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	07/08/2025

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. (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

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for one (1) of three (3) residents (Resident #1) reviewed for falls, the facility failed to ensure that documented grievance resolutions were implemented. The findings include:Resident #1's diagnoses included dementia with agitation, history of falling and anxiety disorder.The significant change Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had severely impaired cognition (Brief Interview for Mental Status (BIMS) score of 0) and required moderate assistance for transfers and ambulation.The Resident Care Plan (RCP) dated 4/24/25 identified that on 4/24/25 Resident #1 had a fall that resulted in a laceration to the back of his/her head (scalp). Interventions included assessing for injuries and notification to the nursing supervisor, provider and family. A nurse's note dated 4/24/25 at 3:34 PM identified Resident #1 had an unwitnessed fall at approximately 3:15 PM, the family and the provider were notified of the incident, and Resident #1 was transferred to the Emergency Department (ED) per physician's orders. Hospital ED notes dated 4/24/25 identified Resident #1 had a laceration to the posterior (backside) aspect of the head, measuring 2.5 centimeters (cm) by 2.5 cm which was cleansed and repaired with five (5) staples, followed by antibiotic ointment and an adhesive bandage. No further directions were documented.A nurse's note dated 4/24/25 at 9:27 PM identified Resident #1 returned to the facility from the ED with 5 staples to the scalp, a new order for Cephalexin (antibiotic) and noted that the staples were to be removed at the facility in seven (7) days.A physician's order dated 4/25/25 directed to monitor 5 staples to the back of the head and report bleeding or signs and symptoms of infection every shift, but failed to direct staple removal until 5/7/25 (13-days after the placement of the staples).A facility grievance dated 5/7/25 identified that per Resident #1's family member, the staples were not removed from the scalp laceration timely. The facility investigation identified that the physician's order for staple monitoring and removal did not include a stop date, a new physician's order was obtained, the 5 staples were removed, and RN #3 received education on ensuring physician's orders included stop dates.Interview with Social Worker #1 (Director of Social Services) on 7/8/25 at 11:55 AM identified she filled out the grievance form and communicated the resolution to the complainant but she was not involved in the investigation. She identified RN #4 (previous DNS) directed her in what to write in the investigation section of the grievance form. She identified that she never saw a documented education for RN #3 but that if it was done, the Administrator would have it.Interview with the Administrator on 7/8/25 at 12:12 PM identified that if a grievance form reported that the corrective action was to include education to the nurse involved, the education should have been documented and available.Interview with RN #3 (Infection Control nurse) on 7/8/25 at 3:25 PM identified she entered the physician's order dated 4/25/25 directing to monitor the staples to Resident #1's scalp laceration, and further identified she should have included staple removal in the order. She identified she was unaware she had not entered a stop date and the facility never educated her on the incident.Interview with the DNS on 7/8/25 at 3:47 PM identified that the facility was unable to locate education or disciplinary action for RN #3 related to the 4/25/25 physician's order or related to the 5/7/25 grievance. She further indicated that if education was completed, it should have been available. The DNS identified that all grievance forms should be complete and accurate.Although attempted, an interview with RN #4 was not obtained.Review of the Concerns, Complaints and/or Grievances policy dated 11/25/16 directed, in part, that concerns, complaints/grievances brought to the Administration's attention will be actively addressed for resolution and inform the resident/interested party of that outcome. The Director of Social Services, Grievance Official, oversees the process, tracks grievances, leads investigations, maintains confidentiality, issues decisions and coordinates with government agencies. All concerns/complaints are investigated and findings reviewed with the Administrator and a Department Head.

