STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075135	A. Building B. Wing	07/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Masonicare Health Center	22 Masonic Avenue Wallingford, CT 06492

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32738 Based on review of the clinical record, facility documentation, facility policy and interviews for one (1) of three (3) residents (Resident #1) reviewed for behaviors, the facility failed to notify a physician when a resident who was exhibiting behaviors was administered an as needed medication for behaviors that was ineffective. The findings include: Resident #1's diagnoses included dementia with anxiety. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 was severely cognitively impaired, required extensive assistance with bed mobility, transfers, and toileting. The Resident Care Plan dated 4/1/24 identified that Resident #1 was at risk for alterations in mood and behaviors related to a diagnosis of dementia with interventions that directed to administer medications as ordered, psychiatric consults as needed and to report and document restlessness, agitation and wandering. A physician's order dated 5/9/24 directed to administer Trazodone 50 mg (a sedative) by mouth every 8 hours as needed for anxiety, restlessness or agitation. A psychiatric provider note dated 6/5/24 at 11:46 PM identified that Resident #1 had presented with increased agitation and was often unable to be redirected noting that in the past the resident was able to be calmed with food, but that food was no longer comforting. Further, the note indicated that the facility was pending a decision for hospice admission for Resident #1 and recommended to continue to follow up with psychiatric services. A psychiatric note dated 6/6/24 at 8:54 PM identified that per nursing staff the resident had episodes of yelling out and displayed occasional agitated behaviors. A physician's order dated 6/6/24 directed to discontinue the previous Trazadone order and to administer Trazodone 50 milligrams (mg) by mouth every 6 hours as needed for depression and/or anxiety (the previous order was to administer every 8 hours as needed). Review of the Medication Administration Record (MAR) identified that LPN #1 had administered Trazodone 50mg for restlessness and agitation on 6/15/24 at 4:20 PM and the medication was ineffective. (continued on next page)

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
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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nursing progress note dated 6/15/24 at 6:44 PM identified that Resident #1 fell on to the floor head first out of his/her wheelchair. A nursing progress note dated 6/15/24 at 7:16 PM identified that the nursing supervisor had been called by the charge nurse reporting an unwitnessed fall and heavy bleeding was noted from the forehead. Pressure was applied to the area and Resident #1 was transferred to the hospital for evaluation. Review the facility reportable event dated 6/15/24 identified that Resident #1 had an unwitnessed fall out of the wheelchair on 6/15/24 at 6:30 PM in the hallway in front of the nurse's station. The resident sustained a laceration to the forehead and was sent to the emergency department for further evaluation and treatment. Interview with NA #1 on 7/8/24 at 11:56 AM identified that Resident #1 had been agitated from the start of the 3:00 PM to 11:00 PM shift on 6/15/24, the resident was self-propelling back and forth down the hallway in his/her wheelchair, looking for the elevator, and calling his/her spouse's name loudly and repeatedly. She indicated she had tried to calm the resident down by speaking to him/her in a calm manner and attempting to redirect the resident away from rooms [ROOM NUMBERS], as the resident believed the elevator was in those rooms. NA #1 reported the last time she had provided care to the resident on 6/15/24 at approximately 4:30 PM, and the last time she had visualized the resident was around 6:15 PM, in the wheelchair at the nurse's station Interview with LPN #1 on 7/8/24 at 12:16 PM identified that Resident #1 had a history of yelling, self-propelling around the unit looking for the elevator to go up to the third floor, approaching other residents thinking they were his/her spouse. LPN #1 indicated she usually attempts to redirect the resident with food, drinks, toileting, and bringing him/her to the dayroom for a change of scenery, however, when these interventions are unsuccessful, she will administer the resident as needed Trazodone. She identified that on 6/15/24, NA #2 had given Resident #1 a sandwich around 3:30 PM but that he/she was still agitated, so she administered the Trazodone 50 mg prior to dinner time. The Trazodone was noted to be ineffective as the resident continued the behavior of yelling for h/her spouse and looking the for the elevator in room [ROOM NUMBER] and 309. She stated that she last saw the resident around 6:15 at the nurse's station. At approximately 6:30 PM she was at the nurse's station preparing medications and heard a thump and the resident yell but stated due to the height of the nurse's station, she did not witness the fall. LPN #1 identified that she did not notify the supervisor that the Trazodone was ineffective or try any other interventions as she usually would to address the resident's agitation because she was busy passing medications and with other tasks. Interview with RN #1 on 7/8/24 at 12:24 PM identified that during shift report on 6/15/24, it was communicated that the resident did not have any behaviors on the prior shift, however, to do rounds on Resident #1 for mood and behaviors because he/she tends to scream and have sundowning behaviors in the afternoon. She indicated she visualized him/her at 3:30 PM eating a sandwich, then she saw the resident again at 6:00 PM sitting to the right of the nursing station and reported the resident did not appear agitated and was not exit seeking at those times. She identified she got a call from LPN #1 around 6:30 PM reporting that the resident had fallen from the wheelchair onto the floor and was bleeding. RN #1 reported that LPN #1 had told her she had given Resident #1 Trazodone prior to dinner, however, did not inform her that the medication had not been effective, if she had been notified that the medication was ineffective, she would have called the provider and requested further direction. