

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075232	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2024
NAME OF PROVIDER OR SUPPLIER Cobalt Lodge Health Care and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 29 Middle Haddam Rd Cobalt, CT 06414	

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)
<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to organize and participate in resident/family groups in the facility.</p> <p>47402</p> <p>Based on review of resident council minutes, and interviews, the facility failed to ensure resident concerns/grievances were addressed. The findings include:</p> <p>Review of the resident council meeting minutes for August, September, and October 2024 identified that expressed concerns were not addressed. The minutes did not contain any references to how the concerns were addressed by facility administration, and the minutes also did not contain any recording of old business.</p> <p>Interview with the Resident Council group on 11/18/24 identified that concerns brought up during the resident council meetings were not formally addressed with the resident council group. They noted there was no follow up at the next meeting that addressed concerns from the previous meeting. The group further noted that the only way they knew concerns were followed up on is if they saw changes made in the facility. Additionally, they identified there were ongoing issues regarding food, and laundry that have been repeatedly brought up in resident council with no decisions, resolutions and/or rationales brought back to the group.</p> <p>Interview on 11/18/24 at 3:30 PM with the Recreation Director identified she never documents the resolutions to the concerns expressed by the resident council group. She noted that the concerns are discussed during the morning meeting, but there is nothing in writing or verbal that is brought back to the resident council group to indicate that the concern was addressed. The Recreation Director could not identify what the resolutions were to the concerns identified in the resident council minutes.</p> <p>Interview on 11/19/24 at 2:40 PM with the President/Owner identified that concerns expressed by the resident council group are discussed during morning meeting, however, he could not provide documentation of what issues had been addressed or the resolution to the concerns.</p> <p>The policy regarding resident council directed that the Recreational Director facilitates the meetings and acts as the liaison between the council and facility leadership. The facilitator is responsible for taking minutes, managing time and dates and ensuring proper communication is done with the facility administration. The policy further noted the facility will act promptly to any issues or concerns discussed by the resident council.</p>

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: 075232	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2024
NAME OF PROVIDER OR SUPPLIER Cobalt Lodge Health Care and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 29 Middle Haddam Rd Cobalt, CT 06414	
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)		
<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47489</p> <p>Based on review of the clinical record, review of facility policy/procedures and interviews for one of two sampled residents (Resident #26) reviewed for advance directives, the facility failed to ensure the physician's order accurately reflected the resident's chosen code status. The findings include:</p> <p>Resident #26 was admitted to the facility in October of 2024 with diagnoses that included acute respiratory failure with hypoxia, dependence on supplemental oxygen, congestive heart failure and Alzheimer's disease.</p> <p>The physician's order dated [DATE] directed a code status of Do Not Resuscitate, A do-not-resuscitate order, or DNR order, is a medical order written by a health care provider. It instructs providers not to do CPR (cardiopulmonary resuscitation) if a patient's breathing stops or if the patient's heart stops beating. Do Not Intubate, A do not intubate (DNI) order is a medical directive that instructs medical professionals not to insert a breathing tube into a patient's trachea. A DNI order is part of an advanced directive for patients with life-limiting illnesses and is used when a patient or their surrogate believes that resuscitation would not be in their best interest. The order further directed: Nurse may pronounce, and body may be released to the funeral home in the event of cardiac arrest.</p> <p>The Admission MDS dated [DATE] identified Resident #26 had moderately impaired cognition, utilized a walker, was taking an anticoagulant (blood thinner), a diuretic, and an opioid (pain medication), and was receiving continuous oxygen.</p> <p>The care plan dated [DATE] identified Resident #26 had a code status of Do Not Resuscitate with an intervention to not perform CPR in the event the resident's heart/breathing stops.</p> <p>Review of the electronic health record (EHR) on [DATE] at 8:19 AM identified an Advance Directive form dated [DATE] that was scanned into the EHR that identified Resident #26 had elected to receive CPR. The form was signed by Resident #26 and RN #4.</p> <p>The advance directive form dated [DATE] and the physician's order dated [DATE] were incongruent and did not reflect the same code status.</p> <p>Interview with the DNS on [DATE] at 7:36 AM identified that in the event a resident stops breathing, the nurse is supposed to check the resident's signed advanced directive form against the physician's orders to verify the resident's code status. She further noted that there books located on the units that contain the signed advance directive forms.</p> <p>A review of the unit 1's advance directive book on [DATE] at 9:14 AM failed to identify a signed Advance Directive form for Resident #26.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075232	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2024
NAME OF PROVIDER OR SUPPLIER Cobalt Lodge Health Care and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 29 Middle Haddam Rd Cobalt, CT 06414	
