STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075214	A. Building B. Wing	06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Portland Care & Rehab Center	333 Main St Portland, CT 06480

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48950 Based on review of the clinical record, review of facility documentation, and interviews for 1 of 3 sampled residents (Resident #18) who were reviewed for falls, the facility failed to utilize a gait belt during a transfer resulting in a major injury from a fall. The findings include: Resident #18's diagnosis included chronic obstructive pulmonary disease, heart failure, and history of falling. Review of the Resident Transfer Policy dated 6/14/22 directed that gait belts are used with all transfers unless contraindicated. A Fall Risk assessment dated [DATE] identified Resident #18 was at a moderate risk of falling. Review of the Reportable Event dated 6/23/23 identified Resident #18 fell while being transferred back to bed with the assistance of Nursing Assistant #1 (NA#1). Review of the submitted conclusion summary, written by the DNS, dated 6/28/23 identified that the investigation led to conflicting information from staff, however, after all staff were interviewed it was determined that NA #1 had not followed the care card for Resident #18's transfer status (had failed to utilize a gait belt). The quarterly Minimum Data Set assessment dated [DATE] identified Resident #18 was cognitively intact and required partial/moderate assistance from staff with toileting, bathing, transfers, and dressing. The Resident Care Plan dated 5/4/23 identified Resident #18 was at risk of falling. Interventions directed to transfer as ordered, encourage/remind the resident to call for assistance when needed, and to report any difficulties or changes in transfers or ambulation. The physician's orders dated 5/26/23 directed the assistance of 1 staff for transfers, including toileting using a 2 wheeled walker. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A nurse's note dated 6/23/23 at 7:53 PM identified Resident #18 lost his/her balance and had a witnessed fall. Resident #18 complained of pain in his/her right hip along with a skin tear to his/her right elbow. Resident #18 was unable to move his/her legs and the Advanced Practice Nurse directed that the resident be sent to the emergency room for an evaluation. The nurse's note dated 6/23/23 at 11:29 PM identified that the hospital called the facility stating that Resident #18 had a right hip spiral fracture of the proximal right femur which required surgery. Interview with NA #1 on 6/12/24 at 10:16 AM identified that she did not use a gait belt on 6/23/23 when she transferred Resident #18 to bed. NA#1 stated she did not use a gait belt because it was a quick transfer and was not a long distance. NA#1 identified that although the facility policy directed that all NA were to use a gait belt when transferring residents, she did not utilize a gait belt during this transfer. NA#1 stated that she did not try to prevent the fall because she was afraid of hurting herself. Interview and review of facility documentation with Physical Therapist #1 (PT #1) on 6/12/24 at 11:18 AM identified an Interdisciplinary Screening Form (PT/OT/ST) dated 4/20/23 directed Resident #18 required the assistance of 1 for transfers up to 100 feet using a 2 wheeled walker. PT #1, after reading and reviewing the reportable event, indicated that NA#1 should have used a gait belt and a 2 wheeled walker while transferring Resident #18, but NA #1 had utilized a wheelchair for the transfer instead of the 2 wheeled walker and failed to use a gait belt. PT#1 stated that a gait belt would not prevent a fall but is used to assist/lower a resident to the floor, preventing a hard impact should the resident fall. PT#1 identified that all staff are trained on the policy of transfers utilizing a gait belt and NA #1 was trained on 5/8/23 which directed that gait belts will be used on all residents during transfers and ambulation unless contraindicated (which was not the case for Resident #18). PT #1 indicated that if NA #1 had utilized a gait belt, Resident #18 may have had a fall with a less severe injury. Interview with the Director of Nurses (DNS) on 6/13/24 at 10:08 AM identified during the facility investigation that NA#1 stated that she utilized a gait belt while transferring Resident #18, however, the DNS indicated that through interviews with other staff, a gait belt had not been used during Resident #18's transfer. The DNS indicated that the NA Care Card (care plan) for Resident #18, had not been followed. The DNS indicated that the facility policy was to use a gait belt with all residents and that NA #1 did not follow the facility policy. Additionally, NA#1 had been educated on 5/8/23 on the gait belt policy with transfers.