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	02/11/2025

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, facility documentation, facility policy and interviews for one (1) of three (3) sampled residents (Resident #1) who were reviewed for Methadone (a medication used to treat Opioid Use Disorder) medication management, the facility failed to implement the facility policy when a dose of methadone was dropped and spilled and there was no Methadone available for a scheduled dose. The findings include: Resident #1's diagnoses included opioid dependence (a class of drug used to reduce moderate to severe pain, which are usually safe when taken for a short time and as prescribed by a health care provider, but they can be highly addictive and as a result have often been misused or abused). The quarterly Minimum Data Set assessment dated [DATE] identified Resident #1 had no memory recall deficits and was alert. The Resident Care Plan dated 11/19/24 identified Resident #1 had a history or active diagnosis of substance abuse as well as Methadone maintenance treatment. Interventions directed to refer the resident to psych services on admission and as needed, offer the option of attending substance abuse groups, social service and nursing support as needed, assist resident with substance abuse counseling as available, assist resident with transportation to Methadone clinic and for appropriate required follow up as needed, monitor resident for changes if Methadone dose is adjusted and report to provider, and provide resident with daily dose of Methadone for self-administration. A physician's order dated 12/14/24 directed for Methadone 10 milligrams (mg) per milliliter (ml), give 110 mg (11 ml) daily, resident to take from lock box after nurse opens to self-administer. The Chain of Custody Record (a document of the number of doses of Methadone received from the clinic along with a sign off after each dose was administered) dated 1/2/25 with doses for the date range of 1/3/25 through 1/14/25 identified one (1) dose of Methadone was spilled on 1/4/25. The Chain of Custody Record identified on 1/13/25 after Resident #1 was given a dose of Methadone, there were no additional doses left. The Chain of Custody Record failed to identify the Methadone Clinic was notified of the dropped/spilled dose or of the missing dose for 1/14/25. The nurse's note dated 1/14/25 at 2:11 PM identified Resident #1's Methadone was not available, the Advanced Practice Registered Nurse (APRN) was notified and a new order directed to administer Oxycodone (an opioid medication used to treat pain) 5 mg by mouth for one dose. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075219	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/11/2025
NAME OF PROVIDER OR SUPPLIER: Waterbury Center for Nursing & Rehabilitation LLC		STREET ADDRESS, CITY, STATE, ZIP CODE: 177 Whitewood Road, Waterbury, CT 06708	

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The physician's order dated 1/14/25 directed to give Oxycodone 5 mg by mouth for one (1) dose. Interview with a licensed Alcohol and Drug Counselor from the Methadone Clinic, Person #1, on 2/7/25 at 9:33 AM identified the facility did not inform the Methadone Clinic when Resident #1's Methadone dose was dropped/spilled on 1/4/25, nor did they inform the clinic on 1/14/25 when Resident #1 did not have a dose of Methadone for that day. Person #1 explained the facility should have called the Methadone Clinic as this would be considered an internal incident and the facility should have called to inquire as to what the next step should have been. Person #1 identified had the facility called the clinic, the clinic could have delivered a dose the same day, but at the very least the clinic would have reported it to their medical director. Interview with the Nursing Supervisor, Registered Nurse (RN) #1, on 2/7/25 at 12:14 PM identified on 1/14/25 it was reported to her that a dose of Resident #1's Methadone had been previously dropped/spilled and there was no dose for 1/14/25. RN #1 identified although she reported this to the APRN, she did not call the Methadone Clinic. RN #1 identified she was not aware of what the facility policy directed regarding a missing dose of Methadone, but was now aware that this should have been reported to the Methadone Clinic. Interview with a charge nurse, Licensed Practical Nurse (LPN) #1, on 2/7/25 at 12:17 PM identified on 1/14/25 when she went to administer Resident #1's regular Methadone dose, it was identified that a previous dose had been spilled and there was no dose available for 1/14/25. LPN #1 identified she notified the APRN and the supervisor. LPN #1 identified she did not report this to the Methadone Clinic as Resident #1 was scheduled to go to the clinic the next day to pick up the next 2-weeks doses and an order had been given by the APRN. Interview and clinical record review with the Director of Nursing (DON) on 2/7/25 at 12:36 PM identified this was the first incident she had encountered with a spilled dose of Methadone. The DON identified the normal procedure when there is no Methadone available would be to call the Methadone Clinic to get another dose, but because this happened on a Saturday and the Methadone clinic closes early around 10:00 AM, the clinic was not called. The DON identified she was not aware if the clinic had any on-call availability. The DON identified facility policy directed to call the Methadone Clinic when a resident's dose of Methadone was spilled or not available and not to replace the Methadone with another medication. Interview with the Assistant Director of Nursing (ADON) on 2/7/25 at 12:43 PM identified on 1/14/25 it was reported to her that Resident #1 did not have a dose of Methadone available as one (1) dose had been spilled earlier in the schedule which required the facility to use a second dose on the day of the spill. The ADON identified the Methadone Clinic was not notified of the dropped/spilled dose on 1/4/25, nor were they made aware of the missing dose for 1/14/25. The ADON identified she did not advise LPN #1 to call and report the missing dose to the Methadone Clinic on 1/14/25 because Resident #1 had an appointment the following day and Resident #1's needs were felt to be met with the one-time dose of Oxycodone prescribed by the APRN. The ADON identified facility policy directs to call the Methadone Clinic when a dose of Methadone was spilled/dropped or not available for a resident's scheduled dose. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the APRN on 2/7/25 at 12:44 PM identified on 1/14/25 it was reported that Resident #1's Methadone dose was not available. The APRN identified at that time she gave an order to give Oxycodone 5 mg one-time only to prevent withdrawal. The APRN identified she was not usually involved in the Methadone program and that is why she did not advise facility staff to call the Methadone Clinic. The APRN identified Oxycodone was not a substitute for Methadone, but she prescribed it to prevent Resident #1 from experiencing any withdrawal symptoms. Although attempted, an interview with the facility Medical Director was not obtained. Review of the facility policy titled Liquid Methadone ROM MAT/MMTP (Medication Assisted Treatment/Methadone Maintenance Treatment Program), last revised 11/22/21, directed, in part, for any missed or held dose nursing will update the clinic with any missed doses or late administration. Additionally, the policy directed, in part, in the even of a spilled bottle, nursing will have two nurses verify the pill and immediately clean the spill and destroy any residue in the container and nursing will contact the clinic immediately for replacement.