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)		
<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on [DATE] at 9:14 AM with RN #4 identified Resident #26 had a physician's order that indicated the resident's code status was DNR. She further noted Resident #26's responsible party had filled out an advance directive form after Resident #26 completed an advanced directive form on [DATE]. She further noted that Resident #26's Responsible Party indicated that the resident was not capable of making a decision regarding code status.</p> <p>Interview on [DATE] at 9:29 AM with Resident #26 identified the resident would like CPR administered in the event his/her heart stops and remembers having a conversation with the nurse and signing a form that indicated this decision. Resident #26 further noted he/she could not recall having a discussion with the physician or his/her responsible party regarding code status.</p> <p>Interview on [DATE] at 9:42 AM with the DNS identified she found an additional Advance Directive form dated [DATE] that was signed by the Responsible Party. The Advance Directive had been initiated by the son under the election I do not want CPR. The DNS was not able to confirm the validity of this and identified that the resident was alert and oriented and should be able to make the decision about an advanced directive.</p> <p>Interview on [DATE] at 12:39 PM with the Medical Director identified that if a resident is alert and oriented and able to discuss and make a decision regarding Advanced Directives then the decision of the resident should be followed. If the resident has a power of attorney (POA), then the decision could be changed by that POA if the resident had a sudden cognitive deficit, or loss of the ability to clearly make the decision. The Medical Director identified that in this instance Resident #26's decision and the physician's order should match. He further noted that he had not spoken with the Resident #26's responsible party regarding the resident's code stats. He could not explain why the order and the advanced directive form signed by the resident were incongruent.</p> <p>Interview on [DATE] at 12:52 PM with SW #1 identified Resident #26 was able to decide and sign the advance directive if alert and oriented. The facility process was that nursing explains the Advance Directive to the resident and obtains the signature. SW #1 identified the only way the POA would be able to sign a different code status is if the resident had a significant change in cognition and could no longer make decisions. SW#1 indicated Resident #26 would be able to make the Advance Directive Decision.</p> <p>Although contact was attempted on ,d+[DATE] and [DATE], Resident #26's Responsible party could not be reached.</p> <p>The facility policy for Advance Directives identified the facility recognized the right of each resident to make decisions regarding treatment and to execute directives, and if incapacitated, to have these decisions made on their behalf by the appropriate substitute decision maker. Additionally, the policy indicated all signed advance directives would be kept in a code book on wing 2 and uploaded into the electronic chart.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075232	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2024
NAME OF PROVIDER OR SUPPLIER Cobalt Lodge Health Care and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 29 Middle Haddam Rd Cobalt, CT 06414	
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)		
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46117</p> <p>Based on clinical record review, facility policy review, and interviews for one sampled resident (Resident #31) reviewed for weight loss, the facility failed to notify the dietician, and physician regarding a significant weight loss. The findings include:</p> <p>Resident #31's diagnoses included congestive heart failure, disorder of kidney and ureter, depression, anxiety, and atrial fibrillation.</p> <p>Physician's orders dated 5/15/24 directed to check weight three times per week and notify physician for weight gain or loss equal to 3 pounds (lbs.).</p> <p>Physician's orders dated 8/26/24 directed Resident #31 be provided a regular diet of regular texture, thin liquids and fluid restriction of 1500 milliliters(ml) per day.</p> <p>Review of the weight and vital summary record identified Resident #31 was weighed on 9/25/24 at 11:20 AM with a noted weight of 238.6 pounds.</p> <p>The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #31 had intact cognition, and dependent for bed mobility, toileting, hygiene, transfers, and was non-ambulatory. The assessment further identified Resident #31 was independent with eating with set-up assistance and identified the resident had not experienced a weight loss within the past six months.</p> <p>Resident #31's weight record identified a weight of 223.4 on 10/3/24 (a weight loss of 15.2 lbs.), which was a 6.4 % (percent) weight change in less than a month. The weight record further identified a weight of 219.6 on 10/14/24 (a loss of 19 lbs.) indicative of a 7.9% weight loss in less than thirty days (The standard for determining significant weight loss is 5% within thirty days, 7.5% within three months, and 10% within six months).</p> <p>The Resident Care Plan (RCP) dated 10/10/24 identified Resident #31 had a potential nutritional risk related to depression, anxiety, and obesity. Care plan interventions included: provide and serve diet as ordered, monitor intake and record each meal, dietician to evaluate and make diet recommendations as needed weigh at the same time of the day and record.</p> <p>Review of Resident #31's clinical record from 9/25/24 to 11/1/24 failed to identify that the Physician and/or Dietician was notified of the significant weight loss.</p> <p>Interview with MD #1 on 11/19/24 at 8:45 AM identified the dietician is responsible for following up on residents who have experienced a weight loss. He also identified that the facility should notify the dietician and the physician when there is a weight loss for any resident. He further identified that they follow the weight loss policy when addressing resident weight loss and identified that he typically evaluates the root cause of the weight loss to determine whether it is from a lack of eating or an acute illness. Additionally, MD #1 identified that he was not notified of Resident #31's weight loss but should have been notified.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075232	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2024
