Printed: 02/11/2025
Form Approved OMB
No. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075230 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 08/14/2024 |
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Ledgecrest Health Care Center | 154 Kensington Rd<br>Kensington, CT 06037 |

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

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46117<br><br>Based on clinical record review, facility documentation review, facility policy and interviews for 1 of 3 sample residents (Resident #149) reviewed for abuse, the facility failed to ensure Resident # 149 was free from physical abuse by Resident #28. The findings include:<br><br>1. Resident #28 's diagnoses included Alzheimer's disease, mood disorder due to known physiological condition with depressive features, and type 2 diabetes mellitus.<br><br>The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #28 had severe cognitive impairment and noted independent with bed mobility, toileting, dressing, hygiene, transfer, and ambulation without use of assistive device.<br><br>The Resident Care Plan (RCP) dated 1/10/24 identified Resident #28 had chronic and progressive decline in intellectual functioning related to Alzheimer's disease. Interventions directed to introduce yourself to the resident, explain each activity or care procedure prior to starting the procedure, repeat communications to the resident more than one method such as: words, gestures, and facial expressions, and to administered medications per physician orders.<br><br>The nurse's notes dated 3/8/24 at 2:00 PM identified Resident #28 hit Resident #149 on the left arm and left leg with a plate cover with spilled drink. Resident #28 was also noted to scatter personal belongings on the floor. Resident #28 was placed on 1 to 1 direct observation. The Advanced Practice Registered Nurse (APRN) psychiatrist, medical APRN, Administrator, responsible party and police department were all notified. Resident #28 was evaluated via telehealth by the APRN psychiatrist with new physician's orders to discontinue 1 to 1 direct observation, administered Trazodone(anti-depressant) 50 Milligrams (MG) by mouth for one dose, Trazodone 25 MG by mouth daily for 7 days, Trazodone 25 MG by mouth every 8 hours as needed for 7 days, collect urine for urinalysis and culture. Resident #28's family members went to the facility to provide support to the resident.<br><br>(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 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The psychiatrist APRN progress note dated 3/8/24 identified Resident #28 was evaluated via telehealth related to striking another resident (Resident # 149). The evaluation identified Resident #28 became upset when someone came into his/her house and took out his/her belongings. Resident #28 had assumed Resident #149 removed his/her belongings out of the room and subsequently hit Resident #149. Resident #28 has a history of yelling out and packing belongings. However, Resident # 28 had no history of physical aggression toward others. The APRN identified Resident # 28's belief that his/her belonging was moved out of the room was the exacerbating factor that resulted to hitting Resident # 149.<br><br>The social worker progress notes written by Social Worker (SW #2) on 3/11/24 at 12:30 PM identified s/he spoke to Resident #28 related to the incident that had occurred with Resident #149. Resident #28 was receptive to the SW #2 visit and Resident #28 had difficulty recalling the incident that occurred. Resident #28's demeanor was calm, laughing, and engaging.<br><br>2. Resident #149's diagnoses included lymphedema, low back pain, spinal stenosis, type 2 diabetes mellitus, and morbid obesity.<br><br>The RCP dated 1/10/24 identified Resident #149 needs staff assistance with Activity Daily Living (ADL's). Interventions directed to assist resident with toileting as needed, keep commonly used items within resident reach, delivered meal and set-up as needed, and transfer per physician orders.<br><br>The admission MDS assessment dated [DATE] identified Resident #149 with intact cognition and dependent for bed mobility, toileting, dressing, hygiene, and transfer.<br><br>The nurse's note dated 3/8/24 at 2:11 PM identified Resident #149 had been hit on the left arm and leg with a plate cover by Resident #28. Resident #149 was assessed and noted with redness to the left arm and denied any pain. Resident #149 was moved to another room and was adjusting well to the new room.