

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  075196	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/09/2024
NAME OF PROVIDER OR SUPPLIER  Harbor Village North Health and Rehabilitation Cen		STREET ADDRESS, CITY, STATE, ZIP CODE 78 Viets St Extension New London, CT 06320	

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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 47402</p> <p>Based on observation, review of facility policy, and interviews for one sampled resident (Resident #33) reviewed for dignity, the facility failed to provide care and speak to the resident in a dignified manner. The findings include:</p> <p>Resident #33's diagnoses included unspecified dementia, personal history of traumatic brain injury, and Asperger's syndrome.</p> <p>The quarterly MDS assessment dated [DATE] identified Resident #33 had moderately impaired cognition, utilized a manual wheelchair, was dependent for eating, oral hygiene, toileting, bathing, personal care, and dressing.</p> <p>Resident #33's care plan dated 6/4/24 identified an ADL (activities of daily living) self-care performance deficit and noted the resident required assistance, had poor motivation, cognitive impairments, weakness, and kyphosis with interventions that directed: provide privacy for all care, encourage resident to assist with care, anticipate needs.</p> <p>Observation on 7/2/24 at 5:20 AM identified NA#1 providing morning hygiene care to Resident #33 with the door to the resident's room in the open position. The resident was lying in the bed closest to the door on his/her right side with a full-frontal view of the naked body visible from the hallway. The curtain in the room was present but not closed. Resident #33 repeated I smell the smell, four times. NA #1 replied to the resident in a frustrated manner, that's your ass (inserted Resident's #33's first name), that's your ass, that's your ass (inserted Resident #33's first name), that's your ass. This was repeated three times. NA#1 then visualized the surveyor and closed the door to the room.</p> <p>Interview on 7/2/24 at 6:25 AM with NA #1 identified the door should have been closed during care and he should have provided privacy and that the comment to Resident #33 just came out, and that he should not have said it to the resident and that he should have spoken to the resident with respect.</p> <p>Interview on 7/2/24 at 6:38 AM with LPN#1 identified privacy should always be given to the resident and if the door was not closed the curtain should have been drawn, as well as the way in which NA#1 spoke to Resident #33 was verbal abuse and it needed to be reported immediately to the supervisor.</p> <p>(continued on next page)</p>

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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 7/2/24 6:45 AM LPN#1 found RN#1 to make the report with Corporate Director RN#4, Administrator and surveyor present. Corporate RN #4 reported that she would immediately suspend NA#1 pending investigation, start retraining immediately, and make a report to FLIS (Facility Licensing and Investigations Section.)</p> <p>Interview with RN#1 on 7/2/24 at 6:55 AM identified the curtain should have been draw if the door was not closed for care of the resident, as well as an introduction should be made when you walk into the room and knocking on the door and that no matter whether the person was alert or oriented or confused NA#1 should not have spoken to the resident like that and that he should have spoken to the resident with dignity, respect and provided privacy.</p> <p>Review of facility policy titled Quality of Life Dignity Revised 2009 directed residents shall be treated with dignity and respect at all times. Staff shall speak respectfully to residents at all times. Staff shall promote maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures.</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 46117</p> <p>Based on clinical record review, facility documentation review, facility policy review, and interviews for two of three sampled residents (Resident #16 and Resident #43) reviewed for significant change in condition, the facility failed to notify the physician when the residents experienced a significant changes in condition. The findings include:</p> <p>1. Resident #16 's diagnoses included chronic anemia secondary to blood loss, cirrhosis of the liver, chronic kidney disease, gastroesophageal reflux disease (GERD), abdominal hernia, atrial fibrillation, heart failure, and congenital malformation of heart.</p> <p>The quarterly MDS assessment dated [DATE] identified Resident #16 was cognitively intact, required limited assistance for toileting, dressing, and hygiene, was independent with bed mobility, transfers, and was ambulatory with a rolling walker.</p> <p>The care plan dated [DATE] identified Resident #16 had a gastro-intestinal problem related to an abdominal hernia and GERD. Care plan interventions directed to observe and document gastro-intestinal (GI) condition and frequency, duration, aggravating and/or alleviating factors, treat GI symptoms, administer medications as ordered, report to the physician when there is a change of condition, and follow diet as prescribed.</p> <p>The nurse's note dated [DATE] at 9:48 PM identified Resident #16 complained of generalized abdominal pain, refused pain medication when first offered and vomited a tiny amount of liquid. The note further identified Resident #16 accepted Tramadol 50 mg (analgesic pain medication) at 9:53 PM.</p> <p>APRN #1's progress note dated [DATE] identified Resident #16 was evaluated related to an acute onset of nausea and vomiting with decreased appetite. The assessment identified Resident #16 denied abdominal pain, diarrhea and/or constipation, and did not have a fever or chills. The note further identified Resident #16 vomited undigested food three times, APRN #1 ordered an abdominal KUB (Kidney, Ureter, and Bladder) x-ray, abdominal ultrasound (diagnostic imaging to visualize organ), and nothing by mouth after midnight in preparation for the abdominal ultrasound scheduled for the following day. Further, the note identified that APRN #1 also ordered a clear liquid diet, monitor bowel movements and abdominal assessment every shift for nausea/vomiting for 2 days, and Zofran 4 mg (anti-emetic medication) by mouth every 4 hours as needed for nausea/vomiting, encourage oral hydration, obtain CBC (Complete Blood Count) and CMP (Comprehensive Metabolic Panel), and monitor for signs and symptoms of infection, bleeding or worsening conditions.</p> <p>The nurse's note dated [DATE] for the ,d+[DATE] shift failed to identify that an abdominal assessment was completed as ordered. The note also did not identify whether or not the resident had any of the following: signs and symptoms of infection, bleeding and/or worsening symptoms.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>The nurse's note dated [DATE] at 7:47 AM written by RN #1 identified Resident #16 vomited a small amount of bile yellow/green emesis at approximately 12:00 AM; Zofran 4 mg was administered with good effect. The note further identified Resident #16 was pale, complained of abdominal pain upon palpation, noted a large mass, firmness and tenderness to the left lower quadrant, bowel sounds positive in all four quadrants. In addition, the note identified Resident #16 had had a large bowel movement on [DATE] and did not have a fever.</p> <p>The nurse's note dated [DATE] at 10:20 AM written by RN #2 identified Resident #16 was on a clear liquid diet, alert/oriented with no mental changes, no signs and symptoms of cardiopulmonary distress. It further identified Resident #16 complained of abdominal discomfort and nausea. The KUB x-ray was obtained, and the result was negative, APRN #1 was updated with the results. The ultrasound technician arrived at the facility at 10:10 AM to do the abdominal ultrasound to rule out hernia. Resident #16's bowel sounds were positive, and no signs of rebound tenderness was noted.</p> <p>The nurse's note dated [DATE] at 2:40 PM written by LPN #3 identified Resident #16 had a fever of 100.9 degrees Fahrenheit in the morning, Tylenol (anti-reducer fever medication) was administered and Resident #16's body temperature reduced to 98.7 degrees Fahrenheit. The note further identified the resident's white blood cell count (WBC) was elevated and intravenous (IV) fluid of dextrose-sodium chloride (NACL) , d+[DATE].45 for hydration was ordered and infused at 75 milliliters (ml) per hour to the left forearm. Further, Resident #16 was clammy with cold sweats and oxygen saturation was 87 percent (normal range is 95% to 100%) oxygen at 2 liters per minute via nasal cannula was administered. Resident #16 had no appetite, did not eat lunch but accepted 240 milliliters of apple juice. No nausea and vomiting, heart rate slightly elevated at 112 per minute prior administering medication, APRN #1 made aware of the findings.</p> <p>APRN #1's progress note dated [DATE] identified Resident #16 was seen for follow-up related to nausea/vomiting and decreased appetite. The note further identified Resident #16 was tolerating the clear liquid diet, denied abdominal pain, diarrhea or constipation. The abdominal KUB and abdominal ultrasound were unremarkable. The nursing staff was updated with treatment plan and to monitor loosely for any changes in condition. Resident #16 had a poor appetite and slight acute kidney injury. APRN #1 ordered IV for hydration. change IV site every 72 hours, change IV dressing with each site change and as needed, to administer dextrose-NACL solution ,d+[DATE].45 percent at 75 milliliters(ml) per hour via IV every shift for elevated BUN for 3 days, monitor vital sign every 4 hours for GI distress for 2 day.</p> <p>The nurse's note dated [DATE] at 7:28 PM identified Resident #16 was alert to self only, had shortness of breath, labored breathing and was on oxygen at 2 liters via nasal cannula. It further noted Resident #16 had complaints of pain and discomfort, had active bowel sounds in all quadrants, a low-grade fever of 100.6 and Tylenol 650 mg was administered. Further, the RN supervisor was called to assess the changes in Resident #16's condition.</p> <p>The nurse's note dated [DATE] at 8:03 PM written by RN #4 (,d+[DATE] nursing supervisor) identified Resident #16 pulled out his/her peripheral IV. RN#4 replaced with 22 gauge in the left lower arm and resumed the dextrose-NACL solution ,d+[DATE].45 percent infusing at this time at 75 ml per hour to the left lower arm.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview and medical record review with MD#1 (Medical Director) on [DATE] at 12:10 PM identified Resident #16 had multiple co-morbid medical diagnoses that put the resident at high risk for sudden death. He identified that he was notified of the sudden death of Resident #16 the following morning when he was at the facility. MD#1 also identified that if he had witnessed the onset of the resident's new signs/symptoms of fever, oxygen desaturation, SOB/labored breathing and elevated heart rate, despite the negative abdominal KUB and ultrasound, he would have sent the resident out to the hospital at the time because there currently was no known cause of the resident's condition. MD#1 could not identify whether the outcome would be different because of Resident #16's medical co-morbid diagnoses. He identified that he would not have continued to monitor the resident's condition in the facility when the resident continued to develop new symptoms. He further identified that he was not notified when Resident #16' clinical condition worsened.</p> <p>Interview with RN #4 (,d+[DATE] shift supervisor) on [DATE] at 3:30 PM identified Resident #16 was not feeling well, had nausea and vomiting and aware he need to monitor resident's condition and assessed resident abdomen. He identified that he last saw the resident at approximately 6:30 PM in the room with the HOB elevated. He identified that Resident #16 had pulled the IV line out and he started a new IV line and resumed the dextrose-NACL ,d+[DATE].45 percent at 75 ml per hour. He also identified that he was aware of Resident #16's low grade fever, but he was not aware of the SOB and labored mouth breathing of the resident. He identified that he did not do the physical assessment of the resident, but only visually observed the resident and did not note any respiratory distress. He further identified that he should have done a physical assessment of the condition of the resident rather than only visually observing.</p> <p>The Change in a Resident's Condition or Status policy identified that the facility would promptly notify the resident's, attending physician and representatives of the changes in the resident's condition. The policy also identified that the prior to notifying the physician, the nurse would make a detailed observations and gather relevant pertinent information for the provider.</p> <p>2. Resident #43's diagnoses included congestive heart failure (CHF), diabetes, and dementia.</p> <p>A physician's order dated [DATE] directed obtain weekly weights for four weeks then monthly.</p> <p>The Quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #43 was severely cognitively impaired, required moderate assistance with eating and extensive assistance of 2 persons with transfers and toileting.</p> <p>The Resident Care Plan (RCP) dated [DATE] identified Resident #43 with Congestive Heart Failure. Interventions included diuretic use (Lasix), fluid restrictions, lab work as ordered, monitoring, documenting, and reporting to the provider any signs and symptoms of CHF such as dependent edema of legs and feet, periorbital edema, shortness of breath upon exertion and weight gain unrelated to intake.</p> <p>Review of Resident #43's clinical record identified that he/she weighed 165.8 Lbs. on [DATE]; 160.0 Lbs. on [DATE]; 161.2 Lbs. on [DATE]; 196.3 Lbs. on [DATE]; 197.4 Lbs. on [DATE]; 196.5 Lbs. on [DATE]; 171.0 Lbs. on [DATE]; and 168.5 Lbs. on [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Further review of Resident #43's clinical record identified that he/she gained 35.1 Lbs. between [DATE] (161.2 Lbs.) and [DATE] (196.3 Lbs.). Additionally, the clinical record did not indicate whether Resident #43 was re-weighed, and/or physician notification of the significant weight gain.</p> <p>A physician's order in effect on [DATE] directed to administer Torsemide (diuretic) 20mg by mouth daily.</p> <p>A physician's order dated [DATE] directed to administer Torsemide 10mg by mouth daily.</p> <p>A physician's order dated [DATE] directed to administer Torsemide 20mg daily for bilateral lower edema for increased edema with reduction in dose.</p> <p>A physician's order dated [DATE] directed to obtain daily weights for 7 days for weight gain.</p> <p>An interview with APRN #1 on [DATE] at 1:00 PM identified that monitoring of weights was required for Resident #43 due to CHF and concerns of signs of fluid overload. APRN #1 stated that even though she was not employed at the facility at that time, Resident #43 should have been reweighed, physically assessed and the diuretic (water pill) order readjusted. APRN #1 confirmed after record review that the previous APRN was not notified when Resident #43 gained 35.1 Lbs. within 2 weeks.</p> <p>An interview and record review with LPN #3 on [DATE] at 9:50 AM identified that he/she documented resident #43's weight in the computer on [DATE] after obtaining the weight from a Certified Nurse Assistant (CNA). LPN #3 stated that she did not notice that Resident #43 had gained 35.1 Lbs. within 2 weeks. LPN #3 stated that that Resident #43 should have been reweighed within a day to verify the weight and physician notified due to significant weight gain based on the facility's weight policy. LPN #3 stated that the dietician should have noted the significant weight gain and requested for Resident #43 to be re-weighed since he/she is responsible for monitoring weights.</p> <p>Interview with the Dietician on [DATE] at 10:50 AM identified that he/she monitors weights weekly assisted by the Director of Nursing (DNS). In addition, the Dietician identified that he/she normally makes a list of residents that need to be weighed and gives it to the nurse and any weight changes of 3 pounds should be re-weighed within 24 hours and physician notified. The Dietician also identified that weight issues are normally discussed during weekly risk meetings attended by the DNS, Assistant Director of Nursing, (ADNS), MDS nurse and the Medical Director, (MD).</p> <p>Interview and clinical record review with the Dietician on [DATE] at 12:30 PM failed to identify that Resident #43 was reweighed after a significant weight gain on [DATE]. The Dietician stated that he/she was on bereavement leave during this time and could not address the issue but identified that there was potential need for the doctor to address Resident #43's weight gain due to CHF concerns. The dietician further stated that upon her return from the bereavement leave, she did not address Resident #43's weight issue or notify the physician because he/she thought the wheel chair could have added to the Resident #43's weight. She also identified that she found it difficult to address issues with the previous providers because they were not approachable.</p> <p>(continued on next page)</p>		

