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

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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 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. 48335 Based on review of the clinical record, review of facility documentation, review of facility policy/procedures and interviews for 6 of 12 sampled residents (Resident #17, #18, #66, #67, #99 & #100) reviewed for resident assessment, the facility failed to ensure the MDS (minimum date set) assessments were transmitted to CMS (Centers for Medicare & Medicaid Services) within fourteen days of the care plan completion date and/or the MDS completion date. The findings include: Resident #17 had an annual MDS assessment with an assessment reference date (ARD) of 11/6/23. The next annual MDS assessment should have had an ARD of 11/6/24 (an annual assessment is required to be done within 366 of the last annual/comprehensive assessment). The assessment had a care plan completion date of 11/12/24. The assessment should have been transmitted by 11/26/24 (with 14 days). The transmittal record identified the assessment was transmitted on 12/13/24, which made it three days overdue. Resident #18's had a quarterly MDS assessment with an ARD of 8/11/24. The next scheduled assessment was a quarterly MDS assessment with an ARD of 11/11/24 (quarterly assessments must have an ARD of no more than 92 days from the last assessment). The MDS completion date for the assessment was 11/17/24, which indicates that the assessment was required to be transmitted by 12/1/24. The transmittal record identified the assessment was transmitted on 12/15/24, which made it fourteen days overdue. Resident #66 had a significant change MDS assessment with an ARD of 8/12/24. The quarterly MDS assessment should have had an ARD of 11/12/24. The MDS completion date for the assessment was 11/18/24, which indicates the assessment was required to be transmitted by 12/2/24. The transmittal record identified the assessment was transmitted on 12/15/24, which made it thirteen days overdue. Resident #67 had an annual MDS assessment with an ARD of 8/2/24. Review of the facility's MDS system identified a change in condition MDS assessment with an ARD of 11/2/24. The care plan completion date was 11/8/24, which indicates the assessment was required to be transmitted by 11/22/24. The transmittal record identified the assessment was transmitted on 12/13/24, which made it twenty-one days overdue. Resident #99 had an annual MDS assessment with an ARD of 8/2/24. Review of the facility's MDS system identified a quarterly MDS assessment with an ARD of 11/2/24. The MDS completion date was 11/8/24, which indicates the assessment was required to be transmitted by 11/22/24. The transmittal record identified the assessment was transmitted on 12/13/24, which made it twenty-one days overdue. (continued on next page)

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

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F 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	Resident #100's discharge MDS assessment was dated 11/17/24. The assessment had an MDS completion date of 11/23/24, which indicates the assessment was required to be transmitted by 12/7/24. The transmittal record identified the assessment was transmitted on 12/13/24, which made it five days overdue. Because the assessments were not transmitted in a timely manner to CMS, the MDS system registered the assessment as not done because there was no data entered to register that the assessment were completed. Interview on 12/18/24 at 2:02 PM with the Director of Nursing (DNS) identified LPN #1 was the only MDS Coordinator for the building, and they are recruiting for a part time position to help with MDS's. Interview on 12/19/24 at 12:42 PM with the DNS indicated there was not a report (audit trail) she could run to check to see when the assessments were actually completed if in real time. The MDS policy identified that the assessment coordinator or designee is responsible for ensuring resident assessments are submitted in accordance with current federal and state submission timeframes.