<br><br>A Reportable Event form dated 3/8/24 identified Resident #149 was lying in his/her bed when Resident #28 walked across the room and hit him/her on the left arm with a breakfast plate cover.<br><br>The revised RCP dated 3/9/24 identified Resident #149 was hit with a plate cover by another resident (Resident # 28). Intervention directed to move resident to another room.<br><br>The nurse's note dated 3/10/24 at 2:30 PM identified Resident #149 had a bruise to the left arm and left pinky finger. Resident #149 had denied any pain or discomfort and indicated s/he was adjusting well to his/her new room.<br><br>The social worker progress note written by SW #2 on 3/11/24 at 9:06 AM identified Resident #149 had an incident with Resident #28. Resident #149 was able to recall the incident with Resident #28 and s/he reported bruising to the left arm. Resident #149 reported s/he was emotionally fine, and s/he was not afraid of Resident #28. Resident #149 was aware that Resident #28 had cognitive issue and s/he would not retaliate, but s/he did curse in frustration at the time of the incident.<br><br>(continued on next page) |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview with Nurse Aide (NA #1) on 8/8/24 at 1:30 PM identified Resident #28 became upset when s/he (NA#1) cleaned out Resident # 28's room and took out the old linen from his/her room. NA #1 further identified Resident #28 alleged his/her roommate told her/him to clean out his/her room. NA #1 further indicated s/he did not witness when Resident #28 hit Resident #149 with a plate cover. NA#1 also identified that s/he did not let Resident #28 know s/he would take out the old linen and NA #1 did not expect Resident #28 to become upset and hit Resident #149 with a plate cover. NA #1 further identified this was the first time Resident #28 hit another resident.<br><br>Interview with SW #2 on 8/12/24 at 12:50 PM identified s/he was filling in at the facility at the time of the altercation between Resident #28 and Resident #149. SW#2 could not recall the details of the altercation between Resident #28 and Resident #149; however, SW#2 identified Resident #149 was able to recall that Resident #28 hit him/her with a breakfast plate cover and Resident #149 had a bruise to left arm after s/he got hit with a plate cover.<br><br>Interview with the Administrator on 8/12/24 at 1:00 PM identified Resident #28 was in the bathroom and NA#1 was cleaning and fixing his/her room. When Resident #28 came out from the bathroom, Resident #28 became upset and alleged his/her roommate (Resident # 149) told NA #1 to clean out his/her room. The Administrator identified Resident #149 had no cognitive impairment and was able to report and recall the hitting incident. Resident #149 reported that s/he got hit with a plate cover on his/her left arm and left leg. The Administrator confirmed that Resident #149 developed a bruise to the left arm after s/he was hit with a plate cover. The Administrator further identified Resident #149 requested a room change after the incident and was immediately removed from his/her room.<br><br>The facility failed to protect Resident #149 from physical abuse by Resident # 28.<br><br>A review of facility nursing policy titled Abuse/Resident identified the facility will ensure that each resident is treated with kindness, compassion, and in a dignified manner. Abuse Prevention notes residents have the right to be free from verbal, sexual, physical, mental, corporal punishment, mistreatment, neglect and misappropriation of property. The facility staff will monitor and supervise the delivery of resident care and services to assure the care was provided as needed. The facility will identify, correct and intervene in situations in which abuse has occurred. The facility would take appropriate action to treat all consequent ill effects experienced by the resident for the alleged incident and to safeguard the resident from further incident re-occurrence. |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46046<br><br>Based on review of the clinical record, review of facility policy and interviews for 1 of 4 Residents (Resident #31) reviewed for Pressure Ulcers, the facility failed to ensure staff obtained a physician's order for the use of fastening offloading boot devices, monitoring the effectiveness of the boot devices as a nursing measure and failed to ensure all staff was made aware of the wound physician's recommendation to stop using the green offloading boots. The findings include.<br><br>Resident #31's diagnosis included Parkinson's Disease, severe protein-calorie malnutrition, failure to thrive and Stage 3 Pressure ulcer.