STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075158	A. Building B. Wing	11/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
New London Sub-Acute and Nursing	88 Clark Lane 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** 37721 Based on clinical record reviews, observations, facility documentation, facility policy and interviews for one (1) of three (3) residents, (Resident #1), reviewed for wounds, the facility failed to ensure the resident care plan identified an actual skin impairment that required treatment. The findings include: Resident #1's diagnosis included end stage renal disease (ESRD), sepsis, diabetes mellitus, heart failure and history of cellulitis to the left lower limb. Nursing Clinical Admission Documentation dated 10/7/23 identified Resident #1 had no skin lesions. A Nurse's note dated 10/10/23 completed by Licensed Practical Nurse, LPN #1 identified Resident #1 had four (4) soft scabbed areas to the left shin with no drainage noted. The shin was swollen,and the peri wound was red. The Advanced Practice Registered Nurse (APRN) was updated, and a new treatment was prescribed for Medi honey to the scabbed areas followed by non-woven gauze with Kling (wrap) to secure. A physician's order dated 10/10/23 directed to apply Medi-honey to the scabbed areas of the left lower extremity, cover with a non-woven drain gauze to secure, change daily and as needed, monitor the area daily for signs and symptoms of infection and document in clinical record and report changes to the nursing supervisor. The admission Minimum Data Set assessment dated [DATE] identified Resident #1 was without cognitive impairment, required supervised touch assistance with bed mobility and transfers using a wheelchair or walker, was at risk for the development of skin injury and had no pressure ulcer or venous/arterial ulcers. A subsequent physician's order dated 10/17/23 directed cleaning the left lower extremity abrasion with wound cleanser, apply xeroform followed by a dry protective dressing every other day. Monitor for signs and symptoms of infection, report changes to the Registered Nurse (RN) supervisor and document in the progress note(s). (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Resident Care Plan (RCP) dated 10/19/23 identified Resident #1 had the potential for skin breakdown secondary to fragile skin incontinence and anticoagulant therapy with interventions that directed to inspect skin daily while providing care and alert the charge nurse of any changes and provide skin treatments according to physician orders. The care plan failed to address the skin impairment identified 10/10/23. An interview with the Director of Nursing (DNS) on 11/21/23 at 2:30 PM identified the care plan should have included the skin impairment identified on 10/10/23. A review of the facility policy for Care Plans directed an interdisciplinary care plan be developed to achieve and maintain optimal status and include the residents needs, realistic goals, and the care and services need to meet those goals. The RCP will include physical, cognitive, and psycho-social problems and will address the residents' needs on an individualized basis.

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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 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** 37721 Based on clinical record reviews, observations, facility documentation, facility policy and interviews for one (1) of three (3) residents, (Resident #1), who were reviewed for wounds, the facility failed to ensure a wound assessment or evaluation was completed for a resident who developed a skin impairment. The findings include: Resident #1's diagnosis included end stage renal disease (ESRD), sepsis, diabetes mellitus, heart failure and history of cellulitis to the left lower limb. Nursing Clinical Admission Documentation dated 10/7/23 identified Resident #1 had no skin lesions. A Nurse's note dated 10/10/23 completed by Licensed Practical Nurse, LPN #1 identified Resident #1 had (4) soft scabbed areas to the left shin. No drainage was noted. The shin was swollen, peri wound red. The Advanced Practice Registered Nurse (APRN) was updated, and a new treatment was prescribed for Medi honey to the scabbed areas followed buy non-woven gauze with Kling (wrap) to secure. A physician's order dated 10/10/23 directed to apply Medi-honey to the scabbed areas of the left lower extremity, cover with a non-woven drain gauze to secure, change daily and as needed, monitor the area daily for signs and symptoms of infection and report to the nursing supervisor and document in the progress note(s). The admission Minimum Data Set assessment dated [DATE] identified Resident #1 was without cognitive impairment, required supervised touch assistance with bed mobility and transfers using a wheelchair or walker, was at risk for the development of skin injury and had no pressure ulcer or venous/arterial ulcers. A subsequent physician's order dated 10/17/23 directed cleaning the left lower extremity abrasion with wound cleanser, apply xeroform followed by a dry protective dressing. The Resident Care Plan dated 10/19/23 identified Resident #1 had the potential for skin breakdown secondary to fragile skin incontinence and anticoagulant therapy with interventions that directed to inspect skin daily while providing care and alert the charge nurse of any changes and provide skin treatments according to physician orders. A review of the nursing progress notes, and physician progress notes dated 10/10/23 through 10/21/23 identified no documented assessment or evaluation of the newly identified skin impairment. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with LPN #1 on 11/21/23 at 12:29 PM and 11/28/23 at 12:02 PM identified she assisted the wound physician during weekly rounds and was provided oversight by RN #1, the wound nurse. LPN #1 observed the change in skin integrity on 10/10/23 and reported the change to APRN #1, the Director of Nursing (DNS) and RN #1. Treatment orders were obtained with instructions to monitor and report changes. LPN #1 indicated Resident #1 received specialty services in the outside community on Mondays, Wednesdays, and Fridays during the day, so the new skin integrity issue was never assessed by a registered nurse. LPN #1 indicated that although the area was improving, she did not know if the skin impairment was ever evaluated by the wound physician. An interview with APRN #1 on 11/21/23 identified she did not evaluate the wound on Resident #1's left lower leg but recalled approving orders for a wound treatment after being contacted by LPN #1. APRN #1 would have expected the skin impairment to have been assessed and Resident #1 placed on a list for the wound physician to evaluate the area. An interview with the DNS on 11/21/23 at 2:30 PM identified he would have expected the wound to have been assessed by a higher-level licensed staff and deferred to the wound physician if needed. An interview with RN #1 on 11/28/23 at 10:42 AM identified she began overseeing wound care beginning 11/1/23, therefore would not have seen Resident #1's skin impairment. A subsequent interview with the DNS on 11/28/23 at 10:44 AM identified he or an assigned RN would have been responsible for overseeing wound management prior to 11/1/23. The DNS stated the area was scabbed and a treatment was in place but could not recall why he did not assess the skin impairment. Although a policy for wound management was requested, none was provided.