NAME OF PROVIDER OR SUPPLIER Cobalt Lodge Health Care and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 29 Middle Haddam Rd Cobalt, CT 06414	

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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with the DNS on 11/19/24 at 9:20 AM identified that Dietician #1 is responsible for assessing residents for weight loss. She identified that she was not sure what the facility's policy for significant weight loss entailed, but identified she would follow what the policy indicated. Further, the DNS identified that she had not conducted any at risk meetings since she started her position. She further identified that Dietician #1, and MD #1 should had been notified of Resident #3's significant weight loss.</p> <p>Interview with LPN #1 on 11/19/24 at 1:00 PM identified that the routine for obtaining weight is the nurse aide obtains the resident's weight and records it on paper, the nurses enter the weight into the electronic health record. LPN #1 identified that she was not sure what the facility's policy was for reporting weight loss. Further, she identified she was not trained on what constituted a significant weight loss and/or when to report the weight loss to the dietician and physician. In addition, she identified that she documents in the nursing notes when there is a significant change in condition which would include weight loss.</p> <p>Attempts to interview Dietician #1 were unsuccessful.</p> <p>The Weight Loss policy identified that the threshold for a significant unplanned weight loss is greater than 5 percent in 1 month and greater than 10 percent in 6 months. It further noted that once the weight loss is verified, nursing should notify the dietician, physician, and family.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075232	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2024
NAME OF PROVIDER OR SUPPLIER Cobalt Lodge Health Care and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 29 Middle Haddam Rd Cobalt, CT 06414	
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)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48335</p> <p>Based on review of the clinical record, review of facility documentation, review of facility policy and interviews for one sampled resident (Resident #13) reviewed for abuse, the facility failed to ensure that an injury of unknow origin was reported to the state survey agency. The findings include:</p> <p>Resident #13's diagnoses included Parkinson's, dementia, and insomnia.</p> <p>The quarterly MDS assessment dated [DATE] identified Resident #13 was severely cognitively impaired, had physical behavioral symptoms directed at others, and required total assistance for bed mobility, transfers, dressing and personal hygiene. The assessment further identified the resident was non-ambulatory and had no functional limitations in range of motion.</p> <p>A nurse's note dated 9/3/24 at 11:30 PM written by RN #2 identified Resident #13 was found with a bruise below the left eye that measured 4 cm by 1 cm and was dark purple in color. The resident was unable to communicate what occurred, neurological checks were initiated, and the on-call APRN, the DNS and Resident #13's Responsible Party were notified.</p> <p>The Reportable Event Report and the skin tear/bruise incident report and investigation forms dated 9/3/24 identified NA#1 reported Resident #13 had a bruise below the left eye. The reports identified they could not identify how the bruise occurred. The forms were missing signatures of the Administrator and/or DNS.</p> <p>A check of the state survey agency's reportable event portal identified that this bruise was not reported to the state survey agency although the reportable event report identified that the facility did not know the origin of the bruise.</p> <p>The care plan dated 9/4/24, identified Resident #13 was at risk for alteration in skin integrity, related to a bruise below the left eye, with interventions that included observing proper technique in positioning and transferring the resident.</p> <p>Interview on 11/18/24 at 8:52 AM with the DNS identified that she had not submitted a reportable event report to the state survey agency regarding Resident #13's bruise because she thought that the cause of the bruise was known (witnessed).</p> <p>In a second interview with the DNS on 11/18/24 at 12:55 PM, she noted that the night shift staff had reported Resident #13 hit his/her head on the wheelchair and noted that this was reported to the on-coming day shift staff. The DNS could not identify who witnessed the accident/incident or why there were not an Accident and Report completed. The DNS was also unable to locate nursing notes or any other documentation regarding the accident.</p> <p>Interview on 11/19/24 at 8:47 AM with the Nursing Supervisor (RN #3) for the 11-7 shift identified that she did not recall any injuries occurring on the 11-7 AM shift.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075232	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2024
NAME OF PROVIDER OR SUPPLIER Cobalt Lodge Health Care and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 29 Middle Haddam Rd Cobalt, CT 06414	
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)		