<br><br>The annual Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #31 as severely cognitively impaired and dependent on 2 staff members for bed mobility, transfer and dressing and noted limited mobility of both arms and legs.<br><br>The RCP dated 8/2/2024 for Resident #31 identified at risk for skin breakdown due to immobility, incontinence, poor nutrition, pronounced body prominence, poor circulation altered sensation and mechanical forces. Interventions included: to inspect skin when providing care for signs and symptoms of skin breakdown, off load heels while in bed, pressure reducing mattress on bed and in the wheelchair, and to turn and reposition per standards of nursing practice. Further interventions included inspecting skin during care for signs of skin breakdown.<br><br>A wound physician's progress note dated 8/6/2024 directed to hold off using the heel booties as increasing pressure to the lateral foot may be contributing to the declining wound.<br><br>An observation on 8/7/2024 at 10:17 AM identified two puffy green boots each with a strap on Resident #31's bedside table while Resident #31 was in bed.<br><br>An interview with NA#3 indicated s/he had worked the 3-11 PM shift and now works 7-3 PM and noted the utilization of the boots. NA#3 indicated hearing from the nurse or the off going NA if the boots were to be used or not used. NA #3 also indicated s/he did not recall if the booties were listed on Resident #31's assignment and could not explain why Resident # 31's booties were not applied today.<br><br>An interview with charge nurse LPN #1 on 8/8/2024 at 2:55 PM identified the boots have been used for quite some time. LPN #1 indicated the boots were used while up in the wheelchair but not in bed. LPN #1 further indicated s/he did not know who recommended the use of the booties but thought it may have been the therapy department.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An interview and record review with Physical Therapist (PT #1) on 8/8/2024 at 2:58 PM indicated Resident #31 remained on therapy and was evaluated 3/21/2024 with the mention of offloading boots in a long-term goal. PT #1 indicated the therapy notes from 7/19/2024 through 8/1/2024 indicated the donning of the green booties to Resident #31's bilateral feet. PT #1 also indicated therapy never recommended the use of the green booties as it was nursing who implemented the use. S/he also indicated PT #1 was unaware of the 8/6/2024 wound physician recommendation to use the green booties. PT #1 indicated the Rehabilitation Director who is currently off are made aware of changes during morning report. However, a review of the clinical record from 7/19/24 through 8/6/24 failed to reflect a physician's order and nursing measures for the utilization of the green booties. The clinical on 8/6/24 failed to reflect the physician's order and recommendation not to utilize the booties due to wound worsening.<br><br>An interview and clinical record review with the DNS and RN#6 on 8/8/2024 at 1:15 PM indicated there was no physician's orders for use of the booties and RN #6 indicated the booties were used as a nursing measure to off load heels. Although, the use of nursing measures is not a standard of professional nursing practice, the DNS and RN #6 indicated they would look for facility policies for use of offloading boots and the use of nursing measures. However, no policies were found.<br><br>An interview with Medical Doctor (MD #2) on 8/8/2024 at 2:01 PM indicated Resident #31's stage 3 pressure ulcer was becoming worse and on 8/6/2024 s/he recommended holding off using the boots due to pressure as the lateral foot might be contributing to the wounds decline. MD#2 further indicated Resident #31's foot had become red and swollen and the resident was started on antibiotic therapy and was being evaluated for osteomyelitis (bone infection) which could be a large contributing factor to the wounds decline. MD #2 further indicated s/he did not recommend the booties this was a nursing measure. MD#2 also indicated s/he could not say that using the booties without specific orders for use and monitoring could have caused the wound to decline.<br><br>An interview with the DNS on 8/13/2024 at 10:15 AM indicated his/her understanding was that booties used in the facility were a nursing measure for offloading.