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Physician #1(the psychiatric provider) on 7/8/24 at 1:12 PM identified that he had been attempting to manage Resident #1's behaviors since his/her admission to the facility, indicating that the staff had reported agitation, restlessness, yelling, and exit seeking behaviors. He reported the staff had communicated that the Trazodone was occasionally ineffective and that he had adjusted both the Depakote (a medication that can be used to treat agitation) and the Trazodone in accordance with the staff's concerns. He identified that Trazodone takes about 20 minutes to become effective and if it's not, the staff should notify him of any acute issues, or any issues related to safety. Further, he indicated that if the staff had notified him of Resident #1's continued behaviors after the Trazadone administration, he could have made an adjustment on the dose of either the Depakote or the Trazodone and could have given one time medication order to address the continued agitation. Interview with the DNS and Administrator on 7/9/24 at 3:20 PM identified that the nurse should have reported the ineffectiveness of the trazadone to the supervisor and if reported the supervisor could have called the physician for further direction. Review of the change in condition policy directed in part to notify the physician of a change in condition.

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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 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** 32738 Based on clinical record review, facility documentation, and interview, for one (1) of three (3) residents reviewed for incontinence, (Resident #1), the facility failed to ensure that the resident was had a comprehensive care plan in place for urinary incontinence. The findings include: Resident # 1 had a diagnosis of urinary retention and benign prostatic hyperplasia (prostate gland enlargement). An admission Minimum Data Set (MDS) assessment dated [DATE] identified that the resident had severe cognitive impairment, required extensive assistance with Activities of Daily Living (ADL's) and had an indwelling urinary catheter within the assessment period. Review of physician's orders dated 12/17/23 directed to discontinue the indwelling urinary catheter. Review of a quarterly MDS assessment dated [DATE] identified that the resident was frequently incontinent of urine. Review of ADL flow sheets for March, April, and May 2024 identified that the resident was incontinent of urine. Review of the clinical record failed to identify a care plan was developed to address urinary incontinence. Interview with the Director of Nurses on 7/8/24 at 2:30 PM identified that once it was determined that the resident was incontinent of urine a comprehensive care plan to address urinary incontinence should have been developed. Review of the care plan policy identified that a patient specific care plan will be developed that is appropriate to meet the specific needs of the resident.

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32738 Based on clinical record review, facility documentation, and interview, for one (1) of three (3) residents reviewed for incontinence, (Resident #1), the facility failed to ensure an assessment was completed to assess for continence after an indwelling catheter was discontinued. The findings include: Resident # 1 had a diagnosis of urine retention and benign prostatic hyperplasia (prostate gland enlargement). An admission Minimum Data Set (MDS) assessment dated [DATE] identified that the resident had severe cognitive impairment, required extensive assistance with activities of daily living and had an indwelling urinary catheter within the assessment period. Review of physician's orders dated 12/17/23 directed to discontinue the indwelling urinary catheter. Review of the clinical record failed to identify a bladder assessment was completed to assess continence status once the indwelling urinary catheter was discontinued. Review of a quarterly MDS assessment dated [DATE] identified that the resident was frequently incontinent of urine. Review of ADL flow sheets for March, April, and May 2024 identified that the resident was incontinent of urine. Interview with the Director of Nurses on 7/8/24 at 2:30 PM identified that once it the indwelling urinary catheter was discontinued the resident should have had a bowel and bladder assessment completed to assess the resident's continence needs. Review of the bowel and bladder management program policy identified that once a change in continent status is identified the bowel and bladder assessment will be completed to assess continence status for a resident who is incontinent, a voiding log will be initiated for three days and reviewed by the clinical manager to formulate a plan to manage the resident's incontinence.