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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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17723 Based on observations, review of the clinical record, review of facility policy and interviews for one sampled resident (Resident #62) reviewed for intravenous therapy, the facility failed to ensure a physician's order was in place directing the flushing of an unused lumen on a peripherally inserted central catheter (PICC) and failed to ensure that medication/solution infusion and administration set was labelled appropriately. The findings include: Resident #62 was admitted to the facility in November of 2024, with diagnoses that included amputation of the left great toe, sepsis, osteomyelitis, type 2 diabetes mellitus. The admission MDS assessment dated [DATE] identified Resident #62 was cognitively intact, independent with personal hygiene, bed mobility, dressing and ambulated 10 feet using a walker. The assessment further identified Resident #62 was receiving intravenous (IV) medications. The physician's order dated 12/10/24 directed Vancomycin (an antibiotic use to treat infections, osteomyelitis) 2 grams intravenous once daily at 9:00 AM The physician's orders for the month of December 2024 failed to identify an order that directed flushing of the unused lumen on the central venous access device. Observation on 12/19/24 at 10:20 AM identified Resident #62 was lying in bed, an IV pole located on the right side of the bed with an IV bag containing Vancomycin 2 gram in normal saline 500 milliliters(ml) infusing via tubing inserted through the electronic infusion device which was connected to the blue lumen on the PICC line that was located on the right upper extremity. The IV medication did not contain a label indicating the administration rate, the date, time and the nurse's initials. In addition, there was an unused lumen with a red cap which was not in used and had a date of 12/13/24 labeled on the dressing. Observation with the ADNS on 12/19/24 at 10:25 AM identified Resident #62 was lying in bed, an IV pole located on the right side of the bed with an IV bag containing vancomycin 2 gram in normal saline 500 milliliters(ml) infusing via tubing inserted through the electronic infusion device which was connected to the blue lumen on the resident's right upper extremity PICC site without a label on the IV medication and administration set indicating the date, time and the nurse's initial. Also, identified another lumen with a red cap which was not in used and a date of 12/13/24 labeled on the dressing. Interview and review of the clinical records with the ADNS on 12/19/24 at 10:25 AM identified that a resident with a PICC line containing two lumens, should have an order for flushing of the unused lumen (s). The ADNS further identified there was not an order to flush the unused lumen and noted that the IV medication should be labelled with the date, time the mediation was started and the nurse's initials who administered the medication. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DNS and the Infection Preventionist (LPN #7) on 12/19/24 at 11:21 AM identified unused lumens should be flushed and it is the supervisor's responsibility to ensure that the orders are in place. LPN #7 was asked if the medication solution and tubing was to be label with what information at the time of infusion in which she responded both the medication solution, and the tubing should be labeled with the date, time and the nurse's initial. Interview with the Charge Nurse (LPN #8) on 12/19/24 at 12:39 PM identified she was having difficulty with mixing the medication and had asked the nursing supervisor for assistance. LPN #8 identified the supervisor placed the IV medication in the IV pole, but she connected the tubing to the resident. She identified that it was her responsibility to label the tubing and the medication with the date, time and her initials; however, she thought the supervisor had already done the labeling. LPN #8 identified she had not flushed the unused lumen on the PICC and had only flushed the lumen where the medication had infused as there was no order indicating the flushing of the unused lumen. Interview with the Nursing Supervisor (RN #2) on 12/20/24 at 11:30 AM identified that when residents are admitted with a PICC it is the responsibility of the admitting nursing supervisor to select the appropriate treatments from the batch orders based on the type of central venous access device. RN #2 further identified when residents are admitted with a PICC line that has 2 lumen orders should be in place to flush both lumens. Interview with the Charge Nurse (LPN #9) on 12/20/24 at 11:51 AM identified she could not recall flushing the unused line as there were no orders directing flushing of the unused lumen. LPN #9 identified she flushes the lumens whenever she changed the PICC dressing, and the resident had only one lumen and had recent returned with 2 lumen. Review of the Central Venous Access Device (CVAD) Flushing policy identified a prescriber order is requires for vascular access device (VAD) flushing, the order will be specific with regards to flush solution, volume and frequency. The policy further identified the VAD would be flushed before and after intravenous medication administration, and routinely, at established intervals, when the VAD is not in use. The policy identifies the purpose of flushing is to maintain patency of a central venous access device catheter. Review of the Labeling Infusion policy identified that all medication or solution containers, VAD site and administration set will be labeled.