<br><br>The facility policy labeled Wound and Skin Care Protocols indicated in part the interdisciplinary plan of care would address interventions directed toward the prevention and/or treatment of pressure ulcers. |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48792<br><br>Based on review of the clinical record, review of facility policy and interviews for the 1 of 1 sampled resident (Resident #45)) reviewed for urinary retention, the facility failed to follow their policy regarding the maximum amount of urine to be removed at one time. The findings include:<br><br>Resident #45's diagnoses included retention of urine, neuromuscular dysfunction of the bladder, chronic kidney disease Stage 3A and malignant neoplasm of prostate.<br><br>A physician's order dated 7/1/24 directed to straight catheterize Resident #45 every shift for urinary retention.<br><br>A nurse's note dated 7/1/24 at 6:19 PM identified Resident # 45 was straight catheterized in the morning and 1300 cubic centimeters (cc) of urine was removed.<br><br>A nurse's note dated 7/2/24 at 11:00 PM written by RN#5 identified Resident # 45 was straight catheterized during the 3:00-11:00 PM shift and 1200 cc of urine was removed.<br><br>The discharge Minimum Data Set assessment dated [DATE] identified Resident #45 as cognitively intact and required moderate assistance for personal hygiene, toileting, and maximal assistance for bathing.<br><br>Interview with RN #5 on 8/8/24 at 3:33 PM identified s/he was aware of the facility policy on catheterization; however, s/he was unaware that there was a maximum amount of urine that could be removed at any one time. RN# 5 further stated you keep going until the bladder is empty and no more urine is coming out.<br><br>In an interview and clinical record review with the DNS on 8/8/24 at 3:40 PM, 1000 cc's is the maximum amount of urine that could be removed from the bladder at a time. Upon review of the clinical record documentation, the DNS identified 2 separate occasions where more than 1000 cc' were removed from the bladder.<br><br>Review of the Catheterization policy undated directed, in part, not to remove more than 1000 cc at one time. |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide enough food/fluids to maintain a resident's health.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46046<br><br>Based on clinical record reviews, review of facility policy and interviews for 2 of 4 residents (Resident#31) reviewed for pressure ulcers and (Resident # 44) reviewed for nutrition, the facility failed to ensure the residents were reweigh for potential weight loss per the facility policy and the dietician was notified of a weight loss. The findings included.<br><br>1. Resident #31's diagnoses included Parkinson's Disease, severe protein-calorie malnutrition, failure to thrive, dementia and stage 3 pressure ulcer.<br><br>A physician's order dated 5/15/2024 directed to obtain a weekly weight every Tuesday.<br><br>The annual Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #31 as severely cognitively impaired and dependent on 2 staff members for bed mobility, transfer and dressing and noted limited mobility of both arms and both legs.<br><br>The RCP dated 4/10/2024 indicated Resident #31 received an artificial means of nutrition related to weight loss and swallowing difficulty. Interventions included: monitoring weights, laboratory blood work and toleration of the feedings.<br><br>The dietitians note dated 6/19/2024 at 10:19 2024 indicated in part questioned the accuracy of the 6/5 and 6/18/2024 weights as Resident #31's weights had been in the low 100's.<br><br>On 8/8/2024 at 1:48 PM a call was placed to the dietician with no response.<br><br>An interview and record review with the DNS and RN # 6 on 8/8/2024 at 1:40 PM indicated on 6/11/2024 Resident #31's weight was 101.4 pounds. The next weight on 6/18/2024 was 75.6 pounds (a weight loss of 25.0 pounds) and on 6/25/2024 the weight was 76.5 and the next day on 6/26/2024 the weight was 100.00 pounds (a gain of 23.5 pounds). The DNS and Regional RN both indicated Resident #31 should have been reweigh on 6/18/2024 and 6/26/2024 and indicated they could not explain why Resident #31 was not reweigh to determine an accurate weight.<br><br>The facility policy labeled Weight Monitoring indicated in part if there is a 5 pound weight discrepancy (plus or minus), a reweight should be obtained, the charge nurse is to compare the weight to last previous weight and determine if there was a 5 percent change in weight in 30 days or 10 percent over 180 days and if so to notify the MD, responsible party, dietitian, the DNS/ Assistant Director of Nursing Services (ADNS) and the Care Plan Coordinator.<br><br>2. Resident #44 's diagnoses included dysphagia, Gastro-Esophageal Reflux Disease and Multiple Sclerosis.