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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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32738 Based on review of the clinical record, facility documentation, facility policy and interviews for one (1) of three (3) residents (Resident #1) reviewed for behaviors, the facility failed to ensure that a resident's behaviors were addressed and failed to code behaviors on the behavior flow sheets. The findings include: 1) Resident #1's diagnoses included dementia with anxiety, atrial fibrillation (irregular heartbeat), difficulty in walking, and muscle weakness. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 was severely cognitively impaired, required extensive assistance with bed mobility, transfers, and toileting. The Resident Care Plan dated 4/1/24 identified that Resident #1 was at risk for alterations in mood and behaviors related to a diagnosis of dementia with interventions that directed to administer medications as ordered, psychiatric consults as needed and to report and document restlessness, agitation and wandering. A physician's order dated 5/9/24 directed to administer Trazodone 50 mg (a sedative) by mouth every 8 hours as needed for anxiety, restlessness or agitation. A psychiatric provider note dated 6/5/24 at 11:46 PM identified that Resident #1 had presented with increased agitation and was often unable to be redirected noting that in the past the resident was able to be calmed with food, but that food was no longer comforting. Further, the note indicated that the facility was pending a decision for hospice admission for Resident #1 and recommended to continue to follow up with psychiatric services. A psychiatric note dated 6/6/24 at 8:54 PM identified that per nursing staff the resident had episodes of yelling out and displayed occasional agitated behaviors. A physician's order dated 6/6/24 directed to discontinue the previous Trazodone order and to administer Trazodone 50 milligrams (mg) by mouth every 6 hours as needed for depression and/or anxiety (the previous order was to administer every 8 hours as needed). a) Review of the Medication Administration Record (MAR) identified that LPN #1 had administered Trazodone 50 mg for restlessness and agitation on 6/15/24 at 4:20 PM and the medication was ineffective. A nursing progress note dated 6/15/24 at 6:44 PM identified that Resident #1 fell on to the floor headfirst out of his/her wheelchair. A nursing progress note dated 6/15/24 at 7:16 PM identified that the nursing supervisor had been called by the charge nurse reporting an unwitnessed fall and heavy bleeding was noted from the forehead. Pressure was applied to the area and Resident #1 was transferred to the hospital for evaluation. (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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review the facility reportable event dated 6/15/24 identified that Resident #1 had an unwitnessed fall out of the wheelchair on 6/15/24 at 6:30 PM in the hallway in front of the nurse's station. The resident sustained a laceration to the forehead and was sent to the emergency department for further evaluation and treatment. Interview with NA #1 on 7/8/24 at 11:56 AM identified that Resident #1 had been agitated from the start of the 3:00 PM to 11:00 PM shift on 6/15/24, the resident was self-propelling back and forth down the hallway in his/her wheelchair, looking for the elevator, and calling his/her spouse's name loudly and repeatedly. She indicated she had tried to calm the resident down by speaking to him/her in a calm manner and attempting to redirect the resident away from rooms [ROOM NUMBERS], as the resident believed the elevator was in those rooms. NA #1 reported the last time she had provided care to the resident on 6/15/24 at approximately 4:30 PM, and the last time she had visualized the resident was around 6:15 PM, in the wheelchair at the nurse's station Interview with LPN #1 on 7/8/24 at 12:16 PM identified that Resident #1 had a history of yelling, self-propelling around the unit looking for the elevator to go up to the third floor, approaching other residents thinking they were his/her spouse. She indicated she usually attempts to redirect him/her with food, drinks, toileting, and bringing him/her to the dayroom for a change of scenery, however, when these interventions are unsuccessful, she will administer the resident as needed Trazodone. She identified that on 6/15/24, NA #2 had given Resident #1 a sandwich around 3:30 PM but that he/she was still agitated, so she administered the Trazodone 50 mg prior to dinner time. The Trazadone was noted to be ineffective as the resident continued the behavior of yelling for h/her spouse and looking the for the elevator in room [ROOM NUMBER] and 309. She stated that she last saw the resident around 6:15 at