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 11/19/24 at 9:02 AM with RN #2 (Nursing Supervisor 11-7 shift, identified she had no knowledge of an accident or injury involving Resident #13.</p> <p>The DNS further identified she did not have documentation that indicated that the origin of the bruise was known. She further identified that accidents and incidents are usually discussed in morning meeting. She could not explain why she was under the impression that the origin of the bruise was witnessed, and although witnessed, there were no statements or other documentation from staff to validate that the bruise was not an injury of unknown origin.</p> <p>The Abuse/Neglect policy directed that injuries of unknown origin will be investigated as if they could be the result of an abuse. An injury of unknown origin is reportable if the source of the injury was not observed by anyone, the resident is unable to explain what occurred and if the injury is suspicious due to the extent of injury or injury location, number of injuries at one time or the incidence of injuries over time. The investigation and findings will be documented and submitted to the facility's medical staff for review.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075232	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2024
NAME OF PROVIDER OR SUPPLIER Cobalt Lodge Health Care and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 29 Middle Haddam Rd Cobalt, CT 06414	

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)
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48335</p> <p>Based on review of the clinical record, review of facility documentation, review of facility policy/procedures and interviews for one sampled resident (Resident #13), with an injury of unknown origin, the facility failed to ensure that an investigation was conducted to ascertain the origin of the bruise. The findings include:</p> <p>Resident #13's diagnoses included Parkinson's, dementia, and insomnia.</p> <p>The quarterly MDS assessment dated [DATE] identified Resident #13 was severely cognitively impaired, had physical behavioral symptoms directed at others, and required total assistance for bed mobility, transfers, dressing and personal hygiene. The assessment further identified the resident was non-ambulatory and had no functional limitations in range of motion.</p> <p>A nurse's note dated 9/3/24 at 11:30 PM written by RN #2 identified Resident #13 was found with a bruise below the left eye that measured 4 cm by 1 cm and was dark purple in color. The resident was unable to communicate what occurred, neurological checks were initiated, and the on-call APRN, the DNS and Resident #13's Responsible Party were notified.</p> <p>The Reportable Event Report and the skin tear/bruise incident report and investigation forms dated 9/3/24 identified NA#1 reported Resident #13 had a bruise below the left eye. The reports identified they could not identify how the bruise occurred. The forms were missing signatures of the Administrator and/or DNS.</p> <p>Review of the Supervisor's Daily Report sheet (24-hour report) dated 9/3/24 for the 11-7 shift, indicated no Accident or Incidents, no changes in condition and no new skin or wound issues. Resident #13's bruise was not documented on the 24-hour report.</p> <p>A check of the state survey agency's reportable event portal identified that this bruise was not reported to the state survey agency although the reportable event report identified that the facility did not know the origin of the bruise.</p> <p>The care plan dated 9/4/24, identified Resident #13 was at risk for alteration in skin integrity, related to a bruise below the left eye, with interventions that included observing proper technique in positioning and transferring the resident.</p> <p>Interview on 11/18/24 at 8:52 AM with the DNS identified that she had not submitted a reportable event report to the state survey agency regarding Resident #13's bruise because she thought that the cause of the bruise was known (witnessed).</p> <p>In a second interview with the DNS on 11/18/24 at 12:55 PM, she noted that the night shift staff had reported Resident #13 hit his/her head on the wheelchair and noted that this was reported to the on-coming day shift staff. The DNS could not identify who witnessed the accident/incident or why there were not an Accident and Report completed. The DNS was also unable to locate nursing notes or any other documentation regarding the incident/bruise.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075232	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2024
NAME OF PROVIDER OR SUPPLIER Cobalt Lodge Health Care and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 29 Middle Haddam Rd Cobalt, CT 06414	
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)		
<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 11/19/24 at 8:47 AM with the Nursing Supervisor (RN #3) for the 11-7 shift identified that she did not recall any injuries occurring on the 11-7 AM shift.</p> <p>Interview on 11/19/24 at 9:02 AM with RN #2 (Nursing Supervisor 11-7 shift, identified she had no knowledge of an accident or injury involving Resident #13.</p> <p>The DNS further identified she did not have documentation that indicated that the origin of the bruise was known. She further identified that accidents and incidents are usually discussed in morning meeting. She could not explain why she was under the impression that the origin of the bruise was witnessed, and although witnessed, there were no statements or other documentation from staff to validate that the bruise was not an injury of unknown origin.</p> <p>The Abuse/Neglect policy directed that injuries of unknown origin will be investigated as if they could be the result of an abuse. An injury of unknown origin is reportable if the source of the injury was not observed by anyone, the resident is unable to explain what occurred and if the injury is suspicious due to the extent of injury or injury location, number of injuries at one time or the incidence of injuries over time. The investigation and findings will be documented and submitted to the facility's medical staff for review. It further identified that an investigation of alleged abuse may include statements from witnesses/staff, consultation of family, physician, DPH and Ombudsman. The resident's medical record will be reviewed. A report of the investigation results will contain the information required by the results of investigation form and sent to DPH within 5 days of the allegation. Injuries of unknown origin will be investigated, as if they could be the result of an abuse. An injury of unknown origin is reportable, if the source of the injury was not observed by anyone, the resident is unable to explain what occurred and if the injury is suspicious due to the extent of injury or injury location, number of injuries at one time or the incidence of injuries over time. The investigation and findings will be documented and submitted to the facilities medical staff for review.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075232	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2024