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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Re-interview, clinical record review, review of work attendance and weekly risk meeting logs/record review with the Dietician on [DATE] at 2:00 PM identified that he/she was only away for one week (.d+[DATE]-, d+[DATE]) he/she acknowledged that attended weekly risk meetings on [DATE], [DATE] and [DATE] but failed to address Resident #43's significant weight gain until [DATE] when she documented the on the issue and recommended daily weights for 7 days to reestablish baseline. Resident #43's re-weight weight was 197.4 Lbs. on [DATE] and 196.5 on [DATE].</p> <p>Interview and clinical record review with the DNS on [DATE] at 12:00PM, identified that CNA's normally weigh the patient and the nurse documents the weight. The DNS further identified that in case there is a difference of 3 pounds or more from the most recent weight, the nurse should instruct the CNA to reweigh the resident. In addition, the DNS identified that the dietician is responsible for monitoring residents' weights and that weight issues are discussed during weekly risk meetings and monthly in QAPI meetings. The DNS was unable to explain why Resident #43 was not re-weighed, physician notified, or Resident #43's weight discussed in weekly risk meetings.</p> <p>Interview with MD#1 on [DATE] at 12:30 PM identified that he/she had not been notified of Resident #43's 35.1 Lbs. weight gain on [DATE]. MD #1 stated that had he been notified, he/she would have requested Resident #43 be re-weighed with a verified scale. In addition, MD #1 identified that he/she would have physically assessed the resident to determine the cause of weight gain. MD #1 further stated that weight gain could have contributed to patient's lower leg edema that was reported in clinical record on [DATE].</p> <p>Further review of facility's weight policy identified, in part, that each resident will be weighed upon admission, weekly for 4 weeks and monthly or more frequently if deemed necessary by the interdisciplinary team. An appropriate type of scale to weigh the resident will be determined by the resident's physical condition. If a resident has a 3 pound or more difference from the most recent weight, the scale shall be re-zeroed, and weight taken again to confirm accuracy. A licensed nurse will be requested to verify and re-weigh the resident within 24 hours for accuracy and documentation purposes. If verification of weight change indicates significant weight change, the physician and registered dietician will be notified, and appropriate interventions put in place.</p> <p>50250</p>		

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<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47402</b></p> <p>Based on observation, interviews, and review of facility policy for one of one sampled resident, (Resident #33) observed for personal care, the facility failed to provide privacy for the resident while receiving care. The findings include:</p> <p>Resident #33's diagnoses included unspecified dementia, personal history of traumatic brain injury, and Asperger's syndrome.</p> <p>The quarterly MDS assessment dated [DATE] identified Resident #33 had moderately impaired cognition, utilized a manual wheelchair, was dependent for eating, oral hygiene, toileting, bathing, personal care and dressing.</p> <p>Resident #33's care plan dated 6/4/24 identified an ADL (activities of daily living) self-care performance deficit and noted the resident required assist for thoroughness, had poor motivation, cognitive impairments, weakness, impaired gait, weakness and kyphosis.</p> <p>Care plan interventions directed: one for care if in bed, provide privacy for all care, encourage resident to assist with care, anticipate needs.</p> <p>Observation on 7/2/24 at 5:20 AM NA#1 was providing morning hygiene care to Resident #33. The door was open, and the resident was lying in the bed closest to the door on his/her right side with a full-frontal view of the naked body visible from the hallway. The curtain in the room was present but not closed. Resident #33 repeated I smell the smell, four times. NA #1 replied to the resident in a frustrated manner, that's your ass (inserted Resident's #33's first name), that's your ass, that's your ass (inserted Resident #33's first name), that's your ass. This was repeated three times. NA#1 then visualized the surveyor and closed the door to the room.</p> <p>Interview on 7/2/24 at 6:25 AM with NA #1 identified the door should have been closed during care and he should have provided privacy, and the curtain should have been drawn if the door was not closed.</p> <p>Interview on 7/2/24 at 6:38 AM with LPN#1 identified privacy should always be given to the resident and if the door was not closed the curtain should have been drawn, and it needed to be reported immediately to the supervisor.</p> <p>Interview with RN#1 on 7/2/24 at 6:55 AM identified the curtain should have been draw if the door was not closed for care of the resident, as well as an introduction should be made when you walk into the room and knocking on the door and that no matter whether the person was alert, or oriented or confused NA#1 should have provided privacy.</p> <p>Review of facility policy titled Quality of Life Dignity Revised 2009 directed staff shall promote maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures.</p>		