the nurse's station. At approximately 6:30 PM she was at the nurse's station preparing medications and heard a thump and the resident yell but stated due to the height of the nurse's station, she did not witness the fall. LPN #1 identified that she did not notify the supervisor that the Trazodone was ineffective or try any other interventions as she usually would to address the resident's agitation because she was busy passing medications and with other tasks. Interview with RN #1 on 7/8/24 at 12:24 PM identified that during shift report on 6/15/24, it was communicated that the resident did not have any behaviors on the prior shift, however, to do rounds on Resident #1 for mood and behaviors because he/she tends to scream and have sundowning behaviors in the afternoon. She indicated she visualized him/her at 3:30 PM eating a sandwich, then she saw the resident again at 6:00 PM sitting to the right of the nursing station and reported the resident did not appear agitated and was not exit seeking at those times. She identified she got a call from LPN #1 around 6:30 PM reporting that the resident had fallen from the wheelchair onto the floor and was bleeding. RN #1 reported that LPN #1 had told her she had given Resident #1 Trazodone prior to dinner, however, did not inform her that the medication had not been effective, if she had been notified that the medication was ineffective, she would have called the provider and requested further direction. (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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Physician #1(the psychiatric provider) on 7/8/24 at 1:12 PM identified that he had been attempting to manage Resident #1's behaviors since his/her admission to the facility, indicating that the staff had reported agitation, restlessness, yelling, and exit seeking behaviors. He reported the staff had communicated that the Trazodone was occasionally ineffective and that he had adjusted both the Depakote (a medication that can be used to treat agitation) and the Trazodone in accordance with the staff's concerns. He identified that Trazodone takes about 20 minutes to become effective and if it's not, the staff should notify him of any acute issues, or any issues related to safety. Further, he indicated that if the staff had notified him of Resident #1's continued behaviors after the Trazodone administration, he could have made an adjustment on the dose of either the Depakote or the Trazodone and could have given one time medication order to address the continued agitation. Interview with the DNS and Administrator on 7/9/24 at 3:20 PM identified that the nurse should have reported the ineffectiveness of the Trazodone to the supervisor and if reported the supervisor could have called the physician for further direction. Review of the change in condition policy directed in part to notify the physician of a change in condition. b) A physician's order dated 6/1/24 directed to monitor for and document the following behaviors every shift: restlessness/agitation, difficulty sleeping, climbing out of bed, wandering, exit seeking, anxiety, and refusing meals, and medications. Review of the Medication Administration Record (MAR) for June 1 through June 15, 2024 identified behaviors present were not present on any of the fifteeen (15) days on the 11:00 PM to 7:00 AM shift. Review of the MAR for June 2024 identified that Resident #1 was administered Trazodone 50 milligrams (mg) seven (7) out of fifteen 15 days on the 11:00 PM to 7:00 AM shift. Interview with LPN #3 on 7/8/24 at 1:50 PM (the charge nurse on the 11:00 PM to 7:00 AM shift) identified that Resident #1 is often agitated and restless on the 11:00 PM to 7:00 AM shift, wanting to get up out of bed, and sitting on the edge of the bed numerous times. She indicated that she attempts to redirect the resident first and if that doesn't work, she will then administer the as needed Trazodone to help calm him/her down. She identified that she usually documents on the behavior monitoring flow sheet at the beginning of the shift that there are no behaviors, and intends to go back and document if the resident exhibits behaviors that she administered the Trazodone for but forgets to go back and change the her previous documentation. Interview with the DNS on 7/8/24 at 2:32 PM identified that she expects if a nurse was to administer an as needed psychotropic medication, that they should be documenting the behaviors that warrant the medication. If there's an order for behavior monitoring, they should be following the physician's order. Review of the Psychotropic Medications and PRN use policy dated 3/28/24 directed, in part, that behavioral monitoring will be completed by nursing to record specified target behaviors, such as biting, kicking, continuous crying, pacing, hitting, scratching, screaming, yelling, etc.