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 47402 Based on observations, review of facility documentation, review of facility policy/procedures and interviews, the facility failed to ensure adequate food supply for the posted menu. The findings included: Initial tour of the kitchen on 12/16/24 at 9:48 AM with the Dietary Manager (DM) identified the walk-in fridge contained no liquid eggs, a box of hard-boiled eggs, and 6 individual eggs in a carton. Fresh cabbage was the only fresh vegetable observed in the walk-in fridge. Observation of dry food storage on 12/16/24 at 10:05 AM with the Dietary Manager identified several bare shelves, 1 box of Scooters cereal, 8 cans of jelly, several boxes of thickener, 6 cans of sauerkraut, and condiments were observed stored on the shelves. Interview on 12/16/24 at 10:16 AM with the DM identified that if scrambled eggs are on the menu and they are out, they could substitute hard boiled eggs, and the fresh cabbage was substituted for the coleslaw they had on the dinner menu that day. She further noted that they would be receiving a delivery of food on 12/17/24 and noted it was common for them to run short on food prior to a delivery due to the fact each order was usually very close in quantity to get through to the next order. Due to budgetary constraints, she cannot order extra to keep on hand to ensure items do not run out and has to keep her orders within the budget which is very tight. Further, she noted substitutions needed to occur on the menu approximately twice per week due to supply and if substitutions are made, she notifies the front desk who makes a page, and they also write it in the substitution log in the kitchen. Review of the substitution log from 9/1/24-12/16/24 identified 17 substitutions had been made during this time. No substitution for scrambled eggs for 12/16/24 were annotated in the book. Interview on 12/16/24 at 10:40 AM with Resident #15 who has intact cognition, identified that they are out of stock of items several times a week. That morning specifically, they were out of milk when he/she asked with it for breakfast, and they had just received a delivery and brought him/her a cup of it. Interview on 12/20/24 at 10:41 AM with the Administrator identified there had been issues with the vendor recently and that they are not always getting what they order. If they were told ahead of time, they were going to be out of stock on something they could order a substitute. Further, the Administrator noted that if they ran out of something in the kitchen and they needed to purchase it, she could always run to the local wholesale club to buy it so there should never be an issue with something being out of stock. When asked when the last time she went to the wholesale club to purchase something for the kitchen she identified it was in the summer time when she went to purchase butter for a picnic. The Administrator identified that if they were out of liquid eggs and had scrambled eggs on the menu, they could utilize the regular eggs to scramble for residents, or substitute a hard-boiled egg. Ordering is done through the central supply, and quantity is determined by their census. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview with the Food Supply Manager on 12/20/24 at 11:12 AM identified that the facility determines the quantity in which they want to order and send the information to him via their system. He then connects the vendors who will supply the order to the facility. The supply includes meats, dairy, bread, most everything they use will go through him to find a vendor for. The supply manager indicated in a general sense they do substitute majority of the time or find another vendor who has the item and occasionally they are out of stock of an items, but it is not very often. Review of the out of stocks on the last 3 months of delivery orders from 9/1/24-12/20/24 identified 11 items were out of stock during this period with substitutions made for 6 of the out-of-stock items. Review of the posted menu did not annotate any changes. Review of facility policy for Menus directed menus for regular and therapeutic diets are written at least two weeks in advance and are dated and posted in the kitchen at least one week in advance. Deviations from posted menus are recorded (including the reason for the substitution and or deviation and archived).

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47402 Based on observations, review of facility policy/procedures and interviews, the facility failed to ensure proper beard coverings were worn in the kitchen. The findings included: Observation of tray line service on 12/18/24 at 11:45 AM identified Dietary Aide #1 plating food with no beard/face covering and a full beard. Interview on 12/18/24 at 11:50 AM with the Dietary Manager identified Dietary Aide #1 should be wearing a beard covering and would tell him at this time to put one on. Review of facility policy titled Beard/Hair Dietary identified staff will be accountable for compliance with this policy and failure to do so will result in disciplinary action. Men with mustaches or beards must fully cover them with a beard net. The beard net must be work in all kitchen premises at all time.

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47900 Based on review of the clinical record, review of facility policy, and interviews for the 1 of 22 sampled residents (Resident #368) reviewed for advanced directives, the facility failed to ensure copies of the advance directives, consents and appointed healthcare proxy documentation were maintained and readily accessible in the resident's clinical records. The findings include: Resident #368 was admitted to the facility in April of 2024 with diagnoses that included heart failure, myocardial infarction, and muscle weakness. The admission MDS assessment dated [DATE] identified Resident #368 was cognitively intact, had no behaviors, required moderate assistance with dressing, toileting hygiene, transfers and utilized a walker for ambulation with minimal assistance. The care plan dated 4/22/24 identified Resident #368 Advance directives/code status as per the physician's order, which is a Do Not Resuscitate (DNR), Do Not Intubate (DNI), and Do Not hospitalized (DNH) with interventions that included to ensure resident/family wishes