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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** Based on review of the clinical record, facility documentation, facility policy and interviews for one (1) of three (3) residents (Resident #1) reviewed for falls, the facility failed to review and revise the plan of care to include a new intervention following a fall in the facility. The findings include:Resident #1's diagnoses included dementia with agitation, history of falling and anxiety disorder.The significant change Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had severely impaired cognition (Brief Interview for Mental Status (BIMS) score of 0) and required moderate assistance for transfers and ambulation.The Resident Care Plan (RCP) dated 4/24/25 identified that on 4/24/25 Resident #1 had a fall that resulted in a laceration to the back of his/her head (scalp). Interventions included assessing for injuries and notification to the nursing supervisor, provider and family.A Fall Risk Evaluation dated 4/24/25 identified Resident #1 had three (3) or more falls in the past 3 months, was disoriented at all times, was incontinent, had a balance problem, decreased muscular coordination, and was at high risk for falls.A nurse's note dated 5/9/25 at 6:12 PM by LPN #2 identified Resident #1 had an unwitnessed fall and was found on the floor by a NA. Upon assessment Resident #1 denied pain, headache or blurred vision, vital signs were stable and the family and the provider were notified of the fall with no new orders.Review of the facility Accident and Investigation (A & I) dated 5/9/25 identified Resident #1 was assisted to bed after visiting with family at 6:00 PM and when NA #2 went to check on Resident #1, he/she was on the floor next to the bed. The A & I failed to identify that an intervention was initiated following the fall. Review of the RCP dated 5/21/25 identified a fall with head laceration on 4/24/25 and a fall with no injuries on 5/21/25. The RCP failed to identify the 5/9/25 fall or that new fall interventions were added following the 5/9/25 fall. Interview with the DNS on 7/8/25 at 1:45 PM identified that following a fall, an appropriate intervention should be added to the RCP to prevent future falls. She identified that no interventions were added to the 5/9/25 fall A & I and no new intervention was added to the RCP. She identified that the RN supervisor was responsible for ensuring the A & I was fully completed following a fall and that A & I's are further reviewed in morning report. Interview with LPN #2 on 7/8/25 at 2:08 PM identified she did not add an intervention for Resident #1 following the 5/9/25 fall and was unaware that an intervention needed to be added to the RCP for falls with no injuries.Although attempted, interviews with RN #2 (Nursing Supervisor at the time of the incident) and RN #4 (previous DNS) were not obtained. Review of the Managing Falls and Fall Risk policy (undated) directed, in part, that if falling recurs despite initial interventions, staff will implement additional or different interventions or indicate why the current approach remains relevant. If underlying causes cannot be readily identified or corrected, staff will try various interventions, based on assessment of the nature or category of falling, until falling is reduced or stopped, or until the reason for the continuation of the falling is identified as unavoidable. In conjunction with the attending physician, staff will identify and implement relevant interventions to try and minimize serious consequences of falling.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy and interviews for one (1) of three (3) residents (Resident #1) reviewed for falls, the facility failed to ensure a physician's order was obtained timely for the removal of staples from a facility acquired scalp laceration which was sustained from a mechanical fall in the facility. The findings include:Resident #1's diagnoses included dementia with agitation, history of falling and anxiety disorder.The significant change Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had severely impaired cognition (Brief Interview for Mental Status (BIMS) score of 0) and required moderate assistance for transfers and ambulation.The Resident Care Plan (RCP) dated 4/24/25 identified that on 4/24/25 Resident #1 had a fall that resulted in a laceration to the back of his/her head (scalp). Interventions included assessing for injuries and notification to the nursing supervisor, provider and family. A nurse's note dated 4/24/25 at 3:34 PM identified Resident #1 had an unwitnessed fall at approximately 3:15 PM, the family and the provider were notified of the incident, and Resident #1 was transferred to the Emergency Department (ED) per physician's orders. Hospital ED notes dated 4/24/25 identified Resident #1 had a laceration to the posterior (backside) aspect of the head, measuring 2.5 centimeters (cm) by 2.5 cm which was cleansed and repaired with five (5) staples, followed by antibiotic ointment and an adhesive bandage. No further directions were documented.A nurse's note dated 4/24/25 at 9:27 PM identified Resident #1 returned to the facility from the ED with 5 staples to the scalp, a new order for Cephalexin (antibiotic) and noted that the staples were to be removed at the facility in seven (7) days.A physician's order dated 4/25/25 directed to monitor 5 staples to the back of the head and report bleeding or signs and symptoms of infection every shift, but failed to direct staple removal until 5/7/25 (13-days after the placement of the staples).A facility grievance dated 5/7/25 identified that per Resident #1's family member, the staples were not removed from the scalp laceration timely. The facility investigation identified that the physician's order for staple monitoring and removal did not include a stop date, a new physician's order was obtained, the 5 staples were removed, and RN #3 received education on ensuring physician's orders included stop dates.Interview with RN #3 (Infection Control nurse) on 7/8/25 at 3:25 PM identified she entered the physician's order dated 4/25/25 directing to monitor the staples to Resident #1's scalp laceration, and further identified she should have included staple removal in the order. She identified she was unaware she had not entered a stop date and the facility never educated her on the incident.Interview with the DNS on 7/8/25 at 3:47 PM identified the 11:00 PM to 7:00 AM shift nurses are responsible for chart checks and reviewing all new orders each day. She identified that the missing order stop date and missing staple removal date should have been identified during a chart check. Additionally, she identified that the facility was unable to locate education for RN #3 related to the 4/25/25 physician's order or any disciplinary action related to the incident.Review of the Medication and Treatment Orders policy (undated) directed, in part, that orders must include the start and stop date and/or specific duration of therapy and any interim follow-up requirements.Review of the admission of a Resident policy (undated) directed, in part, that the nurse shall reconcile medications with the discharging facility's discharge summary/W10. The nurse will notify the attending physician of the resident's arrival and verify orders as ordered and reconciled on the discharge summary/W10.Although requested, a facility policy for physician's orders reconciliation process was not provided.