NAME OF PROVIDER OR SUPPLIER Cobalt Lodge Health Care and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 29 Middle Haddam Rd Cobalt, CT 06414	

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)
<p>F 0623</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>46117</p> <p>Based on review of the facility transfer and discharge report and staff interviews, the facility failed to provide evidence of monthly notification to the state Regional Ombudsman's Office of resident transfers and discharge status in the facility. The findings include:</p> <p>Review of the facility's transfer and discharge summary report for the time period of 5/1/24 through 11/19/24 identified the facility had a total of 34 residents discharged or transferred from the facility.</p> <p>Review of the facility documentation of transfers and discharges from 5/1/24 through 11/19/24 failed to identify that the facility notified the state Regional Ombudsman Office of the transfers and discharges from the facility on a monthly basis.</p> <p>Interview with SW #1 on 11/19/24 at 2:00 PM identified that she received training on the submission of the transfers and discharges to the Regional Ombudsman's portal in September of 2024. She could not provide a reason for not submitting the reports but identified that she would start submitting the report of transfers and discharges this month.</p> <p>Although requested, the facility did not provide a policy regarding the submission of notice of transfers and discharges to the Regional Ombudsman's office.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075232	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2024
NAME OF PROVIDER OR SUPPLIER Cobalt Lodge Health Care and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 29 Middle Haddam Rd Cobalt, CT 06414	
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)		
<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47402</p> <p>Based on review of the clinical record, review of facility documentation, review of facility policy/procedures and interviews for one of five sampled residents (Resident #5) reviewed for unnecessary medications, the facility failed develop a care plan for a resident on an anticoagulant. The findings include:</p> <p>Resident #5's diagnoses included long term use of anticoagulants, peripheral vascular disease, acute coronary thrombosis.</p> <p>The physician's order dated 8/19/24 directed to administer 5mg of Eliquis (anticoagulant) every 12 hours by mouth.</p> <p>The annual MDS assessment dated [DATE] identified Resident #5 was cognitively intact, had no behaviors, required maximal assistance with bed mobility, transfers, dressings and personal hygiene, was ambulatory for short distance with maximal assistance and utilized a wheelchair for mobility. The assessment further identified the resident was taking an anticoagulant.</p> <p>The care plan dated 9/30/24 identified Resident #6 was at risk for altered cardiovascular status related to elevated blood pressure and chest pain secondary to angina, and hypertension with interventions that included: assess for chest pain, enforce the need to call for assistance if pain starts and notify physician of abnormalities. Further review of the care plan failed to identify Resident #6 was taking an anticoagulant and/or the possible side effects of taking an anticoagulant and failed to identified interventions to address possible side effects or precautions to take when providing care.</p> <p>The pharmacy consultant's medication regimen review dated 10/4/24 identified a recommendation to monitor Resident #6 for bruising, bleeding, and to monitor for signs/symptoms of thromboembolism (blood clot) related to the resident being on an anticoagulant.</p> <p>Review of the clinical record failed to identify that the pharmacist's recommendation had been addressed.</p> <p>Interview with the DNS on 11/18/24 at 1:10 PM identified that any staff member inclusive of nursing and the social worker can revise/update the care plans.</p> <p>Review of the Care Plan policy directed daily updates to care plans should be added by any member of the IDT (interdisciplinary team) at the time the change is implemented/during the daily clinical meeting. The comprehensive care plan should be reviewed and revised by members of the IDT and the resident, resident's family, surrogate, or representative, as appropriate in conjunction with completion of the Quarterly Assessment.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075232	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2024
NAME OF PROVIDER OR SUPPLIER Cobalt Lodge Health Care and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 29 Middle Haddam Rd Cobalt, CT 06414	
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)		
