STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075113	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greentree Manor Nursing and Rehabilitation Center	4 Greentree Drive Waterford, CT 06385

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47826 Based on clinical record reviews, facility documentation, facility policy and interviews for two (2) of three (3) sampled residents (Residents #1 and #2) who were reviewed for an allegation of physical abuse, the facility failed to ensure Resident #1 was not punched by Resident #2. The findings include: Resident #1's diagnoses included dementia, depression, and anxiety. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 rarely or never made decisions regarding tasks of daily life, did not exhibit any behaviors, and was independent with ambulating. The Resident Care Plan dated 9/26/24 identified Resident #1 had depression and anxiety. Interventions directed to administer medications as ordered, encourage participation in purposeful activities, psychiatric consult as needed, and schedule regular walks. Resident #2's diagnoses included depression, cardiomyopathy, and chronic kidney disease. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #2 had no memory recall deficits and was oriented to person, place, and time, did not exhibit any behaviors, and was independent with ambulating. The Resident Care Plan dated 8/15/24 identified Resident #2 had altered mood patterns and depression. Interventions directed to encourage resident to verbalize feelings, identify sources of anxiety, encourage diversional activities to redirect attention from anxiety, administer medications as ordered, psychiatric consults as needed, and encourage socialization. The nurse's note for Resident #1 dated 9/26/24 at 10:52 PM identified Resident #1 had an altercation with Resident #2. Resident #1's chest was checked, no bruises were noted to the chest or upper extremities, Resident #1 did not exhibit any signs of pain and was at baseline mentation. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075113	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greentree Manor Nursing and Rehabilitation Center	4 Greentree Drive Waterford, CT 06385

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The social service note for Resident #1 dated 9/26/24 at 11:09 PM identified at approximately 2:45 PM on 9/26/24 another resident, Resident #2, made contact with Resident #1's chest with a closed fist. Resident #1 had significant memory deficits and forgot about the event within five (5) minutes of the occurrence. The social service note for Resident #2 dated 9/26/24 at 10:59 PM identified at approximately 2:45 PM Social Worker (SW) was informed Resident #2 was observed to have made contact with another resident, Resident #1, with a closed fist. The note indicated SW spoke with Resident #2 who proudly stated he/she did hit the other resident, Resident #2 stated Resident #1 tried to reach for my water bottle, so I hit him/her, Resident #1 is an idiot uncle [NAME]. The note identified Resident #2 was belligerent and taunting saying, go ahead call the cops, I know you want to SW stepped away as to not further trigger Resident #2 after ensuring Resident #2 was placed on one (1) to one (1) supervision. Interview with the 7AM-3PM nurse aide, Nurse Aide (NA) #3, on 10/17/24 at 11:35 AM identified on 9/26/24 she saw Resident #1 bend over to pick up Resident #2's thermos that was on the floor, at which time Resident #2 said to Resident #1, I told you to leave my f'ing things alone. NA #3 stated Resident #2 then proceeded to punch Resident #1 in the chest, she immediately removed Resident #1 from the situation and got assistance from the nurse. NA #3 identified she had seen Resident #2 raise his/her cane in the past and tell another resident not to sit next to him/her. NA #3 indicated she has heard Resident #2 swear at other residents in the past and be verbally aggressive towards them. Interview with Resident #2 on 10/17/24 at 12:50 PM identified he/she recalled the altercation with Resident #1. Resident #2 stated Resident #1 initiated the situation. Resident #2 presented as very angry and identified certain residents did not belong at the facility. Resident #2 stated he/she would not go near Resident #1 in the future and identified he/she prefers to spend time alone. Interview with the Social Worker (SW) #1 on 10/17/24 at 1:00 PM identified she spoke with Resident #2 after the altercation on 9/26/24. SW #1 indicated she had spoken to Resident #2 in the past regarding raising his/her cane and being rude to other residents. SW #1 identified Resident #2 was scheduled to go to court on a promise to appear for a misdemeanor on 10/23/24. The facility policy on Resident Rights identified that residents have the right to be free from verbal, sexual, physical, or mental abuse.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075113	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greentree Manor Nursing and Rehabilitation Center	4 Greentree Drive Waterford, CT 06385