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NAME OF PROVIDER OR SUPPLIER  Harbor Village North Health and Rehabilitation Cen		STREET ADDRESS, CITY, STATE, ZIP CODE 78 Viets St Extension New London, CT 06320	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0603</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Protect each resident from separation (from other residents, his/her room, or confinement to his/her room).</p> <p>47489</p> <p>Based on observations, review of clinical records, review of the facility assessment and interviews for thirty-eight sampled residents (R#2, R#9, R#10, R#15, R#23, R#25, R#26, R#28, R#31, R#33, R#41, R#45, R#53, R#60, R#65, R#68, R#71, R#73, R#74, R#75, R#76, R#81, R#82, R#83, R#89, R#91, R#92, R#94, R#95, R#98, R#101, R#102, R#103, R#105, R#106, R#108, R#112 &amp; R#318) residing on the secured dementia unit (South unit) of the total census of 115, the facility failed to assess, care plan, demonstrate that the secured unit was the least restrictive setting, and obtain consents for residents who were selected to reside on the secured unit. The findings include:</p> <p>Observations during all days of the survey June 26th, July 1, 2, 3, 8 &amp; 9, 2024 identified the secured unit (South Unit) located on the first floor had double doors that bordered the center unit that required a number code to be punched into the key pad in order for the doors to open. The unit also contained an exit in the southwest end of the hallway where there was an emergency exit and on the southeast corner of the unit that had an emergency exit. The codes to the doors to enter and exit the secured unit were provided to the survey team on the first day of survey 6/26/2024. Intermittent observations on all days of the survey identified only the staff inputting the code and moving through the doors and opening the doors for visitors to enter or leave.</p> <p>Review of the Facility Assessment on 7/2/24 identified the facility had a secure dementia unit located on the main floor, the South Unit. The assessment described the unit as a secured dementia unit, located on the South East and South [NAME] units of the facility. The Assessment did not include criteria, planning, or specific function of the unit.</p> <p>Interview with the Corporate Director for Clinical Services (RN#5) and the Administrator on 7/2/24 at 1:00 PM identified there were 40 residents on the unit. 37 residents have dementia diagnoses and 3 do not have diagnoses of dementia but have schizoaffective or other psychological diagnoses. Although the facility assessment states secured dementia unit, the administration identified it is a secured unit but is not dementia specific and residents placed on this unit are not care planned for a secured unit.</p> <p>Review of the clinical records of each of the thirty-eight residents residing on the secured unit failed to identify the following:</p> <p>Failed to identify that consent had been obtained from the responsible party for the resident to reside on a secured unit.</p> <p>Failed to identify physician's orders directing the need and/or purpose for the resident being placed on a secured unit.</p> <p>Failed to demonstrate that the secured unit was the least restrictive setting.</p> <p>The care plans did not reflect that the resident's resided on a secured unit or that they and/or their responsible party were in agreement with the resident's placement.</p> <p>(continued on next page)</p>		