are conveyed to any other facility should transfer occur. The physician's order dated 4/18/24 directed a code status Do Not Resuscitate (DNR) and Do Not Intubate (DNI) with an instruction to ensure resident signs Advance Directives form and place a copy in chart. A DNR code status means to withhold cardiopulmonary resuscitation in the event that the resident heartbeat and breathing stops. The physician's order dated 5/11/24 directed a code status DNR/DNI/DNH/RNP- comfort measures no blood pressure, weights are laboratory testing. Review on 12/18/24 of the paper clinical record identified an Advance Directive consent form dated 5/11/24 that indicated a choice of DNR, DNI, DNH, comfort measures only and Registered Nurse Pronouncement (RNP) signed by the resident's Power of Attorney. Review on 12/18/24 of both paper and electronic clinical record identified a Connecticut Statutory Power of Attorney: Long Form which indicates This power of attorney does not authorize the agent to make health care decisions for Resident #368 which was signed and notarized on 6/30/23 along with Resident #368's Last Will and testament document. However, the clinical records both electronic and paper failed to identify any document indicating the appointment of a health care representative nor the advance directive consent form reviewed and signed on admission. Interview with the DNS on 12/18/24 at 12:30 PM identified where would a copy of the appointment of a health care representative document could be found as the document provided in chart and electronic did not identify the appointed health care representative. The DNS who indicated that she was the appointed POA for health identified that she would contact the Attorney to get a copy of the document which identifies her as the POA for health care for Resident #368. The DNS indicated a copy should be in the chart but was unable to recall if she had provided the facility with a copy of the document. (continued on next page)

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Subsequent to surveyor's inquiry, the DNS on 12/19/24 produced a copy of the Health Care Instructions documentation which identified her as the POA, however this document was not located in the chart. Interview with the Admission Coordinator on 12/19/24 at 1:01 PM identified she completes various sections of the resident's face sheet such as the contact information which indicates the resident's responsible party, emergency contact, POA, and conservators. She further identifies the resident would need to provide the supporting documents prior to the facility listing/identifying their responsibilities in the contact information section of the face sheet. She identified both her and the social worker would complete the contact information section, providing that they had received the appropriate documentation from the resident. Interview with the Social Worker (SW #2) on 12/19/24 at 1:04 PM identified prior to a POA indication in the resident's record, the resident would have to provide supporting documents which would verify the appointed individual. The SW #2 reviewed both paper and clinical records and was unable to identify any supporting documents appointing a health care representative. She indicated the document should be a part of the record and the documents provided by the family was uploaded in the computer. Review and interview with the DNS on 12/19/24 at 1:49 PM failed to identify a copy of the advance directive which was completed on admission in the resident's record. The DNS identified they did not keep the old advance directive form because it would confuse the staff, hence only the current advance directives are kept in the chart. Review and interview with Medical Records on 12/20/24 at 12:16 PM failed to identify a copy of the advance directive form signed on admission and the supporting document which identifies Resident #368's appointed health care representative. The Medical Record staff identified she was responsible for uploading documents in the electronic medical record system. She further identified all advance directive consent forms both previous and current are kept the resident's record. She explained that the new advance directive form would be on top, and the previous form would be kept behind the new/current form. Interview with the Nursing Supervisor (RN #2) on 12/20/24 at 11:30 AM identified advance directives are reviewed, and consents are obtained on admission with the resident if they are capable and/the responsible party are signed and kept in the chart. RN #2 was asked when advance directives are change does the previous consent form is remove from the chart in which she responded that they are kept behind of the new/current advance directive consent form. RN #2 further identified the previous and current advance directives should be kept in the resident's record. Review of the Chart Depletion policy identified that items to be retained in the chart at all times included physician's orders with code status code change, advance directives and any consent/permission/policy signed by resident/patient. Review of the Advance Directive policy identified living wills submitted upon admission or pre-admission become part of the resident's chart and are additionally noted for awareness of the interdisciplinary team and resident without living wills are provided with advance directives handouts upon admission. The policy further identified nursing reviews advance directive options and completes form, which is filed in the medical chart.