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47402</p> <p>Based on observation, review of the clinical record, review of facility documentation, review of facility policy/procedures and interviews for one sampled resident (Resident #6) reviewed for medication administration, the facility failed to maintain professional standards and administer medication according to the physician's order and for one sampled resident (Resident #17) reviewed for controlled substance reconciliation, the facility failed to ensure medications that were not administered were documented on the Medication Administration Record (MAR) accurately. The findings include:</p> <p>1. Resident #6's diagnoses included unspecified atrial fibrillation, dysphagia and long-term use of anticoagulants.</p> <p>The care plan dated 7/1/24 identified Resident #1 was at risk for hypertension and atrial fibrillation related to congestive heart failure with interventions that included give cardiac medication as ordered.</p> <p>The quarterly MDS assessment dated [DATE] identified Resident #6 was cognitively intact, required extensive assistance with bed mobility, transfers, dressings and personal hygiene. The assessment further identified that the resident required supervision for eating and had a mechanically altered therapeutic diet.</p> <p>The physician's order dated 11/12/24 directed to administer to administer Eliquis (anticoagulant) 5mg twice daily by mouth.</p> <p>Observation of LPN #2 during medication administration on 11/17/24 at 9:44 AM identified the Eliquis was not administered as ordered due to not having the medication in stock.</p> <p>Interview with LPN #2 on 11/17/24 at 9:50 AM identified Eliquis would be re-ordered from the pharmacy.</p> <p>Interview with LPN #2 on 11/18/24 at 6:45 AM identified Eliquis was re-ordered from the pharmacy on a routine and not emergent status. She further identified that the physician was not updated that Resident #6 did not receive the Eliquis on 11/17/24.</p> <p>Interview with Pharmacist #2 on 11/18/24 at 1:32 PM identified that Eliquis was delivered for Resident #6 on 11/17/24 at 8:55 PM and the medication had not been requested prior to 11/17/24.</p> <p>Interview with MD #1 on 11/19/24 at 8:31 AM identified he was not notified that Resident #6 was not administered Eliquis 5mg on 11/17/24, and noted that if he had been notified, he would have requested the facility to order the medication from the pharmacy on an emergent basis. In addition, he noted that if the medication was unable to be obtained on an emergent basis, he may have opted to order a one-time order for another anticoagulant such as Lovenox. Further, MD #1 noted that it is important for the resident to be administered the Eliquis as ordered because not taking the medication increases the resident's risk for developing a blood clot.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075232	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2024
NAME OF PROVIDER OR SUPPLIER Cobalt Lodge Health Care and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 29 Middle Haddam Rd Cobalt, CT 06414	
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)		
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>According to the literature, Eliquis lowers your chance of having a stroke by helping to prevent clots from forming and not taking it as ordered increases the risk of having a stroke.</p> <p>Review of the medication pass policy directed to remember the five rights of medication: the right resident, the right drug, the right dose, the right route, and the right time and to know the diagnosis and indication for every medication. A change in the form of medication requires a physician's order. Refusal or hold of high-risk medication to include cardiac medication warrants immediate notification to the provider.</p> <p>2. Resident #17's diagnoses included anxiety disorder, major depressive disorder and insomnia.</p> <p>The quarterly MDS assessment dated [DATE] identified Resident #17 was cognitively intact, had no behaviors, required supervision or touch assistance with personal hygiene and was ambulatory with minimal assistance using a walker. The assessment further identified Resident #17 was taking antianxiety medication.</p> <p>The care plan dated 6/20/24 identified Resident #17 used anti-anxiety medication related to anxiety disorder with interventions that included: administer anti-anxiety medications as ordered by physician, monitor side effects and effectiveness every shift, monitor, document and report as needed any adverse reaction to anti-anxiety therapy medication such as drowsiness, lack of energy, slow reflexes, loss of balance and lightheadedness.</p> <p>The physician's orders for the months of August 7, 2024, thru November 2024 directed to administer Lorazepam 1 milligram (mg) by mouth every 12 hours for anxiety or agitation.</p> <p>The physician's order dated 9/11/24 directed Lorazepam 0.5mg by mouth one time a day for anxiety disorder.</p> <p>The physician's order for the month of November 2024 directed Melatonin 5mg by mouth at bedtime for sleep and Carbidopa-Levodopa 25-100 mg give 3 tablets by mouth three times daily for Parkinson's disease.</p> <p>Review of the Medication Administration Record (MAR) identified that the Lorazepam 1mg twice a day doses were scheduled to be administered at 9:00 AM and 9:00 PM. The Lorazepam 0.5mg was scheduled for 2:00 PM and the Carbidopa-Levodopa 25-100 mg give 3 tablets was scheduled for 9:00 AM, 2:00 PM and 9:00 PM and the Melatonin was scheduled to be administered at 9:00 PM.</p> <p>Review of Resident #17's Medication Administration Record (MAR) and the Controlled Substance Disposition Record (CSDR) for the months of September 2024 through November 2024 identified the following discrepancies:</p> <p>1. On 9/21/24, the MAR reflected Lorazepam 0.5mg was administered at 2:00 PM. The CSDR identified Lorazepam 0.5mg was not signed out/administered for the scheduled 2:00 PM scheduled dose. Further review of the Controlled Substance Disposition Record identified Lorazepam 1mg was administered at 2:00 PM (Lorazepam 0.5mg is what should have been administered).</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075232	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2024
NAME OF PROVIDER OR SUPPLIER Cobalt Lodge Health Care and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 29 Middle Haddam Rd Cobalt, CT 06414	
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)		
