STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075219	A. Building B. Wing	12/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waterbury Center for Nursing & Rehabilitation LLC	177 Whitewood Road Waterbury, CT 06708

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility policy review, and interviews for one sampled resident (Resident #87) reviewed for family notification, the facility failed to notify the correct responsible party when the resident sustained a fall with injury. The findings include: Resident #87 had a diagnosis of Alzheimer's disease. Review of the clinical record identified Resident #87's face sheet noted Person #1 was denoted as conservator of person and estate and Person #2 was noted as the contact person for emergencies. The Social Worker (SW #2) progress note dated 4/8/24 at 10:41 AM identified Person #1 was Resident #87's conservator and Person #2 was very involved and supportive of Resident #87. The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #87 had severe cognitive impairment, required extensive assistance with toileting, hygiene, dressing, and required supervision with transfers and ambulation. It further identified the resident had fallen within the past three months but had not sustained injuries from the fall(s). The Resident Care Plan (RCP) dated 7/23/24 identified Resident #87 had a recent fall. Care plan interventions directed to notify physician and responsible party for any changes in condition, neuro-checks per facility policy, and provide call bell and personal items within reach. The nurse's note dated 8/9/24 at 7:00 PM identified Resident #87 was found lying on the floor in the east 2 dining room, had slight swelling to his/her left elbow and complained of pain. The note further identified the physician was notified and ordered Resident #87 be sent to the hospital for evaluation, and charge nurse would notify the family. The nurse's note dated 8/9/24 at 10:32 PM written by LPN #2 identified Person #2 was updated and would meet Resident #87 at the hospital. The nurse's note dated 8/10/24 at 10:20 AM written by the DNS identified Person #1 was updated of Resident #87's fall and returned to the facility with a left distal humerus fracture and splint to the left humerus. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with SW #1 on 12/18/24 at 2:30 PM identified that the nursing staff is responsible for notifying the responsible party after a significant change of condition. She also identified that nursing staff would follow the order of the contact list listed on the resident face sheet and identified the face sheet would indicate who would be the first contact in the event of emergency. She further identified Resident #87 had Person #1 (conservator) as number 1 in the list to be contacted in the event of an emergency. Interview with LPN #2 on 12/18/24 at 2:40 PM identified that she provides an update to the resident's primary responsible party when there is a change in condition. She also identified Person #2 was listed as first contact on the face sheet on 8/9/24. Interview with SW #2 on 12/19/24 at 10:15 AM identified Person #1 had been Resident #87's conservator since April 2024 and should be contacted first when there is a change in condition. She also identified that the social worker is responsible for updating the list of contacts when there is a change. She further identified that she updated the list of contacts for Resident #87 when the conservator was approved in April 2024. Interview with the DNS on 12/19/24 at 10:50 AM identified that the nursing staff notified her on 8/10/24 because Resident #87 had a fall with a left humerus fracture, and when she was reviewing and preparing the reportable event, she noticed that Person #2 was updated of the fall and Person #1 was not. She further identified that she reviewed Resident #87's emergency contact list and Person #2 was designated the first person to be contacted instead of Person #1. Additionally, she identified that she corrected the listing of the emergency contact and called Person #1 after noticing the mistake. The Change of Condition policy identified that the facility would ensure that changes in resident's condition are reported to the provider and responsible party.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, review of the clinical record, review of facility documentation, review of facility policy/procedures and interviews for the one sampled resident (Resident #82) reviewed for abuse, the facility failed to ensure the resident was free from abuse. The findings include: Resident #82's diagnoses included dementia, syncope and collapse, falls, and cerebral ischemia. The quarterly MDS assessment dated [DATE] identified Resident #82 had moderately impaired cognition, was independent with eating, oral hygiene, toileting hygiene, and transfers. The care plan dated 9/18/24 identified Resident #82 was at risk for cognitive loss related to dementia with interventions that included: use non-verbal communication techniques, minimize distractions, provide verbal reminders for tasks, and provide cues and supervision for tasks. Resident #94's diagnoses included encephalopathy and Alzheimer's disease. The annual MDS assessment dated [DATE] identified Resident #94 had severely impaired cognition, rarely understood others and was rarely understood by others, and was independent with transfers and mobility. The care plan dated 10/2/24 identified Resident #94 was at risk for mood/behavior changes with interventions that included: monitor for changes in mood/behavior and report to physician, monitor for side effects of medication and behavior monitoring as indicated. The care plan further identified the risk for cognitive loss related to dementia with intervention that included: assess level of resident's confusion/disorientation, monitor for changes in mood/behavior, and orient/re-orient resident to environment as needed. The physician's orders for October 2024 directed to monitor Resident #94 for targeted behaviors of pacing, restlessness and crying at the end of each shift. A nurse's progress note dated 10/8/24 at 11:42 AM identified Resident #94 had entered another resident's room and urinated in an inappropriate place, had decreased cognition making redirection difficult and a referral to psychiatric services was made. The psychiatric progress note dated 10/10/24 at 11:52 AM identified Resident #94 was on antipsychotic medication for pacing, had a flat affect, poor situational understanding and was reported to have increased pacing. The note further identified Zoloft (antidepressant medication) would be increased and the worsening behaviors were from advancing illness. The psychiatric progress note dated 10/22/24 at 11:45 AM identified Resident #94 experienced agitation and was constantly pacing. The note further instructed to monitor behaviors and the effectiveness of medications and to implement non-pharmacological interventions of redirection and maintain a calm environment. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the medication administration record (MAR) from 9/1/24 through 10/27/24 identified Resident #94 exhibited behaviors of pacing and restlessness 14 out of 57 days. The Reportable Event Report dated 10/28/24 at 7:45 PM identified Resident #94 wandered into Resident #82's room. Resident #82 repeatedly asked Resident #94 to leave, Resident #94 then grabbed Resident #82's right arm, and twisted the skin, which resulted in a hematoma. The report further identified Resident #94 was redirected back to his/her nursing unit following the incident. The physician and/or APRN was notified, and an order was given that directed to apply ice to the affected area for 20 minutes. In addition, the report identified that a Velcro STOP sign was placed across Resident #82's door. On 10/28/24 an intervention was added to Resident #82's care plan that directed to assess for injury, observe for lasting effects from event, offer psychological services and provide validation and support related to the resident being a victim of abuse. A physician's order dated 10/30/24 directed to ensure the stop sign is across the doorway when resident is in the room. On 10/28/24 interventions were added to Resident #94's care plan that included: observe for further abusive behaviors, provide validation and support, and review unacceptable behavior towards others. A psychiatric progress note dated 10/30/24 at 1:14 PM identified Resident #82 was not answering questions coherently when questioned about being afraid following the incident with Resident #94. Observation on 12/16/24 at 11:44 AM identified Resident #94 walking on the east and west unit, and jiggling door handles to stairwell doors. Resident stopped at the doorway of room [ROOM NUMBER] until the room occupant yelled out to keep walking. Interview on 12/18/24 at 9:22 AM with RN#1 identified Resident #94's normal behaviors included pacing, and indicated the resident stops and stares but doesn't usually walk into other residents' rooms. Observation on 12/18/24 at 12:25 PM identified Resident #82 had a mesh stop sign hanging to one side of the doorway, but not across the doorway of Resident #82's room. Resident #82 and his/her roommate were in the room. Review of the Resident Abuse, Mistreatment, Neglect, Exploitation, Misappropriation of Resident Property, and Retaliation policy identified abuse as the infliction of injury with resulting physical harm, pain, or mental anguish. Additionally, the policy indicated that abuse can be intentional or non-intentional.