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47900 Based on observations, review of the clinical records, review of facility policy/procedure, review of facility documentation, and interviews during a review of the Infection Control Program, the facility failed to appropriately track and place a resident with a known Multi Drug Resistant Organism (MDRO) and a resident utilizing a feeding tube on Enhanced Barrier Precautions (EBP), and the facility failed to ensure biohazards were stored appropriately. The findings include: 1. Resident #370's diagnoses included gastrostomy, pneumonia, aphasia, nutritional deficiency, and type 2 diabetes mellitus. The Nursing Admission assessment dated [DATE] identified Resident #370 was alert, and orientation, memory, and thinking were unable to be assessed. The assessment further identified the resident had a gastrostomy tube and required manual lift assist from stretcher to new surfaces, impairment on both upper and lower extremities. The care plan dated 12/6/24 identified Resident #370 had altered health maintenance, EBP may be applied (when contact precautions do not apply) to residents with wounds, indwelling medical devices regardless of MDRO colonization with an MDRO, gastrostomy tube (G-tube) with a goal that identifies EBP as an approach of targeted gown and glove use during high contact resident care activities to reduce the transmission of MDRO with interventions that included signage on the doors, gown, gloves to be worn with high contact with affected source- dressing, bathing/shower, changing linens, hygiene, assisting with toileting, changing a brief, device care central line, urinary catheter, feeding tube. The physician's order dated 12/6/24 directed Resident #370 was to not receive nothing by mouth (NPO) and G-tube feed only. Intermittent observations of Resident #370's room door from 12/16/24 to 12/19/24 failed to identify a posted signage that identified the need for Enhanced Barrier Precautions (EBP) which noted the need for everyone to perform hand hygiene before entering and when leaving the room, providers, and staff to wear gloves and a gown for high-contact resident care activities such as bathing/showering, dressing, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use of a urinary catheter, central line, feeding tube, tracheostomy, wound care: any skin opening along with a green dot beside the affected resident's name on the name plate outside of the room. Review of the facility's Enhanced Barrier Precautions log dated 12/6/24 failed to identify Resident #370 as having a feeding tube which would require EBP usage. Observation on 12/19/24 at 10:09 AM identified after knocking and receiving approval for entering resident's room identified NA #1 was providing care to Resident #370 while he/she was lying in the bed with NA #1 only using a glove. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation with the ADNS on 12/19/24 at 10:30 AM failed to identify a posted signage that identified the need for Enhanced Barrier Precautions (EBP) which noted the need for everyone to perform hand hygiene before entering and when leaving the room, providers, and staff to wear gloves and a gown for high-contact resident care activities such as bathing/showering, dressing, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use of a urinary catheter, central line, feeding tube, tracheostomy, wound care: any skin opening along with a green dot beside the affected resident's name on the name plate outside of the room. The ADNS identified an EBP signage should have been placed on the door along with a green dot beside the affected resident's name on the outside of the room. Interview with NA #1 on 12/19/24 at 10:35 AM identified she was providing personal care to Resident #370 and did not wear both gown and glove during the care activity as the green dot was not placed beside the resident's name nor was a signage indicating EBP was outside of the room. NA #1 further identified she was new to this assignment and had not received any report that the resident was on EBP. NA #1 identified Resident #370 should be on EBP because of the G-tube and should have worn the appropriate PPE such as a gown and a glove when providing care, however she was relying on the appropriate signage outside of the room indicating EBP. Interview with NA #2 on 12/19/24 at 10:35 AM identified she was the nurse aide for Resident #370 the previous week and had not worn the appropriate PPE when providing high contact resident care activities care as there were no signage indicating the resident was on EBP nor could she recall during change of shift report it was mentioned that the resident was on EBP. Interview with the Charge Nurse (LPN #8) on 12/19/24 at 2:10 PM identified she could not recall a signage indicating EBP outside of Resident #370's room neither did she receive such information on report that the resident was on EBP. LPN #8 identified when a resident is on EBP it is indicated by a signage and a green dot beside the resident's name on the outside of the room. Interview with the DNS and the Infection Preventionist (LPN #7) on 12/19/24 at 11:21 AM identified a resident with a feeding tube would be on EBP and staff are made aware using a green dot being placed beside their name on the name plate outside of the room, as well as the EBP signage posted on the outside of the room. LPN #7 further identified that staff is also made aware that a resident is on EBP through the care plan and the face sheet but would not be identified in the physician orders. The DNS and LPN #7 identified it was the responsibility of the management team to ensure the EBP signage was placed on the outside of the resident room. The DNS added that she was responsible for ensuring the signage was there, but somehow missed it as she was the one who updated the care plan to indicate the resident was on EBP. Resident #371's diagnoses included atrial fibrillation, hypertension, and resistance to vancomycin urine. The admission MDS assessment dated [DATE] identified Resident #371 was cognitively intact and required moderate assistance with dressing, toileting hygiene, and maximal assistance with bed mobility. Review of the care plan dated 11/2/24 failed to identify a plan of care for the use of EBP related to history/colonization of a MDRO vancomycin-resistant Enterococcus (VRE). (continued on next page)