<br><br>The RCP dated 7/3/24 indicates potential for nutritional decline related to medical problems. Interventions included to provide my diet as ordered and to weigh as ordered<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The admission MDS assessment dated [DATE] identified the resident as cognitively impaired, requiring supervision or touching assistance for eating. The assessment also noted dependent for sitting to laying and maximum in bed mobility and no swallowing issues.<br><br>A physician's order dated 7/2/24 directed to give regular diet regular texture, thin liquids consistency, for all meats cut into soft bite size.<br><br>The nutritional assessment dated [DATE] indicated admission weight as 186 pounds. Additionally, noted recorded intake 25-75%.<br><br>A review of Resident #44's Electronic Medical Record (ER) records identified Resident #44 weight was 186 pounds on admission and on 8/2/24 weighed 161 pounds indicating the resident had a 25 pound or 13 % weight loss in 1 month. However, the clinical record failed to identify a reweight was conducted<br><br>Interview with LPN #1 on 8/8/24 at 1:48 PM identified once a weight discrepancy is determined then the facility usually will do a reweight to ensure the weight was accurate. LPN #1 further indicated the dietician would be informed via dietician book.<br><br>Review of the Dieticians Book on 8/8/24 at 1:50 PM for the month of July 2024 and August 2024 failed to indicate Resident #44 weight change was reported to the dietitian and a reweight was conducted.<br><br>Interview with RN #2 on 8/08/24 at 1:54 PM, indicated s/he would notify Dietician of changes via weight book or Point Click Care (PCC). RN #2 identified Resident #44 has a weight warning on her/his profile. RN # 2 reported once a weight discrepancy is identified then a reweight would be done, s/he was unable to identify that Resident #44 was reweigh. RN # 2 reported s/he was unable to locate Resident # 44's weight for the last 4 weeks.<br><br>After surveyor inquiry, the staff reweigh Resident # 44<br><br>Interview with Dietician on 8/08/24 at 3:00 PM indicated there was a weight discrepancy. The Dietician also reported s/he was at the facility on 8/7/24 and was not informed of Resident # 44's weight loss. S/he would expect to be notified via book or consults in PCC and or during risk meeting. The Dietician reported if s/he was informed, s/he would have asked for a re weight, put interventions in place and would notify the MD and family.<br><br>Facility policy indicates Residents will be weighted weekly for 4 weeks on upon admission. The policy further indicated if 5 lbs weight discrepancy a reweight should be obtained, the charge nurse should then review the weight and compare the weight to the previous weights to determine if a 5% weight change occurred in 30 days. This should be reported to physicians/APRN, responsible party, Registered Dietician, DNS/ADNS and Care Plan Coordinator.<br><br>49100 |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49100<br><br>Based on clinical record review and staff interviews for 1 of 5 residents for (Resident #41) reviewed for Unnecessary Medications, the facility failed to ensure monthly Medication Regimen Reviews (MRR) were completed for a resident on psychotropic medications. The findings include:<br><br>Resident #41 's diagnoses included anxiety disorder, unspecified dementia with other behavioral disturbances and type 2 diabetics mellitus.<br><br>A physician's order dated 2/28/24 directed to start Lorazepam 5 MG by mouth when needed for 60 days.<br><br>On 7/10/24 a physician's order for when needed Lorazepam was ordered for anxiety and combativeness.<br><br>The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #41 as cognitively impaired and required (full) dependent assistance with eating, transfers and bed mobility. The MDS also identified Resident #41 received antipsychotic and anti-anxiety medications.<br><br>The RCP dated 7/19/24 identified psychotropic drug use. Interventions included to monitor routinely for medication specific side effects and to have Medical Doctor (MD) evaluate effectiveness and side effects of medications for possible decrease/elimination of psychotropic drugs.<br><br>A review of the pharmacy consultations from February 2024 to July 2024 identified Resident #41 did not receive monthly Medication Regimen Reviews (MRR) by the pharmacy consultant for the months of May 2024 and June 2024.<br><br>Interview with DNS on 8/08/24 at 12:45 PM indicated s/he was unable to locate the Medication Regimen Reviews (MRR) and s/he would contact the pharmacist to request the information. |