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47826 Based on clinical record reviews, facility documentation, facility policy and interviews for one (1) of three (3) sampled residents (Residents #3) who were reviewed for an allegation of abuse, the facility failed to stop the provision of care and attempt again later when Resident #3 became agitated during incontinence care and failed to notify the charge nurse Resident #3 was resistive to care as outlined in the care plan. The findings include: Resident #3's diagnoses included bipolar disorder with psychotic features, anxiety, and delusional disorder. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #3 rarely or never made decisions regarding tasks of daily life, experienced hallucinations and delusions, and was dependent on staff for toileting, bathing, personal hygiene, dressing, bed mobility, and transfers. The Resident Care Plan dated 3/22/24 identified Resident #3 required assistance with daily living skills, was non-compliant with care, and exhibited accusatory behavior towards staff. Interventions directed two (2) staff be present to assist the resident with bathing, dressing, hygiene, and transfers, document refusals of care, refer to psychiatric services as needed, update the physician regarding refusals of care, administer medications as ordered, monitor behaviors, techniques to help resident remain calm during care, and if agitated during an activity to stop the activity and attempt again later. The nurse's note dated 4/8/24 at 1:41 AM by the 3-11PM Nursing Supervisor, Registered Nurse (RN) #1, identified the 3-11PM charge nurse reported Resident #3 complained of being abused by a nurse aide. The note indicated when questioned Resident #3 stated the aide attacked me, the aide did not help at all, she pulled me hard when rolling me over, I did not fall completely, she slapped me in the face, she called me names, I called her names, and I asked for help. The note identified when assessed Resident #3 was noted to have a swollen left upper lip. Review of the nurse's notes from 4/7/24 through 4/8/24 failed to reflect documentation Resident #3 was refusing personal hygiene and incontinence care. In an interview and review of the written statement dated 4/7/24 with the 3-11PM nurse aide, Nurse Aide (NA) #1, on 10/17/24 at 12:30 PM identified on 4/7/24 she was assigned to Resident #3. NA #1 explained she identified she asked another nurse aide, NA #2, to come into the room while she provided care because Resident #3 had refused care two (2) prior times on the shift and if she didn't provide care she would have been in trouble. NA #1 identified Resident #3 was incontinent of bowel and bladder, had resisted care, and while being turned Resident #3 yelled for help and continued to yell for help when she exited the room. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075113	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greentree Manor Nursing and Rehabilitation Center	4 Greentree Drive Waterford, CT 06385

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with NA #2 on 10/17/24 at 1:30 PM identified NA #1 asked her to come into Resident #3's room while NA #1 provided incontinence care. NA #2 recalled Resident #3 was very combative and had refused care. NA #2 identified NA #1 provided incontinence care and Resident #3 yelled for help throughout the care, she believed this was because Resident #3 did not want to get cleaned up. Interview with the 3-11PM charge nurse, Licensed Practical Nurse (LPN) #2, on 10/17/24 at 2:40 PM identified on 4/7/24, when she exited another resident's room, she heard Resident #3 calling for help, upon entering Resident #3's room, Resident #3 told her the nurse aides (NA #1 and NA #2) were changing him/her and when being rolled onto the side he/she hit the side rail and got a fat lip. LPN #2 indicated she saw that Resident #3's lip was swollen. LPN #2 explained when NA #1 was interviewed by the police and NA #1 told the police Resident #3 was giving her a hard time about being changed. LPN #2 identified she had not been made aware at any point during the shift that Resident #3 was being resistant to care and had she been informed she would have intervened and talked to the resident. Interview with the Director of Nursing (DON) on 10/17/24 at 2:50 PM identified after Resident #3 alleged NA #1 was rough with him/her during incontinent care while attempting to turn the resident, the facility immediately initiated an investigation. The DON indicated NA #1 explained although Resident #3 had been resistant to care two (2) times prior in the evening and was combative during incontinence care, she continued to provide care while Resident #3 was refusing. The DON identified the facility determined the nurse aides' persistence to provide care that was not desired by the resident, fell outside of the facility's standard of care. The facility policy on Resident Rights identified that residents have the right to be free from verbal, sexual, physical, or mental abuse.