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<p>F 0603</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview with the Administrator on 7/8/2024 at 9:30 AM identified that the secured unit was not a certified dementia unit and that the facility did not have criteria for placement. The decision to place a resident on the unit was based on diagnoses or family (conservator) requests. There is not a process for assessment, nor does the doctor write an order or approve a resident's placement.</p> <p>Interview with RN#5, the Administrator, Social Worker #1, and the dementia unit Program Director (RN #6) on 7/9/24 at 10:30 AM identified the facility does have a secured unit that does house dementia residents. Dementia residents are also housed in other units of the facility. The facility does not have any criteria for admission/placement on the secured unit. Admission is usually discussed interdisciplinary approach but there are no criteria or guidelines for placement. Additionally, there are no re-assessments to determine if the placement is appropriate or the least restrictive approach for the resident. There were no evaluations, no consents, nor permissions for placement on the secured unit.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47489</b></p> <p>Based on observation, review of the clinical record, and interviews for one sampled resident (Resident #39) reviewed for activities of daily living, the facility failed to provide the necessary services to maintain good grooming and personal care related to toenail care. The finding includes:</p> <p>Resident #39's diagnoses included injury of the lumbar spinal cord, sequela, and paraplegia.</p> <p>The treatment administration record for April, May, and June 2024 identified that body assessments and weekly skin checks were completed on shower days.</p> <p>The quarterly MDS assessment dated [DATE] identified Resident #39 had intact cognition, and an impairment on both sides to the upper and lower body and used a wheelchair.</p> <p>Physician's orders dated 6/10/2024 directed for podiatry, audiology, dental, and ophthalmology consults as needed.</p> <p>The care plan dated 5/17/2024 identified Resident #39 had a self-care and mobility performance deficit and needed assistance with hygiene and mobility related to the resident's diagnoses. The care plan interventions identified the resident's ability fluctuated day to day and throughout the course of the day and identified the resident's lower leg edema made legs heavy and difficult to move independently. Interventions identified staff assisted with lower body care as needed and that the resident wore a right brace (afo) as scheduled. Resident #39 preferred to stay in bed but would be encouraged to get out of bed daily.</p> <p>Review of the physician's orders dated 6/10/2024 identified the resident may receive physical therapy, occupational therapy, and speech therapy evaluate and treat as indicated, Braden scale monthly.</p> <p>Observation and interview with Resident #39 on 6/26/2024 at 10:50 AM identified the resident seated in bed, dressed with an afo on the right foot and black sneakers in place. Resident #39 stated he/she was having pain in his/her toes related to the toenails being long. The resident removed the left sneaker without assistance and identified two toenails on the 2nd and 3rd digits that had grown over the end of the toes. The resident identified that the podiatrist attends to the feet regularly but doesn't do much. Observation of the toes on the left foot identified the 2nd through 5th digits are contracted and the middle proximal phalangeal joint is raised and prominent. The skin on the toes is purple in color and appears glossy. The toenails are thickened, yellowed, and brittle with the 2nd and 3rd toenails grown out and curved over the end of the toes.</p> <p>Interview and observation with Resident #39 on 7/8/2024 at 2:00 PM identified the resident had, in place, an afo on the right foot with black boots in place. NA #2 removed the sneakers, socks, and afo for visualization of the toes and toenails. The resident identified the end of the toes were painful at times. The toes are contracted, the skin is peeling and flakes off with removal of the socks. The toenails are yellow, brittle, thickened, flaking, and long with three of the nails wrapping over and around the end of the toes. Interview with NA#2 identified the facility provides shower care but does not provide specific foot care and the resident is seen by the facility podiatrist.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the clinical chart identified the resident had been seen by the visiting podiatrist on 5/5/2024, 3/5/2024, 12/15/2023, 10/11/2023, 8/28/2023, 7/10/2023, 5/10/2023, 2/24/2023, 11/18/2022, 9/12/2022, 4/15/2022, 2/13/2022, 12/15/2021, 8/15/2021, 6/16/2021, 4/15/2021.</p> <p>Review of the podiatrist treatment notes from visits dated 5/5/24, 3/5/24, 12/15/2023, 10/11/23, 7/10/23, and 5/10/23 identified the resident had bilateral hammertoes on the 2nd, 3rd, 4th, and 5th digits. Identification of the nails prior to treatment on each of the visits identified all nails bilaterally were elongated, discolored, mycotic, thick, yellow, lytic, with subungual debris, and had a thickness of 5 mm. All progress notes identified non-professional treatment of patient's feet is hazardous to patient's podiatric care. Patient's nails are debrided to prevent ingrown nails and promote proper podiatric care. Treatment identified on all visits was all 10 nails debrided without incident and identified that anti-fungal treatment was contra-indicated and nails were reduced in length and Thickness to either 3mm or 2mm with the method of reduction being manual. There is no documentation that Resident #39 had refused any type of care.</p> <p>Interview with the Podiatrist on 7/8/2024 at 12:45 PM identified that she did not recollect the resident, but answered questions based on her documented notes. The resident had fungal nails that were debrided. She is not able to prescribe the anti-fungal medication because it is the medical doctors' responsibility to prescribe oral anti-fungal medications, but she identified she would not make a referral for oral medication because of the age of most of the residents she sees, and co-morbidities. The podiatrist identified that the debridement would address the length of some nails. Additionally, since the resident is bedbound, the length of the nail is less concerning and doesn't interfere with daily activity.</p> <p>Review of the facility Foot Care Policy identified the residents will receive appropriate care and treatment in order to maintain mobility and foot health. The policy identified that residents with foot disorders or medical conditions associated with foot complications will be referred to qualified professionals. And that overall foot care will include the care and treatment in accordance with professional standards of practice.</p> <p>Review of the Healthcare Service agreement between the facility and the Podiatry Group identified the provider shall provide resident care and treatment, in accordance with the highest professional standards.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46117</b></p> <p>Based on clinical record review, facility documentation review, facility policy review, and interviews for two of three residents (Resident #16 and Resident #43) reviewed for change in condition and change in weight, the facility failed to consistently monitor and assess residents for worsening health condition and failed to assess a significant weight gain. The findings include:</p> <p>1. Resident #16 's diagnoses included chronic anemia secondary to blood loss, cirrhosis of the liver, chronic kidney disease, gastroesophageal reflux disease (GERD), abdominal hernia, atrial fibrillation, heart failure, and congenital malformation of heart.</p> <p>The quarterly MDS assessment dated [DATE] identified Resident #16 had no cognitive impairments, required limited assistance for toileting, dressing, and hygiene, was independent with bed mobility, transfers, and was ambulatory with a rolling walker.</p> <p>The care plan dated [DATE] identified Resident #16 had a gastro-intestinal problem related to abdominal hernia and GERD. Care plan interventions directed to observe and document Gastro-Intestinal (GI) condition and frequency, duration, aggravating and/or alleviating factors, treat GI symptoms, administer medications as ordered, report to the physician when there is a change of condition, and follow diet as prescribed.</p> <p>The nurse's note dated [DATE] at 9:48 PM identified Resident #16 complained of generalized abdominal pain, refused pain medication when first offered and vomited a tiny amount of liquid. The note further identified Resident #16 accepted Tramadol 50 mg (analgesic pain medication) at 9:53 PM. Additionally the note identified the medication was effective.</p> <p>APRN #1's progress note dated [DATE] identified Resident #16 was evaluated related to an acute onset of nausea and vomiting with decreased appetite. The assessment identified Resident #16 denied abdominal pain, diarrhea and/or constipation, and did not have a fever or chills. The note further identified Resident #16 vomited undigested food three times, APRN #1 ordered an abdominal KUB (Kidney, Ureter, and Bladder) x-ray, abdominal ultrasound (diagnostic imaging to visualize organ), and nothing by mouth after midnight in preparation for the abdominal ultrasound scheduled for the following day. Further, the note identified that APRN #1 also ordered a clear liquid diet, to monitor bowel movements and abdominal assessment every shift for nausea/vomiting for 2 days, and Zofran 4 mg (anti-emetic medication) by mouth every 4 hours as needed for nausea/vomiting, encourage oral hydration, obtain CBC (Complete Blood Count) and CMP (Comprehensive Metabolic Panel), and monitor for signs and symptoms of infection, bleeding or worsening conditions</p> <p>The nurse's note dated [DATE] at 3:15 PM identified Resident #16 was alert, oriented, tolerated medications, and took fluids. It further noted Resident #16 had an episode of vomiting at approximately 7:15 AM and was administered Zofran 4 mg by mouth with good effect and no further vomiting was noted. Resident #16 did not express complaints of pain.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The nurse's note dated [DATE] at 3:25 PM written by RN#2 (.d+[DATE] shift nursing supervisor) identified Resident #16 had nausea/vomiting at breakfast time. APRN #1 was made aware and new orders were obtained and directed to start a clear liquid diet, monitor bowel movements and perform abdominal assessments, abdomen KUB x-ray, abdomen ultrasound, Zofran 4mg as needed and it was administered with good effect. No further vomiting was noted for the remainder of the shift.</p> <p>The nurse's note dated [DATE] for the .d+[DATE] shift failed to identify that an abdominal assessment was completed as ordered. The note also did not identify whether or not the resident had any of the following: signs and symptoms of infection, bleeding and/or worsening symptoms.</p> <p>The nurse's note dated [DATE] at 7:47 AM written by RN #1 identified Resident #16 vomited a small amount of bile yellow/green emesis at approximately 12:00 AM; Zofran 4 mg was administered with good effect. The note further identified Resident #16 was pale, complained of abdominal pain upon palpation, noted a large mass, firmness and tenderness to the left lower quadrant, bowel sounds positive in all four quadrants. In addition, the note identified Resident #16 had had a large bowel movement on [DATE], did not have a fever.</p> <p>The nurse's note dated [DATE] at 10:20 AM written by RN#2 identified Resident #16 was on a clear liquid diet, alert/oriented with no mental changes, no signs and symptoms of cardiopulmonary distress. It further identified Resident #16 complained of abdominal discomfort and nausea. The abdomen KUB x-ray was obtained, and the result was negative, APRN #1 was updated with the results. The ultrasound technician arrived at the facility at 10:10 AM to do the abdominal ultrasound to rule out hernia. Resident #16's bowel sound were positive, and no signs of rebound tenderness was noted.</p> <p>The nurse's note dated [DATE] at 2:40 PM written by LPN #3 identified Resident #16 was arousable in the morning and continued with nothing by mouth until the abdominal ultrasound was obtained. Resident #16 had a fever of 100.9 degrees Fahrenheit in the morning, Tylenol (anti-reducer fever medication) was administered and Resident #16's body temperature reduced to 98.7 degrees Fahrenheit. The note further identified the resident's white blood cell count (WBC) was elevated and intravenous (IV) fluid of dextrose-sodium chloride (NACL) .d+[DATE].45 for hydration was ordered and infused at 75 milliliters (ml) per hour to the left forearm. Further, Resident #16 was clammy with cold sweats and oxygen saturation was 87 percent (normal range is 95% to 100%) oxygen at 2 liters per minute via nasal cannula was administered. Resident #16 had no appetite, did not eat lunch but accepted 240 milliliters of apple juice. No nausea and vomiting, heart rate slightly elevated at 112 per minute prior administering medication, APRN #1 made aware of the findings.</p> <p>APRN #1's progress note dated [DATE] identified Resident #16 was seen for follow-up related to nausea/vomiting and decreased appetite. The note further identified Resident #16 was tolerating the clear liquid diet, denied abdominal pain, diarrhea or constipation. The abdominal KUB and abdominal ultrasound were unremarkable. The nursing staff was updated with treatment plan and to monitor loosely for any changes in condition. Resident #16 had a poor appetite and slight acute kidney injury. APRN #1 ordered IV for hydration. change IV site every 72 hours, change IV dressing with each site change and as needed, to administered dextrose-NACL solution .d+[DATE].45 percent at 75 milliliters(ml) per hour via IV every shift for elevated BUN for 3 days, monitor vital sign every 4 hours for GI distress for 2 day.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The nurse's note dated [DATE] at 7:28 PM identified Resident #16 was alert to self, had shortness of breath, labored breathing and was on oxygen at 2 liters via nasal cannula. It further noted Resident #16 had complaints of pain and discomfort, had active bowel sounds in all quadrants, a low-grade fever of 100.6 and Tylenol 650 mg was administered. Further, the RN supervisor was called to assess the changes in Resident #16's condition.