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. On 10/10/24, the MAR reflected Lorazepam 1mg was administered at 9:00 AM. The CSDR identified Lorazepam 0.5 mg was signed out for the scheduled 9:00 AM dose instead of the ordered dose of Lorazepam 1mg.</p> <p>3. On 10/13/24, the MAR reflected Lorazepam 1mg was administered at 9:00 PM. The CSDR failed to reflect Lorazepam 1mg was signed out for the scheduled 9:00 PM dose.</p> <p>4. On 10/19/24, the MAR reflected Lorazepam 1mg was administered at 9:00 PM. The CSDR failed to reflect Lorazepam 1mg was signed out for the scheduled 9:00 PM dose.</p> <p>5. On 10/20/24, the MAR reflected Lorazepam 1mg was administered at 9:00 PM. The CSDR failed to reflect Lorazepam 1mg was signed out for the scheduled 8:00 AM dose.</p> <p>6. On 10/20/24, the MAR identified Lorazepam 0.5mg was administered at 2:00 PM, but the Controlled Substance Disposition Record identified Lorazepam 0.5mg was not administered (it was not signed out) for the scheduled 2:00 PM dosage.</p> <p>7. On 10/24/24, the MAR identified Lorazepam 0.5mg was administered at 2:00 PM, but the Controlled Substance Disposition Record identified reflected the Lorazepam 0.5mg was not signed out for the scheduled 2:00 PM administration.</p> <p>8. On 10/27/24, the MAR reflected Lorazepam 1mg was administered at 9:00 PM. The CSDR failed to reflect Lorazepam 1mg was signed out for the scheduled 9:00 PM dose.</p> <p>9. On 11/2/24, the MAR identified Lorazepam 0.5mg was administered at 2:00 PM. The Controlled Substance Disposition Record identified Lorazepam 0.5mg was signed out on 11/2/24 at 7:00 AM instead of the ordered dose of 1mg. further the MAR also reflected Lorazepam 1mg was administered at 9:00 AM, but the CSDR failed to reflect Lorazepam 1mg was signed out for the 9:00 AM dose.</p> <p>10. On 11/9/24, the MAR identified Lorazepam 1mg was administered at 9:00 AM but failed to reflect that Lorazepam 1mg was administered at 9:00 PM. The CSDR failed to reflect Lorazepam 1mg was signed out for the scheduled 9:00 AM or 9:00 PM doses. Further on 11/9/24, the MAR failed to reflect initials of the administering nurse for the scheduled 9:00 PM dose of Melatonin 5mg and Carbidopa-Levodopa 25-100mg (the initials signify that the medication was given and if the medication was not administered, there should be documentation of the reason why the medication was not administered.</p> <p>Interview on 11/18/24 at 10:26 AM with the Nursing Supervisor (RN#4) who worked the 3:00 PM to 11:00 PM shift on 11/9/24 identified she did not sign off the 9:00 PM medications in the MAR when she administered them to the resident. RN #4 did not provide a reason for not initialing the MAR to indicate that the medications were given.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075232	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2024
NAME OF PROVIDER OR SUPPLIER Cobalt Lodge Health Care and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 29 Middle Haddam Rd Cobalt, CT 06414	

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)
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview with the Charge Nurse (LPN #3) on 11/18/24 at 2:37 PM (LPN #3 was identified as responsible for the medication administration discrepancies) identified his process for administering controlled medications, is to remove the medication from the blister pack, sign the resident's control substance disposition record with the date, time, amount taken, signature, and amount left. He further noted that once that is done, he initials the MAR to indicate that the medication was administered. LPN #3 noted that he was a new nurse and new to long-term care. He identified, he was instructed to not administer medications in the dining room and to not wake some of the residents. LPN #3 indicated he was not familiar with the computerized MAR to document when he did not administer the medication, and acknowledged he did not write a note, or report the issue to the Nursing Supervisor or the DNS.</p> <p>Interview with LPN #3 on 11/19/24 at 11:57 AM identified that he was on orientation for a day and half, and a nurse observed him administering medications for only half of a shift. LPN #3 further identified he did not receive medication competency training on orientation.</p> <p>Interview with MD #1 on 11/19/24 at 9:03 AM identified he was not notified that Resident #17 was not receiving his/her scheduled Lorazepam as prescribed until today. MD #1 noted that he expects to be notified when a medication is not administered as ordered. MD #1 further noted that if Resident #17 received an increase dose of Lorazepam (1mg) it could cause over sedation and a decreased Lorazepam dose (0.5mg) dose could cause increased anxiety and if the medication was not administered it could cause the resident to experience an increase in agitation and anxiety.</p> <p>Review of the medication pass policy identified that medications are administered safely and timely per the physician's orders. The policy further identified that administration of medications must be documented at the time of the medication pass, and document medications withheld, refused, or given at a time other than schedule.</p> <p>47900</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075232	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2024
NAME OF PROVIDER OR SUPPLIER Cobalt Lodge Health Care and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 29 Middle Haddam Rd Cobalt, CT 06414	
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)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47489</p> <p>Based on observations, review of clinical records, review of facility documentation, review of facility policy/procedures and interviews for one sampled resident (Resident #17) reviewed for controlled substance reconciliation, the facility failed to ensure medications were administered accurately according to physician's orders and for one sampled resident (Resident #26) reviewed for oxygen use, the facility failed to ensure the physician's order for oxygen use and documentation of resident status including lung sounds were followed. The findings include:</p> <p>1. Resident #17's diagnoses included anxiety disorder, major depressive disorder and insomnia.</p> <p>The quarterly MDS assessment dated [DATE] identified Resident #17 was cognitively intact, no behaviors, required supervision or touch assistance with personal hygiene and ambulated with minimal assistance using a walker. The assessment further identified Resident #17 was taking antianxiety medication.