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50179 Based on observations, interviews, review of the clinical record, and facility policy for the only sampled resident (Resident #5) reviewed for oxygen use, the facility failed to ensure oxygen tubing was connected to the concentrator providing oxygen on 2 occasions. The findings include: Resident #5's diagnoses included chronic obstructive pulmonary disease (COPD), chronic diastolic heart failure, obstructive sleep apnea, and chronic pain syndrome. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #5 was severely cognitively impaired and required total assistance with bathing and dressing, set up assistance with eating, partial moderate assistance with bed mobility, and total assistance with transfers and mobility. The Resident Care Plan dated 5/3/24 identified oxygen therapy since 2019, chronic respiratory failure with long term oxygen use, choosing to remove oxygen and Chronic Obstructive Pulmonary Disease (COPD). Interventions included to remind to keep oxygen on, monitor for signs or symptoms of respiratory distress and report to the physician as needed, oxygen as ordered, position to facilitate ventilation upright position whenever possible. A nurse practitioner's note dated 6/12/24 identified a diagnosis of obstructive sleep apnea, asthma, and chronic respiratory failure with hypoxia or hypercapnia and that Resident #5 was dependent on the use of oxygen noting an oxygen saturation of 94% on 6/11/24. Interview and observation on 6/12/24 at 1:47 PM with NA #4 identified Resident #5 lying in bed and complaining of pain. The nasal cannula oxygen tubing providing oxygen was found disconnected from the oxygen concentrator which prevented the delivery of oxygen to Resident #5. NA #4 reconnected the oxygen tubing at the concentrator and notified LPN #2. Interview and observation on 6/12/24 at 1:48 PM with LPN #2 identified that Resident #5 had taken her oxygen tubing off at times out of her nose. Additionally, the oxygen tubing had been disconnected from the oxygen concentrator to the humidifier bottle, however the nasal cannula was in place. LPN #2 obtained Resident #5's oxygen saturation of 93% which LPN #2 identified as Resident #5's baseline. A physician's order dated 6/13/24 directed to administer oxygen at 3 liters per minute via nasal cannula and attach humidifier filled with distilled water to the compressor. Observation on 6/13/24 at 10:02 AM identified Resident #5 was lying in bed with his/her oxygen nasal cannula in place and complaining of nausea. Additionally, the oxygen tubing was found disconnected from the oxygen concentrator to the humidifier bottle preventing Resident #5 from receiving his/her prescribed oxygen. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and observation on 6/13/24 at 10:07 AM with LPN #2 identified the oxygen tubing was disconnected from the oxygen concentrator to the humidifier bottle. LPN #2 identified she did not know how the oxygen tubing became disconnected, but suspected it was getting bumped when Resident #5 was being transferred via mechanical lift into bed. Additionally, LPN #2 identified that she would start education with the staff to ensure that the oxygen connection was secure after mechanical lift transfers. Review of the Oxygen policy for nasal cannula oxygen administration identified, in part, attach the cannula to the nipple adapter of the oxygen device and or humidifier bottle as needed. Humidifier bottle use directed, in part, to attach oxygen delivery device to the outlet nipple of the humidifier bottle and confirm that oxygen is flowing through the bottle by observing bubbling in the bottle.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50094 Based on clinical record review, interviews, and facility policy for 1 of 5 sampled residents (Resident #14) reviewed for unnecessary medications, the facility failed to attempt a Gradual Dose Reduction (GDR) for a psychotropic medication. The findings include: Resident #14 was admitted on [DATE] with diagnoses of major depressive disorder and personal history of other mental and behavioral disorders. A physician order dated 1/25/23 directed the administration of Lexapro (an antidepressant medication) 20 milligrams daily. An admission MDS dated [DATE] identified Resident #14 had intact cognition, was independent with eating, required supervision with oral hygiene, and partial to moderate staff assistance with transfers. Additionally, Resident #14 had a diagnosis of depression and received an antidepressant. The Resident Care Plan dated 5/1/23 identified Resident #14 was on an antidepressant, interventions included monitoring ongoing signs and symptoms of depression and monitoring side effects and effectiveness of the medication. An Advanced Practice Registered Nurse (APRN) progress note dated 3/6/24 at 6:18 PM identified Resident #14 sometimes having sad days but overall did not feel depressed. Review of the clinical record from 1/25/23 through 6/12/24 failed to indicate a change in the dose of Resident #14's Lexapro or an attempt to complete a GDR. An