</p> <p>Review of the clinical record failed to identify an RN assessment of Resident #16's worsening condition related to the new onset of altered mental condition, shortness of breath and labored breathing. There was also no documentation identifying that APRN #1 was notified of the changes in the resident's condition.</p> <p>The nurse's note dated [DATE] at 8:03 PM written by RN #4 (.d+[DATE] nursing supervisor) identified Resident #16 pulled out his/her peripheral IV. RN#4 replaced with 22 gauge in the left lower arm and resumed the dextrose-NACL solution .d+[DATE].45 percent infusing at this time at 75 ml per hour to the left lower arm.</p> <p>The nurse's note dated [DATE] at 1:00 AM written by RN#1 (.d+[DATE] shift nursing supervisor) identified Resident #16 was pale and jaundice with open mouth labored breathing, and unresponsiveness. Resident #16 was placed on a non-rebreather mask with oxygen set at 10 liter per minute and the head of bed was elevated at 90 degrees. Resident #16's oxygen saturation was 85 percent, skin was cool and clammy, and the dextrose-NACL .d+[DATE].45 percent was infusing at 75 ml per hour to the left lower forearm. Resident #16 had started to vomit black liquid emesis and was suction to clear the airway, the radial pulse was thready and weak at 40 beats per minute, and respirations were at 10 beats per minute. 911 emergency service was called and arrived at approximately 1:15 AM and Resident #16 was transferred to the hospital.</p> <p>Interview with LPN #3 (charge nurse for .d+[DATE] shift) on [DATE] at 1:00 PM identified Resident #16 was not feeling well and had been vomiting. On [DATE] during her morning shift, Resident #16 had a fever of 100.9, heart rate slightly elevated at 112, oxygen saturation down to 87% on room air and appeared cool and sweaty. Tylenol was administered and the temperature went down. In addition, she applied Oxygen at 2 liters per minute. She also identified that Resident #16 had no appetite, but he/she was able to drink 240 ml of apple juice. She identified that the abdominal KUB x-ray was negative and was scheduled for an abdominal ultrasound that morning. She further identified that RN# 2 and APRN #1 were made aware of the finding. She also identified that Resident #16 had a new order for dextrose-NACL .d+[DATE].45 percent IV fluid at 75 ml per hour that she already had started.</p> <p>Interview with RN #2 (.d+[DATE] shift nursing supervisor) on [DATE] at 1:20PM identified she was responsible for assessing resident for new change of condition. She identified that she was aware of Resident #16's nausea and vomiting that had started during the .d+[DATE] shift on [DATE]. She also identified that APRN #1 had assessed Resident #16 for nausea and vomiting and Resident #16 had received a medical work-up. She identified that the APRN #1 order abdominal KUB x-ray, abdominal ultrasound, labs for CBC, CMP, Zofran 4 mg by mouth as needed every 4 hour for nausea/vomiting, monitoring for bowel movements and abdominal assessment every shift. She further identified that the abdominal KUB x-ray and abdominal ultrasound were negative, and the WBC was slightly elevated. She identified that when she started at the facility 6 months ago, she used to read the 24-hour report and was also receiving a shift-to-shift verbal report; however, after the former DNS started in the facility, he took over the reading of the 24-hour report summary.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with LPN #6 (.d+[DATE] charge nurse) on [DATE] at 9:30 AM identified he received a report that Resident #16 was not feeling well and was receiving IV fluids. He also identified that Resident #16 had a fever of 100.7 and respirations of 21 that were noted to be labored with mouth breathing. Resident #16 was only alert to self, but his/her baseline mentation was alert/oriented to person, place, and time. He also noted that Resident #16 was sleeping throughout for .d+[DATE] shift, but he/she would open his/her eyes when called upon. He notified RN #4 (.d+[DATE] shift supervisor) and made him aware of Resident #16's fever, mouth and labored breathing and his/her altered mentation.</p> <p>Interview and clinical record review with the ADNS on [DATE] at 11:15 AM identified that the RN would be responsible for assessing residents when there is a change in condition. She would expect the RN to immediately assess and document in the nursing progress note and/or in the Situation, Background, Assessment, and Recommendation (SBAR) form. She identified that she was aware Resident #16 was not feeling well and had nausea and vomiting. Upon clinical review of nursing notes written on [DATE] (new onset of vomiting), she identified the RN did not write a complete assessment. The nurse should have written a complete assessment to identify whether it was due to her chronic condition or acute condition and notified the physician immediately when it was acute. She also expected the resident condition to be monitored at least every shift or more when needed until the symptoms had resolved. She also identified that Resident #16 had multiple co-morbidities that placed the resident at high risk for acute illness. She further identified that Resident #16 had an abdominal KUB x-ray and abdominal ultrasound which were all negative and received IV fluids during his/her acute illness and she felt that the facility did everything they could to monitor the resident.</p> <p>Interview with APRN #1 on [DATE] at 11:45 AM identified that Resident #16 had extensive medical history which included Barrett's esophagus, colon polyps (non-cancerous), chronic constipation, chronic anemia, congenital heart defect and heart failure. She identified that Resident #16 vomited undigested food x 3 episodes during her initial visit with the resident. Her plan of care was to order an abdominal KUB x-ray, abdominal ultrasound, labs CBC, CMP, monitor for bowel movement and serial abdominal assessments. She identified that the abdominal KUB x-ray and abdominal ultra sound were unremarkable, and the WBC was slightly elevated. APRN #1 identified that she was also aware of Resident #16's bilious yellow/green vomit, low grade fever, oxygen desaturation, and elevated heart rate. After receiving these results, APRN #1 decided not to escalate the care and continued to monitor the resident condition within the facility.</p> <p>Review of the clinical record failed to identify an RN assessment of Resident #16's worsening condition related to the new onset of altered mental condition, shortness of breath and labored breathing on [DATE] on the 3:00 to 11:00 PM shift. There was also no documentation identifying that APRN #1 was notified of the changes in the resident's condition prior to the resident being sent to the hospital emergently on [DATE] on the .d+[DATE]AM shift. The resident expired at the hospital.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview and medical diagnoses review with MD#1 (medical director) on [DATE] at 12:10 PM identified Resident #16 had multiple co-morbid medical diagnoses that put the resident at high risk for sudden death. He identified that he was notified of the sudden death of Resident #16 the following morning when he was at the facility. MD#1 also identified that if he had witnessed the onset of the resident's new signs/symptoms of fever, oxygen desaturation, SOB/labored breathing and elevated heart rate, despite the negative abdominal KUB and ultrasound, he would have sent the resident out to the hospital at the time because there currently was no known cause of the resident's condition. MD#1 could not identify whether the outcome would be different because of Resident #16's medical co-morbid diagnoses. He identified that he would not have continued to monitor the resident's condition in the facility when the resident continued to develop new symptoms. He further identified that he was not notified when Resident #16' clinical condition worsened.</p> <p>Interview with RN #3 (.d+[DATE] shift nursing supervisor) on [DATE] at 2:30 PM identified Resident #16 was not feeling well and had episodes of nausea/vomiting. She identified that Resident #16 had vomited a small amount of yellow/green emesis on [DATE] and on abdominal exam had pain upon palpation, a large umbilical hernia and a large mass-like firmness of left lower quadrant. Resident #16 had positive bowel sounds to all quadrants. She did not call the physician when she noted yellow/green emesis and abnormal abdominal and identified it was because this was not a new change in the resident's condition. She was already aware that Resident #16 had been vomiting and the abdominal KUB was negative. She identified there already was an order for Zofran 4 mg in place for that specific reason and she administered the Zofran 4 mg with good effect. Resident #16 also had an abdominal ultrasound scheduled for the morning of [DATE]. The APRN #1 was already aware of the resident's nausea and vomiting. On [DATE], she identified that she assessed Resident #16 at approximately 12:30 AM and noted Resident #16 was sleeping but arousable, the head of the bed was elevated at 90 degrees, and he/she was visibly not in respiratory distress. The skin was pale and yellow and his/her oxygen saturation at 91% at 3 L/min via nasal cannula. RN #3 identified that the yellow skin color was not Resident #16's baseline skin color. She could not provide a reason why she did not call the physician when she noted the skin color change of Resident #16. She further identified that at 1:00 AM she was called into Resident #16's room because he/she had labored breathing. RN #3 noted Resident #16 was unresponsive with jaundiced pale, cool and clammy skin and open mouth labored breathing. The crash cart, AED and oxygen was obtained. She put Resident #16 on a non-rebreather mask set at 10 L/min. She also noted that Resident #16 had vomited black emesis and started to suction the resident to clear the airway. 911 emergency response was called and arrived at the facility at approximately 1:15 AM and took over the resident's care. She further identified that she did not need to administer CPR because Resident #16 continued to have a pulse and shallow breathing.</p> <p>Interview with RN #4 (.d+[DATE] shift supervisor) on [DATE] at 3:30 PM identified Resident #16 was not feeling well, had nausea and vomiting and aware he need to monitor resident's condition and assessed resident abdomen. He identified that he last saw the resident at approximately 6:30 PM in the room with the HOB elevated. He identified that Resident #16 had pulled the IV line out and he started a new IV line and resumed the dextrose-NACL .d+[DATE].45 percent at 75 ml per hour. He also identified that he was aware of Resident #16's low grade fever, but he was not aware of the SOB and labored mouth breathing of the resident. He identified that he did not do the physical assessment of the resident, but only visually observed the resident and did not note any respiratory distress. He further identified that he should have done a physical assessment of the condition of the resident rather than only visually observing.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Change in a Resident's Condition or Status policy identified that the facility would promptly notify the resident's, attending physician and representatives of the changes in the resident's condition. The policy also identified that the prior to notifying the physician, the nurse would make a detailed observations and gather relevant pertinent information for the provider.</p> <p>2. Resident #43's diagnoses included congestive heart failure (CHF), diabetes, and dementia.</p> <p>A physician's order dated [DATE] directed obtain weekly weights for four weeks then monthly.</p> <p>The Quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #43 was severely cognitively impaired, required moderate assistance with eating and extensive assistance of 2 persons with transfers and toileting.</p> <p>The Resident Care Plan (RCP) dated [DATE] identified Resident #43 with Congestive Heart Failure. Interventions included diuretic use (Lasix), fluid restrictions, lab work as ordered, monitoring, documenting, and reporting to the provider any signs and symptoms of CHF such as dependent edema of legs and feet, periorbital edema, shortness of breath upon exertion and weight gain unrelated to intake.</p> <p>Review of Resident #43's documented weights from [DATE] to [DATE] identified the following weights: [DATE] 165.8 Lbs., [DATE] 165.8 lbs., [DATE] 160.0 Lbs., [DATE] 161.2 Lbs., [DATE] 196.3 lbs., [DATE] 197.4 Lbs., [DATE] 196.5 lbs., [DATE] 196.5 Lbs., [DATE] 171.0 Lbs., [DATE] 168.5 Lbs., [DATE] 167.3 Lbs., [DATE] 167.2 lbs., [DATE] 168.5 Lbs., [DATE] 169.1 Lbs. and [DATE] 165.2 Lbs. Review of documented weights in Medical Administration Record (MAR) identified the following weights; [DATE] 197.4 Lbs. and [DATE] 196.5 Lbs.</p> <p>Review of Resident # 43's clinical record identified that he/she gained 35.1 Lbs. between [DATE] (161.2 Lbs. ) and [DATE] (196.3 Lbs.). Further review of clinical record failed to identify that Resident #43 was reassessed by the provider after a significant weigh gain of 35.1 Lbs. on [DATE]. Resident #43 was not reassessed by the provider until [DATE].</p> <p>An interview with APRN #1 on [DATE] at 1:00 PM identified that monitoring of weights was required for Resident #43 due to CHF concerns to monitor for signs of fluid overload. APRN #1 stated that even though she was not employed at the facility at that time, Resident #43 should have been physically reassessed by the provider after significant weight gain, but the physician was not notified.</p> <p>An interview and record review with LPN #3 on [DATE] at 9:50 AM failed to identify that Resident #43 was reassessed by licensed personnel after significant weight gain.</p> <p>Interview and clinical record review with the Dietician on [DATE] at 12:30 PM identified that there was potential need for the doctor to address Resident #43's weight gain due to CHF concerns, but the physician was not notified or Resident #43's weight gain discussed in risk meetings until after [DATE].</p> <p>Interview with MD#1 on [DATE] at 12:30 identified he would have physically reassessed the Resident#43 to determine the cause of weight gain had he been notified on [DATE]. In addition, MD #1 identified that weight gain could have contributed to patient's lower leg edema that was reported in clinical record on [DATE].</p> <p>(continued on next page)</p>		