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Intermittent observations of Resident #371's room door from 12/16/24 to 12/19/24 failed to identify a posted signage that identified the need for Enhanced Barrier Precautions (EBP) which noted the need for everyone to perform hand hygiene before entering and when leaving the room, providers, and staff to wear gloves and a gown for high-contact resident care activities such as bathing/showering, dressing, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use of a urinary catheter, central line, feeding tube, tracheostomy, wound care: any skin opening along with a green dot beside the affected resident's name on the name plate outside of the room. Review of the urine culture dated 11/13/24 with a collection date of 11/11/24 identified Resident #371 had vancomycin-resistant Enterococcus (VRE) organism. Review of the facility's MDRO tracker with a last update dated of 12/2/24 identified Resident #371 as having a history of VRE in the urine. Review of the facility's Enhanced Barrier Precautions log with a last updated date of 12/6/24 failed to identify Resident #371 as having a history/colonization of VRE. Observation with the ADNS on 12/19/24 at 10:30 AM failed to identify a posted signage that identified the need for Enhanced Barrier Precautions (EBP) which noted the need for everyone to perform hand hygiene before entering and when leaving the room, providers, and staff to wear gloves and a gown for high-contact resident care activities such as dressing, bathing, showering, device care or care of a urinary catheter along with a green dot beside the affected resident's name posted on the outside of the room. Interview with NA #1 and NA #2 on 12/19/24 at 9:05 AM identified that staff knows when a resident is on any precautions such as EBP based on the posted signage outside of the resident's room, which also states the type of PPE to worn and when to wear the PPE along with the green dot beside the resident's name who is affected. Interview with the DNS and the Infection Preventionist (LPN #7) on 12/19/24 at 11:21 AM identified Resident #371 had a history of VRE and was not placed on EBP as the facility was only placing residents with targeted MDRO such as (Carbapenem-resistant Enterobacter [NAME] (CRE) and carriers of an MDRO on EBP. Review of the policy with the DNS identified VRE as an example of the MDRO's in which EBP would be utilized and the DNS responded that those were just examples and was not sure why the policy would indicate such information. The DNS further identified herself as well as LPN #7 was a part of the annual policy review and thought that the policy had indicated only targeted MDRO's and residents who were carriers to be placed on EBP. Review of the Enhanced barrier Precautions policy and procedures identified EBP is a relatively new approach that falls between standard and contact precautions and employs targeted gown and glove use during high contact resident care activities. Examples of MDRO's listed in the policy included: Candida auris, MRSA, VRE, and CRE. The policy/procedure further identified appropriate signage for type of precaution will be posted on room door, a green dot is placed next to the resident's name on the door as an indicator for EBP, when EBP is initiated for a resident, it would be discussed at morning report and at the change of each shift, staff will identify which resident require EBP. (continued on next page)

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

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Observation of the room labelled Biohazard Medical Storage room with the Director of Maintenance on 12/18/24 at 11:05 AM identified a room with several boxes containing clean supplies such incontinent briefs, mask, gloves, isolation gowns and face shield supplies. Continued observation of the left side on entrance to the room identified 6 large red bins labeled Biohazard, Caution, contains medical waste which may be biohazardous, stacked on each other with the top bin opened and overflowing with over 5 sharp containers containing biohazard waste directly next to a cart with shelves containing clean supplies such as: 4 large boxes of incontinent brief and 4 packages of incontinent briefs that were outside of the boxes. Interview with the Central Supply staff on 12/18/24 at 11:15 AM identified she was responsible for collecting the sharp containers from the soiled utility rooms on the units and place them into the red bin in the Biohazard Medical Storage room for pick-up. The Central Supply staff was asked if clean supplies should be stored directly next to the biohazard waste in which she responded that they should not be stored together. She identified the red bin containers contained contaminated needles and other contaminated items in the room which also contained boxes of extra cleaned supplies for emergency usage. Interview with the Administrator on 12/18/24 at 11:35 AM identified biohazards are stored behind a lock door in the basement awaiting to be picked up by the vendor. The Administrator identified that the biohazard should not be stored amongst the clean supplies. She further identified the biohazards were stored in the same room as the outside shed in which they were previously stored is broken and waiting to be rebuilt, however she added the biohazard should not have been stored in close proximity of the clean supplies. Interview with the DNS and the Infection Preventionist (LPN #7) on 12/19/24 at 11:21 AM identified biohazard and clean supplies should not be stored together as it poses a risk for cross contamination. Review of the Medical Waste Storage policy identified medical waste stored for treatment, disposal, or pickup shall be protected in accordance with established policies and procedures. The policy further identified the IP or designee with the administrative staff shall monitor the medical waste storage areas to assure that medical waste is treated, disposed of, or picked up by the authorized vendor on a timely basis.