interview with the psychiatric APRN, (APRN #1) on 6/12/24 at 11:05 AM identified that a GDR should be considered for a resident taking antidepressants. If a GDR was not indicated, then the reason for not attempting the GDR should be documented in the clinical record. APRN #1 further identified that psychiatry did not follow Resident #14 so she could not explain why a GDR was not attempted for the resident. Interview and clinical record review with the DNS on 6/12/24 at 3:12 PM failed to provide information that a GDR was ever attempted for Resident #14's Lexapro. The DNS was unable to explain the reason a GDR was never attempted but indicated that the pharmacist and facility providers who follow Resident #14 were responsible to ensure GDRs were recommended and attempted. The DNS further identified she was unaware that a GDR needed to be attempted for antidepressant medications and did not know the facility policy. Interview with the primary care APRN (APRN #2) on 6/13/24 at 10:59 AM identified that the psychiatric practitioner normally handles the GDR but if they are not following the resident, then the primary care provider would be responsible to address any required GDR attempts. APRN #2 further stated that she did not attempt a GDR because no one brought it to her attention. APRN #2 identified that a GDR attempt should be made 1 or 2 times in a calendar year. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility policy for Psychotropic Medication Management identified review of psychotropic medication management should include verification that adequate indications for use of the psychotropic medication exist, the medications are not being used for extended duration, and residents are free of duplicate therapy and being monitored for adverse consequences, per current professional standards of practice and in accordance with federal and state guidelines.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50250 Based on the tour of the Dietary Department, staff interview, and facility documentation, the facility failed to ensure open food items were dated, failed to ensure canned foods in the emergency stock were not expired, and failed to ensure food was served under sanitary conditions. The findings included: During a tour of the Dietary Department on [DATE] 10:31 AM with the Dietary Director the following was identified: a. 2 ceiling fans directly over the prep area were noted to be oscillating with a heavy accumulation of dust. A dietary worker was cutting a cake directly under one of the fans. In addition, the ceiling fan in the dish room was noted with a heavy accumulation of dust. b. An uncovered pan of gravy and flour mixture was observed to be on top of the preparation (prep) table. The side and underneath area of the prep table were noted to have a heavy accumulation of dirt and debris. c. The pipes behind the conventional convection oven and the flooring behind the oven was observed with a heavy accumulation of dust, grime, and dirt. The top of the convection oven was observed with a heavy accumulation of dirt, debris, and grime. d. The hood vent area was noted to have heavy accumulation of dirt and dust. e. The eye wash station adjacent to the prep area was noted to have dirt, debris, and stains on the stainless sink and the area behind the sink. f. The microwave was noted with a heavy accumulation of stains and finger prints on the outside. Interview and observations with the cook on [DATE] at 10:56 AM identified that he cleaned the microwave on the previous day, and he only removed some and not all of the debris. g. The refrigerator door and handles were noted to have a heavy accumulation of dirt, debris, drip marks, and accumulation of finger prints. Interview and observations with the Dietary Director at [DATE] at 10:57 AM indicated that he cleaned the top of the stove a few days ago. He further identified that he didn't know the reason the convection oven was still soiled. h. The beverage cooler which contained milk and health shakes had a 5-foot gasket section under the door that was noted to have a heavy accumulation of black like substance/material. i. The walk-in freezer was noted to contain a 2-pound bag of broccoli that was half full and 7 individually wrapped pieces of cake that were not labeled/dated when opened. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	j. The dry storage room had the following food items with no open dates and time: 10 lbs. (half full) bag of pasta, ,d+[DATE] lbs. of orzo that was open to air, ,d+[DATE] full box of gluten free pasta and flour in a 10-gallon container that was ,d+[DATE] full and the lid and handle had heavy accumulation of dried on white substance. k. A 3-day emergency supply of food was noted to have expired expiration dates and included: 12 (28 oz) boxes of cream of wheat with an expiration of [DATE], 6 (108 oz) cans of Beef Ravioli with an exp of [DATE], 4 cans of 6 lbs. 10 oz, 4 (10 oz) cans of mandarin oranges with an exp of ,d+[DATE], 12(10 oz) cans of tomato soup with an exp of (,d+[DATE]), 6 (4 lbs. 2.5 oz) cans of Tuna fish with no expiration date. Interview and observation with Dietary Director on [DATE] at 11:35 AM indicated that he was responsible for checking the 3-day emergency food supply and expiration dates. Additionally, he noted that food items in the 3 day supply were also used whenever needed for in-house stock, were rotated whenever they are low, and were discarded when expired and replaced. l. The steam table which contained roasted chicken, baked fish, macaroni and cheese, green beans, peas, mashed potatoes, cream of chicken soup and pasta fagioli, on [DATE] at 12:20 PM was noted to have a heavy accumulation of dirt and debris on the bottom drawer and the front of the steam table. In addition, the steam table was observed being transported from the Dining Room to room [ROOM NUMBER] (approximately 80 feet in distance) without the benefit of covering the catering pans. The meals were plated from the steam table for residents who were eating in their rooms. After residents who ate in their rooms were served, the steam table was brought from room [ROOM NUMBER] to 201 (approximately 22 feet) without the benefit of covering the catering pans, however the lids were noted to be on the bottom shelf of the steam table. Interview and observations with the cook on [DATE] at 1:07 PM identified that food should be covered with lids while being transported in the hallway. He further stated that he forgot to cover the food. Interview with the Maintenance Manager on [DATE] at 2:00 PM identified that distance from the dining room to room [ROOM NUMBER] as 80 feet and from room [ROOM NUMBER] to room [ROOM NUMBER] as 22 feet. The facility was unable to provide a policy regarding labeling and dating of foods, however, an interview with the Dietary Director on [DATE] at 12:30 PM stated that opened food should be dated when opened and discarded by the expiration date on the container.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50094 Based on observation and interviews for 1 of 5 sampled residents (Resident #1) reviewed for the environment, the facility failed to maintain adequate temperatures for a resident refrigerator on the 2nd floor. The findings include: Resident #1 was admitted to the facility on [DATE] with diagnoses of anxiety, dysphagia, and gastro-esophageal reflux disease. Observation of resident rooms on 6/13/24 identified Resident #1's refrigerator tempeature guage read 50 degrees and the following foods were stored in the refrigerator, yogurt and leftover food from dining service. Additionally, the temperatures recorded on a log for June 2024 ranged between 48 and 50 degrees Fahrenheit (F) (normal at or below 41 degrees F). Interview with the Director of Maintenance on 6/13/24 at 11:00 AM identified the refrigerators belonged to the facility and that housekeeping was responsible to check the temperatures of the refrigerators. If the temperatures were out of range, the facility would replace the malfunctioning refrigerator with a new one. The Director of Maintenance further identified that refrigerator temperatures were supposed to be between 36 to 42 degrees F. The Director of Maintenance could not recall if the abnormal temperature of Resident #1's refrigerator had been reported for maintenance during the month of June. Interview with Housekeeper #1 on 6/13/24 at 11:25 AM identified housekeepers checked the refrigerator temperatures daily for all the rooms on the 2nd floor that had a refrigerator, and if the temperature was out of range, they reported it to their supervisor who then informed maintenance. Housekeeper #1 also identified that they would report temperatures that were below 50 or 60 degrees F but was unaware of what the acceptable refrigerator temperatures ranges should have been. Interview with the Director of Housekeeping on 6/13/24 at 11:40 AM identified that housekeeping was supposed to check the refrigerator temperatures in resident rooms and if the temperatures were out of range, they were supposed to tell him or maintenance. The Director of Housekeeping identified that temperatures were supposed to be between 36 to 46 degrees and was unable to explain why the out of range temperatures in Resident #1's room were not reported. The Director of Housekeeping further identified that each new hire for housekeeping was shown the temperature log indicating what to do if temperatures were out of range. Review of the facility Refrigerator/Freezer policy identified the temperature readings would be entered daily in the appropriate box on the calendar log. If a housekeeping staff member notices a temperature outside the range, they were to adjust the coolness dial and recheck the temperature in 1 or 2 hours. Food should be labeled and moved to the pantry until the temperature resolves. If the temperature remains outside of range, housekeeping would contact maintenance for service.