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F 0684  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Review of facility's Resident change in condition/Notification of change, identified in part, that resident's change in condition will be reported immediately to the Unit Manager or shift Nursing Supervisor. The licensed nurse will assess the resident for signs and symptoms of physical or mental change in condition. If the change in condition is non-emergent the licensed nurse will complete a progress note. Notification of the physician and family will be documented in the progress note and each condition documented on 24-hour report.  50250

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 47402</p> <p>Based on clinical record review, review of facility policy and interviews for two of five sampled residents (Residents #14 &amp; #33) reviewed for unnecessary medication, the facility failed to implement pharmacy review recommendations. The findings include:</p> <p>1. Resident #14's diagnoses included gastro-esophageal reflux disease (GERD), bipolar disorder, and chronic obstructive pulmonary disease (COPD).</p> <p>The admission MDS assessment dated [DATE] identified Resident #14 had intact cognition, independent with toileting hygiene, bed mobility, required supervision with personal hygiene, and utilized a walker.</p> <p>Resident #14's care plan dated 10/31/23 identified Resident #14 utilized pain medication and psychotropic medication with interventions that included observing for potential or possible side effects such as constipation and diarrhea.</p> <p>The physician's order from December 2023 through July 2024 directed Miralax oral packet (Polyethylene Glycol 3350) to give one packet by mouth as needed for constipation.</p> <p>Review of the clinical record and pharmacy notes identified that the pharmacist made recommendations for the following dates: 12/13/23, 1/17/24, 2/14/24, and 3/20/24 identified that the medication regimen was reviewed by the pharmacist and recommendations were made.</p> <p>Review of the pharmacy recommendation obtained from the pharmacist, dated 12/13/2023 identified to clarify Resident #14's as needed (PRN) Miralax order to include a frequency, which the physician/prescriber response section was not completed as to indicate whether they agreed, disagreed or other. Another pharmacy recommendation obtained from a stack of pharmacy recommendation sheets provided by the facility dated 3/20/24 identified to clarify Resident #14's as needed (PRN) Miralax order to include a frequency in which the physician/prescriber response section was completed by APRN #1, which identified a response of agreement with her signature.</p> <p>Review of physician's orders between 12/1/23 to 7/2/24 failed to identify an order for Miralax that clarified the frequency of which the medication should be administered following the pharmacy recommendation and the providers agreement.</p> <p>Interview on 7/2/24 at 1:26 PM with Pharmacy Consultant #1 identified she would email the recommendations to the DNS and ADNS for them to follow up on, but as of last month she now emails them to the now DNS (former ADNS) and the APRN. A report would be provided for the facility indicating which recommendations were still pending, as well as would be discussed at meetings, and a report would be generated to the facility indicating which items had been followed up on and which were outstanding. The Pharmacy Consultant #1 identified she would review the resident's orders to check if a recommendation that was made previously were addressed and if it wasn't, she would add the recommendation again and make a note as the facility had 30 days to act upon the recommendation.</p> <p>(continued on next page)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with the ADNS on 7/2/24 at 2:07 PM indicated they are now (within the past few weeks) emailing the recommendations to the APRN, (APRN #1) to cut out the [NAME], as in the past they were emailed to her and the DNS, and the DNS oversaw them.</p> <p>Interview with APRN #1 on 7/2/24 at 2:31 PM identified she started in February of 2023, and the then DNS would give the pharmacy recommendations to the APRN to address. APRN #1 added that she would input the orders herself as they were to be addressed by the 15th of the month. APRN #1 identified that it was her signature on Resident 14's pharmacy recommendation sheet dated 3/20/24 and the order got missed by her as she typically input the orders in the electronic medical record system. She added that she would sign and return the pharmacy recommendation to the DNS, and they would forward it back to the pharmacy that they were addressed. APRN #1 added that Miralax is typically administered daily and if given more than the prescribed frequency it could result in the resident having diarrhea.</p> <p>Review of the facility policy titled Medication Monitoring Medication Regimen Review and Reporting dated 1/24 directed the findings of the Medication Regimen Reviews (MRR) to be communicated to the director of nursing or designee and the medical direction. These findings are documented and filed with the other consultant pharmacist recommendations in the resident's chart. Resident-specific MRR recommendations and findings are documented and acted upon by the nursing care center and/or the physician. The nursing care center follows up on the recommendations to verify that appropriate action has been taken. Recommendations should be acted upon within 30 calendar days or per facility specific protocols. For those issues that require physician intervention, the attending physician either accepts and acts upon the report and recommendation or rejects all or some of the report and should document his or her rationale of why the recommendation is rejected in the resident's medical record.</p> <p>2. Resident #33's diagnoses included unspecified dementia, unspecified psychosis not due to a substance or known physiological condition, and Asperger's syndrome.</p> <p>The annual MDS assessment dated [DATE] identified Resident #33 had moderately impaired cognition, utilized a manual wheelchair, was dependent for eating, oral hygiene, toileting, bathing, personal care and dressing.</p> <p>Resident #33's care plan dated 3/20/24 indicated resident utilized Psychotropic medications.</p> <p>Care plan interventions directed: ortho bp's as ordered, administer medications as ordered. Observe/document for side effects and effectiveness.</p> <p>Review of the pharmacy recommendation dated 3/21/24 indicated: Resident #33 had an order for Seroquel which may cause orthostatic hypotension. Please monitor orthostatic BP weekly x 4 weeks and then monthly thereafter. With a Physician/Prescriber response of AGREE signed and dated 3/15/24.</p> <p>Review of the pharmacy recommendation dated 5/16/24 indicated: Resident #33 had an order for Seroquel which may cause orthostatic hypotension. Please monitor orthostatic BP weekly x 4 weeks and then monthly thereafter. With a Physician/Prescriber response of AGREE signed and dated 6/10/24.</p> <p>Review of Resident #33's vitals reviewed between the time of 3/21/24 and 6/30/24 failed to identify any orthostatic blood pressures were taken.</p> <p>(continued on next page)</p>		

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<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of physician's orders between 3/1/24 to 6/30/24 failed to identify an order for orthostatic BP's were put into place following the pharmacy recommendation and the providers agreement.</p> <p>Interview on 7/2/24 at 1:26 PM with Pharmacy Consultant #1 identified she would email the recommendations to the DNS and ADNS for them to follow up on and as of last month she now emails them to the now DNS (former ADNS) and the APRN. A report would be provided to the facility indicating which recommendations were still pending, as well as for the monthly meetings a report would be generated to the facility indicating which items had been followed up on and which were outstanding.</p> <p>Interview with the ADNS on 7/2/24 at 2:07 PM indicated they are now (within the past few weeks) emailing the recommendations to the APRN to cut out the [NAME]. In the past they were emailed to her and the DNS, and the DNS was in charge of them. They are part of the medical chart and should be kept in the chart, however, were provided to the survey team from a stack that was kept outside of the medical chart.</p> <p>Interview with APRN #1 on 7/2/24 at 2:31 PM identified she started in February of 2023, and the DNS would give the recommendation for the APRN to address, and she would put the order in or the DNS would offer to put the order in. They would have to be addressed by the 15th of the month. The recommendation may have been missed by her, however in April the DNS offered to put the order in the computer as they were back logged, I would sign and then give them back. Once it was signed it would be returned to the DNS and they would forward it back to the pharmacy that it was addressed.</p> <p>Review of the facility policy titled Medication Monitoring Medication Regimen Review and Reporting dated 1/24 directed the findings of the Medication Regimen Reviews (MRR) to be communicated to the director of nursing or designee and the medical direction. These findings are documented and filed with the other consultant pharmacist recommendations in the resident's chart. Resident-specific MRR recommendations and findings are documented and acted upon by the nursing care center and/or the physician. The nursing care center follows up on the recommendations to verify that appropriate action has been taken. Recommendations should be acted upon within 30 calendar days or per facility specific protocols. For those issues that require physician intervention, the attending physician either accepts and acts upon the report and recommendation or rejects all or some of the report and should document his or her rationale of why the recommendation is rejected in the resident's medical record.</p> <p>47900</p>

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 50250</p> <p>Based on observation, review of the clinical record, facility policy, and interview for one of two sampled residents (Resident #111) reviewed for Medication Administration, the facility failed to ensure a medication error rate of less than 5%. The findings include:</p> <p>Resident #111's diagnoses included hypertension, depression, repeated falls, and anxiety.</p> <p>The Minimum Data Set (MDS) assessment dated [DATE] identified that Resident # 111 was severely cognitively impaired, required moderate assistance for personal hygiene, bed mobility and transfers and supervision assistance with eating.</p> <p>Physician's order in effect on 7/1/24 directed to give oral chewable Aspirin enteric coated (EC) 81mg, 1 tablet by mouth one time a day for blood thinner, Bupropion Hydrochloride (HCl) extended release (ER) 150mg, 1 tablet by mouth one time a day for depressive episodes and Metoprolol succinate ER Tartrate 25 mg, 1 tablet by mouth one time a day for hypertension, (HTN, blood pressure).</p> <p>Observation of medication preparation for Resident #111 on 7/1/24 at 11:30 AM, with LPN #2 identified he/she dispensed scheduled medications and crushed all the medications together and mixed in apple sauce to administer to Resident #111. LPN #2 entered Resident #111's room to administer the medication but was interrupted by the surveyor.</p> <p>Review of the pharmacy directions on the medication instructions with LPN #2 on 7/1/24 at 11:37 AM directed not to crush or chew the EC and/or the ER medications. Review of the Medication Administration Record with LPN #2 identified orders for Aspirin enteric coated (EC), Bupropion HCL ER and Metoprolol Succinate ER medications.</p> <p>Interview with the LPN #2 on 7/1/24 at 11:40 identified she should have read the directions fully on the medication administration record and instructions on the medication label prior to mixing and crushing the medications. LPN #2 indicated that she is not the regular nurse for that specific unit and that she was nervous hence failed to correctly follow medication administration instructions.</p> <p>Interview with the RN Nursing Supervisor (RN#2) on 7/1/24 at 11:53 AM, identified that administration orders should have been followed while administering medications.</p> <p>Interview with the Pharmacy Consultant on 7/2/24 at 8:45 AM, identified that Enteric coated medications and extended-release medications are designed to be released for an extended period. He/she further stated if Metoprolol ER is crushed it will be released faster in a short period and therefore will lower blood pressure faster, if Aspirin EC is crushed, it will cause irritation to the stomach and that bupropion HCl ER will be released faster.</p> <p>The total facility medication error rate was 12%.</p> <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility policy for Medication Administration directed, in part, that medications must be administered in accordance with the orders including any time frame and facility staff administering the medication should check the label 3 times to verify the right resident, right medication, right dose, right time and right method (route) of administration before giving the medication.</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47402</b></p> <p>Based on observation, interview, and review of facility policy for two of two sampled residents, (Resident #20) reviewed for food, the facility failed to provide food that was prepared in a manner to conserve nutritive value and in a palatable manner. The findings include:</p> <p>1. Resident #20's diagnoses included unspecified dementia, major depressive disorder, and diabetes insipidus.</p> <p>The quarterly MDS assessment dated [DATE] identified Resident #20 had moderately impaired cognition, utilized a cane/crutch, utilized set up or clean up assistance with eating, independent with oral hygiene, supervision with toileting, set up or clean up assistance with personal care and dressing.</p> <p>Resident #33's care plan dated 5/6/24 identified a nutritional problem or potential nutritional problem r/t morbid obesity, diuretic use, diabetes, hypertension, and GERD.</p> <p>Care plan interventions directed: controlled carbohydrate diet, no added salt, regular consistency with thin liquids, small starch portions.</p> <p>Interview with Resident #20 on 6/26/24 at 10:30 AM identified the food was horrible. There is not a lot of variety or flavor, and they utilize a lot of pasta.</p> <p>Review of the menu for 6/2/24 to 7/13/24 identified:</p> <p>Week #3 6/2/24 to 6/8/24 pasta was on the menu 4 times.</p> <p>Week #4 6/9/24 to 6/15/24 pasta was on the menu 3 times.</p> <p>Week #1 6/16/24 to 6/22/24 pasta was on the menu 4 times.</p> <p>Week #2 6/23/24 to 6/29/24 pasta was on the menu 4 times.</p> <p>Week #3 6/30/24 to 7/6/24 pasta was on the menu 4 times.</p> <p>Week #4 7/7/24 to 7/13/24 pasta was on the menu 3 times.</p> <p>Observation and taste testing on 7/2/24 of lunch meal test tray ordered at 12:10 PM contained pork with gravy, mashed potatoes, zucchini on one plate and a second plate contained broccoli and cheese quiche. The pork was light pink in color and questioned if it was cooked thoroughly. Zucchini was mushy with bland flavor. The quiche crust was raw. The menu stated the meal of Pork should have been served with a side of broccoli not zucchini.</p> <p>(continued on next page)</p>

