Resident #187 was admitted to the facility in the month of August 2024 with diagnoses that included dislocation of internal right hip prosthesis, right artificial hip joint and dementia.<br><br>The annual MDS assessment dated [DATE] identified Resident #187 had severely impaired cognition.<br><br>Review of Resident #97's immunization consents and/records, along with the new admission vaccine audit documentation for August 2024 with the Infection Preventionist (RN #2) on 11/7/24 at 9:45 AM failed to identify that the COVID-19 vaccine was offered and/or assessed for past immunization.<br><br>Interview with RN #2 on 11/6/24 at 11:33 AM identified that the COVID-19 vaccine was not offered to the residents as the facility was not offering the vaccine at the time. RN #2 identified that she would review the resident's COVID-19 vaccine status vaccination history, as when the vaccine became available, she would know what vaccine was needed.<br><br>Interview with the Administrator and RN #2 on 11/6/24 at 2:30 PM identified that the COVID-19 immunization facility's policy in 2023 and 2024 did in fact indicated that the residents would receive the vaccine and the booster vaccine. The Administrator identified for some reason the vaccine was not offered and prior to this inquiry the COVID-19 vaccine consent was not apart of the admission packet. RN #2 identified that on admission the admitting nurse would obtain vaccine consents for all required vaccine, then obtain a physician's order for the requested vaccine for the vaccine to given by the nurse. The Administrator identified that the COVID-19 vaccine was schedule for November 2024, however, failed to identify that consents were provided to residents.<br><br>Interview with the DNS on 11/7/24 at 10:55 AM identified that she thought that the COVID-19 vaccine was being offered to the residents as it was the infection preventionist responsibility to assess the resident's COVID-19 vaccination information on admission.<br><br>Interview with the Nursing Supervisor/Unit Manager (RN #3) on 11/7/24 at 10:11 AM identified that vaccine consents were obtained by the charge nurse and the nursing supervisor for resident who were responsible for themselves and cognitively intact, but it was primarily the responsibility of the charge nurse. RN #3 identified that tetanus, pneumococcal and influenza vaccine consents were discussed and reviewed on admission, while for the COVID-19 vaccine, the nurses would inquire about the resident COVID-19 vaccine status but would let the resident know that the vaccine was not available currently and when it became available it would be administered. RN #3 identified that she could only recall the primary series (1st dose and 2nd dose) and one booster vaccine being offered and administered to the residents. RN #3 was asked if she recalled the COVID-19 vaccine being offered in 2023 and 2024 like the influenza vaccine in which she responded that it was not offered on an annual basis like the influenza vaccine.<br><br>Interview with RN #2 on 11/8/24 at 10:00 AM identified that the COVID-19 vaccine was last offered for administration to the residents in January of 2023. RN #2 was asked if she was aware of the newsletter mailing with COVID-19 consents that was mailed to resident in October of 2023, which she responded that she was informed of the mailing that was going to be sent out, however did not received a consent form from the resident. RN #2 identified that she was and would be responsible for any COVID-19 vaccine administration as she would be the individual who orders the vaccine, ensured the consents were obtained and the vaccine was schedule to be administered. After surveyor's inquiry facility stating that the vaccine would be offered in November 2024, however consents are mailing yet to be obtained or initiated.<br><br>(continued on next page) |

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| F 0887<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Interview with the Pharmacy Technician #1 (the pharmacy provider of the facility) on 11/8/24 at 11:20 AM identified that the last ordering and delivered COVID-19 vaccine from the facility was on January 11, 2023, and failed to identify any order for the COVID-19 vaccine that was schedule for this year yet. The Pharmacy Technician #1 identified that she could not recall the pharmacy not having the COVID-19 vaccine available for homes and that there might had been a delay of a day or two but there was nothing major. In addition, the Pharmacy Technician #1 identified that homes (nursing homes) would schedule a clinic for the vaccine administration and notify the pharmacy of the schedule date so that the vaccines could be delivered timely.<br><br>Interview with the DNS on 11/8/24 at 11:29 AM identified when asked where the facility obtained and/order vaccines in which the DNS identified that all vaccines are obtained and/order from the same pharmacy who provides the facility with all medications.<br><br>Interview with Unit Manager (RN #5) on 11/8/24 at 12:00 PM identified that the COVID-19 vaccine consents were not completed in the resident's chart. RN #5 was asked since she was the unit manager of a long-term care unit if any resident had inquired about the COVID-19 vaccine, which she responded that the residents were asking especially with the influenza vaccine being offered and administered. RN #5 further identified that the COVID-19 vaccine was not offered as it was not available and was told recently after she had inquired about the COVID-19 vaccine that the vaccine would be offered to the residents soon.<br><br>Review of the Infection Prevention and Control Manual Coronavirus (COVID-19) section of COVID-19 immunization dated 5/15/2023 and 10/3/24 identified in both that residents or resident representatives and staff at the facility will be provided education regarding the benefits and potential side effects associated with the Covid-19 vaccine and any boosters recommended and offered the vaccine when it is available to the facility, unless it is medically contraindicated, or resident or staff has already been immunized. |