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NAME OF PROVIDER OR SUPPLIER  Harbor Village North Health and Rehabilitation Cen		STREET ADDRESS, CITY, STATE, ZIP CODE  78 Viets St Extension New London, CT 06320	
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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview with Food Service Manager on 7/2/24 at 12:50 PM identified the quiche crust was indeed raw and the zucchini is typically overcooked due to the fact it is a frozen vegetable. They ran out of the broccoli due to the fact the truck was late in arriving and they were hoping to utilize the broccoli that was coming on the delivery truck for the lunch service. The food service manager was responsible of the ordering, but the cooks determined how much they need per service. The residents were not notified of the change.</p> <p>Interview with [NAME] #1 on 7/2/24 at 1:02 PM who has worked in the kitchen for [AGE] years. Identified the broccoli ran out due to the fact the delivery truck was late and that the broccoli that was cooked was withered. This was an issue that happened with the broccoli, zucchini, squash, and cauliflower mix. This could be prevented by steaming however they had previously asked for a steamer and did not get one. The quantity of food was determined by the menu tickets, so they know how much to prepare for that meal. [NAME] #1 indicated the food did not look palatable, however they had to cook it long enough so that that it held the temperature, and that steaming would have been the preferred method of cooking.</p> <p>Interview with Dietician on 7/3/24 at 10:01 AM identified consuming undercooked or raw foods could cause GI symptoms and that if food was overcooked such as the broccoli the nutritional value could be lost if it was cooked over temperature to the point it turned to mush.</p> <p>Review of facility policy titled Proper Cooking Temperatures dated 5/20/20 identified cooling and cooking temperatures are designed to have foods remain outside of the food danger zone 41degrees to 135 degrees during the meal service cycle in order to create an environment where bacteria do not thrive and increase. Proper cooking temperature does not account for the temperature needed to plate the meal, transport the meal and have it remain greater than or equal to 135 degrees.</p> <p>2. Resident #39's diagnoses included unspecified injury to unspecified level of lumbar spinal cord, sequela, paraplegia unspecified, personal history of other infectious and parasitic diseases.</p> <p>Review of physician's orders dated 6/10/2024 identified regular diet, regular texture, regular thin liquid consistency and no extra breads or rolls.</p> <p>Review of the clinical record identified Resident #39 stated he/she did not like the food choices nor the way the food is cooked. He/she further identified the food is sometimes over cooked or served undercooked and, at times, not edible. These issues are being discussed at the food committee meetings that piggyback the resident council meetings weekly.</p> <p>Observation of Resident #39 on 6/26/24 at 1:30 PM identified the resident had pushed his lunch tray away and was not eating. He had a sandwich set off to the side, wrapped in paper towel and three cups of orange juice with covers sitting on the tray table. Resident did identify that he consumed his breakfast with exception of the juices.</p> <p>Observation and tasting of facility test tray on 7/2/24 at 12:0 PM identified on plat that contained pork with gravy, mashed potatoes, and zucchini. The vegetable on the menu was broccoli and the served item was zucchini and was cooked and served overcooked and mushy, with no flavor. The pork was light pink in color. The second plate contained Quiche that was served was undercooked, the crust was doughy and the eggs still slightly watery.</p> <p>(continued on next page)</p>		

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F 0804  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Some	Interview with Food Service Manager on 7/2/24 at 12:50 PM identified that the zucchini was served instead of broccoli because the delivery truck was late, and the kitchen intended to use the broccoli being delivered that day to make up the deficit. The food service manager agreed the quiche was undercooked but denied that the pork was undercooked. The food service manager identified the kitchen used frozen vegetables and identified that frozen vegetables do not maintain their integrity.  47489		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 47900</p> <p>Based on observations, review of facility policy, and interviews, the facility failed to ensure that the kitchen was kept in a clean and sanitary manner and failed to discard expired foods. The findings include:</p> <p>During a tour of the Dietary Department on [DATE] at 9:50 AM with the Food Service Manager the following was identified:</p> <p>One ceiling fan covered with a heavy coat of brownish dust-like matter blowing directly over washed silverware and mugs.</p> <p>The walls of the dish washing room area were covered with a coat of greyish dust-like matter.</p> <p>The sink area in the dish washing room was noted to have a foul odor with an accumulation of grime and dirt on the walls underneath the sink with the exposed pipes under the sink noted to have a thick black coating.</p> <p>The walls above the paper towel dispenser at the handwashing sink before entering the dishwashing room noted to have a heavy accumulation of dust.</p> <p>The ceiling tiles in the dish room, and the food cart placement area noted to have an accumulation of dust and dirt.</p> <p>The vent above the stove noted to have an accumulation of dust like particles while a cranberry sauce was being prepared.</p> <p>Review of the cooks and the dietary aide cleaning schedule log failed to identify fans, walls, and ceiling tiles as a part of the areas to be cleaned by the kitchen staff.</p> <p>Interview with the Food Service Manager on [DATE] at 10:00 AM identified he had only started in his position now 4 weeks and had identified that the kitchen walls, ceiling, and dishwashing area needed to be steam cleaned. He indicated he had reported the issue of the cleanliness of the kitchen in the morning meetings wherein the Maintenance Director at the time agreed to have the cleaning done. However, he was relieved of his position on Friday. The Food Service Manager identified that the kitchen had a cleaning schedule, and it was the responsibility of the kitchen staff to clean the fans. However, the cleaning schedule of the kitchen did not include areas such as the fans, ceilings, or walls and he would have to make changes to the schedule's cleaning areas moving forward. He indicated that the cleaning of the kitchen ceiling was the responsibility of the maintenance and housekeeping department.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Interview with the Sanitarian (Person #1) on [DATE] at 11:11 AM identified that she last inspected the kitchen in February and identified the fan in the dishwashing area needed cleaning and the overall cleanliness of the kitchen required cleaning. Person #1 added that when she came on [DATE] at 3:30 PM, the staff were on their hands and knees scrubbing and washing the walls in the rear dishwashing area and in the dry storage area where the emergency supplies were been stored and will have to plan another follow-up visit with the facility.</p> <p>Review of the Cleaning Schedule policy identified that it was the responsibility of the dietary department to maintain all areas of the facility's kitchen and related areas in a clean and sanitary manner. The policy further identified that the the food service director should consistently look for and identify new areas needing cleaning and and then add to the cleaning schedule as necessary.</p> <p>Observation on [DATE] at 9:50 AM of the 3-day emergency food supply area located in the rear side across the dishwashing room of the kitchen identified the following items on a wire rack storage shelving unit:</p> <p>2 boxes of Toasty Oats Cereal containing 4 bags of 32ounce packages with an expiration date of ,d+[DATE]</p> <p>6 large cans of Butter Scotch pudding with an expiration date of ,d+[DATE]</p> <p>12 large cans of Diced Peaches with a best buy (BB) date of [DATE]</p> <p>6 large cans of Mixed Vegetables with an expiration date of ,d+[DATE]</p> <p>6 large cans of Diced Pears with expiration date of ,d+[DATE]</p> <p>6 packages of Non-Dairy Milk with an arrival date of [DATE] and an expiration date of [DATE]</p> <p>12 cans of Chicken Dumpling with a best buy date of [DATE]</p> <p>6 large cans of Apple Sauce unsweetened with an expiration date of [DATE]</p> <p>6 large cans of [NAME] Beans with an expiration date of ,d+[DATE]</p> <p>6 large cans of Dice Beets with an expiration date of ,d+[DATE]</p> <p>Observation on [DATE] at 9:50 AM with the Food Service Manager identified the following in the walk-in freezer:</p> <p>One package of opened sausage wrapped with clear plastic wrap with an opened date of [DATE] and expiration date of [DATE].</p> <p>One package of opened salami with an expiration date of ,d+[DATE]</p> <p>One package opened turkey pepperoni with an expiration date of [DATE].</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Interview with the Food Service Manager on [DATE] at 10:45 AM identified he would be responsible for checking the emergency food supply expiration dates but has not done so yet as he had started with the current dry storage area. He indicated that he was only at the facility for 4 weeks now and had a lot of items on his list to complete. The Food Service Manager identified that it was the responsibility of whoever is stocking the freezer to check expiration dates and rotate the stock. He also indicated that the kitchen did not have 3 days' supply of food in its regular supply as they received delivery on Tuesday and Thursday but will be discarded all the items and reordered immediately.</p> <p>Interview with the Dietician on [DATE] at 10:01 AM identified the cleanliness of the kitchen was identified during the environmental rounds wherein some improvements were made. The dietician added that if residents are served expired can foods as the ones identified that the resident could become ill and experience gastrointestinal symptoms.</p> <p>Interview with the Administrator on [DATE] at 11:18 AM identified she was aware of the issues of cleanliness of the kitchen and had made improvements such as changing the grease trap in the dishwashing area, had the housekeeping department clean the kitchen floors monthly, and the fans were cleaned. She added that the fans were not on a cleaning schedule and that she would instruct the staff to clean the fans as needed and whenever she observed it needing cleaning during her rounds. The Administrator added that the ceiling tiles would not be cleaned but it was the responsibility of the maintenance department to replace the tiles.</p> <p>Review of the facility Date Marking policy identified that the date marking system was to be implemented to identify how old foods are and when those foods must be discarded by having a designated employee(s) that would be assigned to monitor products within department refrigerators, and freezers.</p> <p>Review of the Food Storage policy identified that the facility utilized a date marking policy to ensure that ready-to-eat, closed, or opened foods maintain an expiration or used by dating system.</p>		

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<p>F 0842</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 47900</p> <p>Based on clinical record review, review of facility policy and interviews for one sampled resident (Residents #14) the facility failed to ensure medical records were readily accessible and complete. The findings include:</p> <p>Resident #14's diagnoses included gastro-esophageal reflux disease (GERD), bipolar disorder, and chronic obstructive pulmonary disease (COPD).</p> <p>The admission MDS assessment dated [DATE] identified Resident #14 had intact cognition, independent with toileting hygiene, bed mobility, required supervision with personal hygiene, and utilized a walker.</p> <p>Review of the monthly medication regimen review pharmacy notes identified that the pharmacist made recommendations for the following dates: 12/13/23, 1/17/24, 2/14/24, and 3/20/24.</p> <p>Interview with the DNS (the former ADNS) on 7/1/24 at 1:30 PM identified that the pharmacy recommendations are kept in the resident's paper chart on the unit.</p> <p>A request was made to the facility on [DATE] at 8:30 AM to provide the signed copy of the pharmacist recommendations report for Resident #14 from December 2023 to June 2024 (12/13/23, 1/17/24, 2/14/24, and 3/20/24), as they were not in the resident's medical records, to identify whether the prescriber agreed or disagreed with the pharmacist, the facility failed to provide a signed copy of the 12/13/23, 1/17/24, and 2/14/24 pharmacist recommendation reports.</p> <p>Interview with the ADNS on 7/2/24 at 2:07 PM indicated they are now (within the past few weeks) emailing the recommendations to the APRN to cut out the [NAME]. The DNS further identified that the pharmacist recommendations are part of the resident's medical chart and should be kept in the chart, however, were provided to the survey team from a stack that was kept outside of the medical chart.</p> <p>Interview with the former DNS (RN #3) on 7/3/24 at 12:48 PM identified he was unable to recall if he had given the pharmacy recommendations to the medical record personnel to file after the APRN had reviewed the recommendations.</p> <p>Interview with the Medical Records #1 on 7/3/24 at 2:20 PM identified that pharmacy recommendations papers are placed in her mailbox located in the copier room for her to file. She added that she checks her mailbox daily and if a pharmacy recommendation paper was to be filed it would file under the pharmacy tab in the resident's chart.</p> <p>Review of the facility policy titled Medication Monitoring Medication Regimen Review and Reporting dated 1/24 directed the findings of the Medication Regimen Reviews (MRR) to be communicated to the director of nursing or designee and the medical director. These findings are documented and filed with the other consultant pharmacist recommendations in the resident's chart.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>46117</p> <p>Based on observation, facility documentation review, facility policy review, and interviews, the facility failed to follow through a resolution after identifying an issue during environmental rounds and failed to maintain a clean laundry area. The findings include:</p> <p>Review of the monthly facility environmental rounds from January 2024 to June 2024 identified the facility noted issues of the cleanliness in the kitchen, further review of the documentation failed to identify how the lack of cleanliness was addressed.</p> <p>Interview with Infection Control Nurse (ICN) LPN #5 in the presence of RN# 5 (Regional Clinical Specialist) on 7/3/24 at 10:45 AM identified that the maintenance, housekeeping, and LPN #5 were responsible for conducting the monthly environmental rounds. LPN #5 had noted an issue of the cleanliness in the kitchen during the monthly environmental rounds. She identified that the facility had 10 days to offer a resolution and/or resolve the issue found in the environmental rounds; however, she could not provide evidence that the cleanliness noted in the monthly environmental rounds had been addressed. She further identified that the cleanliness of the kitchen remained an issue from January 2024 through June 2024.</p> <p>Observation on 7/3/24 at 11:45 AM in the laundry area located in the basement with LPN #5 and the Laundry Manager identified the back wall, ceiling wall, the metal pipe, and the floor where the two washing machines were located was covered with a significant amount of lint debris.</p> <p>Interview with the Laundry Manager (laundry regional director) on 7/3/24 at 12:05 PM identified that the laundry manager was responsible for maintaining the cleanliness of the laundry area. He identified that the laundry manager position has not been filled for several months and he was covering for the facility in the laundry area. He further identified that he could not provide documentation of when the identified areas containing the lint debris had last been cleaned.</p> <p>The Environmental Rounds Best Practice policy identified that environmental rounds would be conducted by infection preventionist designee, maintenance, dietary and housekeeping representatives monthly. After the completion of environmental rounds, a report would be created, and all problem areas would be given to the specific department for resolution. Each department had 10 days to resolve the problem areas and complete a written summary to resolve the problem.</p>

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47489</b></p> <p>Based on observations, review of facility documentation and interviews for resident rooms #'s 15, 18, 20, 26 and the hallway in the Northeast wing of the facility, the facility failed to ensure the environment was free of pests, specifically flies and fruit flies and the facility failed to ensure the kitchen food storage environment was free from visible signs of rodent infestation. The findings include:</p> <p>1. Observations on 6/26/2024 at approximately 1:30 PM of rooms (rm)15, 18, and 20 of the Northeast wing identified fruit flies were present. In room [ROOM NUMBER], there were cups of orange juice with caps and a sandwich wrapped in a paper towel. There were an excessive amount of fruit flies in the room, on the cups, on the resident's overbed table, side table and bed.</p> <p>Rm 15 also had fruit flies near the window and on the room divider curtain. The area near the window had items stacked on top of one another, clothing was piled on some of the boxes. There was no food that was able to be visualized.</p> <p>Rm 20 had fruit flies on the curtains separating the beds.</p> <p>Review of the pest control company's invoice and inspection report dated 2/8/24 identified the facility was treated for rodents at that time. Additionally, there is a list of potential items that need to be fixed in order to prevent pests from entering the building. This is the last documented treatment from [NAME] as provided by the facility.</p> <p>Review of another company's pest control services invoice dated 6/5/24 and 6/21/24 identified the facility's interior had been treated for ants and mice and the exterior treated for rodents.</p> <p>The facility was notified of the fruit flies on 6/26/24 at 3:00 PM and provided plastic storage bins for the residents to secure snacks and condiments in these rooms. Additionally, the facility contacted the pest control contractor to address fruit flies in the North East unit.</p> <p>Review of the pest services invoice dated 6/27/24, subsequent to surveyor inquiry, identified the company spot treated window area in room [ROOM NUMBER] for fruit flies and the representative identified that he spoke with staff about sanitation issues that need to be addressed.</p> <p>Observations on 07/01/24 at 2:01 PM identified fruit flies found on the northeast wing of the facility in room [ROOM NUMBER], 18 and 20 and in the hallway of the Northeast wing hallway.</p> <p>Observation on 7/8/24 at 2:30 PM identified Someone had placed cups of vinegar on top of the freestanding closet in room [ROOM NUMBER] and the flies were plentiful in the room on the closet, the dresser, the dividing curtains, and the bed. Interview with the resident in the room at that time identified the flies had increased over the weekend and were crawling on the resident throughout the day and night.</p> <p>(continued on next page)</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview with the Administrator on 7/8/24 at 1:48 PM identified the facility used a different pest control company previously but do not have any documentation on what was done at the facility. They weren't doing much. That's why I let them go.</p> <p>Interview with the DNS on 7/8/24 at 2:35 PM identified the facility had contacted the pest control service and had the area treated for fruit flies. Additionally, the DNS identified the treatment for the fruit flies was done outside because they grow in the ground. She identified the chemical cannot be used inside the building. She identified the facility is doing deep cleaning of each of the rooms and had moved the resident from Rm 20 out of the room with the resident's permission in order to clean the room.</p> <p>2. Observation on 6/26/24 at 9:50 AM of the 3-day emergency food supply area located in the rear side across the dishwashing room of the kitchen identified the following items on a wire rack storage shelving unit:</p> <p>12 large cans of Diced Peaches in its original box casing noted to have chewed markings creating a hole in the bottom of the box.</p> <p>6 large cans of Carrots in its original box casing noted to be covered with fecal droppings.</p> <p>One case of canned Corn Beef Hash was noted to have fecal droppings inside and outside of the box casing.</p> <p>6 large cans of Diced pears noted to have fecal droppings on the top of the cans.</p> <p>6 large cans of [NAME] Beans noted to have fecal droppings on the top of the cans.</p> <p>6 large cans of Chili Beans noted to have fecal droppings on the top of the cans.</p> <p>6 large cans of Dice Beets noted to have fecal droppings on the top of the cans.</p> <p>The flooring underneath and to the right of the wire storage rack containing the emergency food supplies was coated with fecal droppings.</p> <p>A rodent trap box was noted underneath the wire storage shelves, in the dry storage rooms, and on the floor in the coffee beverage station area.</p> <p>Interview with the Food Service Manager on 6/26/24 at 10:45 AM identified that the facility does have a rodent issue previously wherein treatment is done by a pest control company twice monthly. The Food Service Manager added he had just started working at the facility 4 weeks ago and has quite a bit of things on his list to review and check but had not check and review the emergency food supply dry storage area.</p> <p>Review of the former pest control company's invoice and inspection report dated 2/8/24 identified the facility was treated for rodents at that time. Additionally, there is a list of potential items that need to be fixed to prevent pests from entering the building. This was the last documented treatment provided by the facility.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Harbor Village North Health and Rehabilitation Cen		STREET ADDRESS, CITY, STATE, ZIP CODE 78 Viets St Extension New London, CT 06320	

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)
<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the current pest services invoice dated 6/5/24 and 6/21/24 identified the facility interior had been treated for ants and mice and the exterior treated for rodents.</p> <p>Interview with the Sanitarian (Person #1) on 7/1/24 at 11:11 AM identified that her last visit was in February of 2024 when she identified that the facility had issues with mice. Person #1 then recommended that food in the dry storage area be stored in plastic containers. Person #1 indicated that on her visit to the facility on [DATE], identified items in the dry storage area being stored in plastic containers.</p> <p>Review of the pest services invoice dated 6/27/24, subsequent to surveyor inquiry, identified the company spot treated window area in room [ROOM NUMBER] for fruit flies and the representative identified that he spoke with staff about sanitation issues that need to be addressed, which they had started on as of yesterday (6/26/24). Also, treated room [ROOM NUMBER] for reported sightings of mice. This report failed to mention any treatments for mice in the kitchen area.</p> <p>Interview with the Administrator on 7/3/24 at 11:18 AM identified she was unaware of the mice droppings in the emergency dry food storage area until it was identified by the surveyor. The Administrator added that a pest control company came twice monthly when she started 10 months ago and had since changed to weekly visit base on the sightings. She added that they were not seeing any improvements or change company with the previous company and decided to go with another pest control company. The Administrator indicated that the new company comes twice monthly and has seen improvement since the start of the new company.</p> <p>Review of the Food Storage policy identified that food storage to include dry storage, refrigerators, freezers, and chemical rooms would be clean and sanitary.</p> <p>47900</p>