</p> <p>The care plan dated 6/20/24 identified Resident #17 uses anti-anxiety medication related to anxiety disorder with interventions that included to administer anti-anxiety medications as ordered by physician, monitor side effects and effectiveness every shift, monitor, document and report as needed any adverse reaction to anti-anxiety therapy medication such as drowsiness, lack of energy, slow reflexes, loss of balance and lightheadedness.</p> <p>The physician's order for the months of August 7, 2024, thru November 2024 directed lorazepam 1 milligram (mg) by mouth every 12 hours for anxiety or agitation.</p> <p>The physician's order dated 9/11/24 directed lorazepam 0.5mg by mouth one time a day for anxiety disorder.</p> <p>Observation of Resident #17's Controlled Substance Disposition Record for Lorazepam 1mg for the month of October 2024 and November 2024 with LPN #2 on 11/18/24 at 6:39 AM identified the following:</p> <p>On 10/24/24 identified Lorazepam 1mg was given/taken for scheduled 2:00 PM dosage instead of the Lorazepam 0.5 mg ordered by the physician.</p> <p>On 10/27/24 identified Lorazepam 1mg was not given/taken for scheduled 9:00 PM dosage.</p> <p>On 11/2/24 identified Lorazepam 1mg was not given/taken for scheduled 8:00 AM dosage.</p> <p>On 11/9/24 identified Lorazepam 1mg was not given/taken for scheduled 9:00 AM dosage.</p> <p>Interview with the Charge Nurse (LPN #2) on 11/18/24 at 6:39 AM identified she does not work on the unit during the day shift, as the resident's Lorazepam medications were scheduled to be administered on the day and evening shifts.</p> <p>Review of Resident #17's August 2024 thru November 2024 Controlled Substance Disposition Record for Lorazepam 1mg tablets identified the following:</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075232	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2024
NAME OF PROVIDER OR SUPPLIER Cobalt Lodge Health Care and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 29 Middle Haddam Rd Cobalt, CT 06414	
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)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 9/21/24 identified Lorazepam 1mg was given/taken for the scheduled 2:00 PM dosage instead of the Lorazepam 0.5mg ordered by the physician.</p> <p>On 10/10/24 identified Lorazepam 0.5 mg was given/taken for the scheduled 9:00 AM dosage instead of the Lorazepam 1mg ordered by the physician.</p> <p>On 10/13/24 identified Lorazepam 1mg was not given/taken for scheduled 8:00 PM dosage.</p> <p>On 10/19/24 identified Lorazepam 1mg was not given/taken for scheduled 9:00 PM dosage.</p> <p>On 10/20/24 identified Lorazepam 1mg was not given/taken for scheduled 8:00 AM dosage.</p> <p>Review of Resident #17's Medication Administration Record (MAR) for the months of August 2024, thru November 2024 of Lorazepam 1 mg administration identified the following:</p> <p>The MAR on 10/10/24 identified Lorazepam 1mg was administered at 9:00 AM by LPN #3.</p> <p>The MAR on 10/13/24 identified Lorazepam 1mg was administered at 9:00 PM by LPN #3.</p> <p>The MAR on 10/19/24 identified Lorazepam 1mg was administered at 9:00 PM by LPN #3.</p> <p>The MAR on 10/20/24 identified Lorazepam 1mg was administered at 9:00 PM by LPN #3.</p> <p>The MAR on 10/24/24 identified Lorazepam 1mg was administered at 8:00 AM by LPN #3.</p> <p>The MAR on 10/27/24 identified Lorazepam 1mg was administered at 9:00 PM by LPN #3.</p> <p>The MAR on 11/2/24 identified Lorazepam 1mg was administered at 9:00 AM by LPN #3.</p> <p>The MAR on 11/9/24 identified Lorazepam 1mg was administered at 9:00 AM by LPN #3.</p> <p>Review of Resident #17's August 2024 thru November 2024 Controlled Substance Disposition Record for Lorazepam 0.5mg tablets identified the following:</p> <p>On 9/21/24 identified Lorazepam 0.5mg was not given/taken for scheduled 2:00 PM dosage.</p> <p>On 10/20/24 identified Lorazepam 0.5mg was not given/taken for scheduled 2:00 PM dosage.</p> <p>On 10/24/24 identified Lorazepam 0.5mg was not given/taken for scheduled 2:00 PM dosage.</p> <p>On 11/2/24 at 7:00 AM Lorazepam 0.5mg one tablet was given/taken instead of the Lorazepam 1mg ordered by the physician for 8:00 AM schedule dosage.</p> <p>Review of Resident #17's Medication Administration Record (MAR) for the months of September 2024, thru November 2024 of Lorazepam 0.5mg administration identified the following:</p> <p>The MAR on 9/21/24 identified Lorazepam 0.5mg was administered at 2:00 PM</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075232	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2024
NAME OF PROVIDER OR SUPPLIER Cobalt Lodge Health Care and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 29 Middle Haddam Rd Cobalt, CT 06414	

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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The MAR on 10/20/24 identified Lorazepam 0.5mg was administered at 2:00 PM</p> <p>The MAR on 10/24/24 identified Lorazepam 0.5mg was administered at 2:00 PM</p> <p>Review of Resident #17's clinical record failed to identify any reason as to why the schedule Lorazepam 0.5mg daily dosage at 2:00 PM and Lorazepam 1mg every 12 hours at 9:00 AM and 9:00 PM was not administered to the resident.</p> <p>Interview with the DNS on 11/18/24 at 7:35 AM identified that the facility does not store emergency supply of controlled substances, however, the facility will begin to have emergency-controlled substance on-hand as the secured lock box was recently installed in the medication storage room.</p> <p>Interview and review of the MAR for September 2024 thru November 2024 with the Charge Nurse (LPN #3) on 11/18/24 at 2:37 PM identified when asked what his process was for administering controlled drugs and he responded that he would remove the medication from the blister pack, then sign the resident's control substance disposition record with the date, time, amount taken, signature and amount left. He further identified if the control substance disposition record was not signed then the medication was not administered to the resident. LPN #3 identified the initials on the MAR was his and he had worked the unit on the days of the missed dose and incorrect dose administration for Resident #17. He further identified his initial on the MAR indicates that the medication was administer to the resident. LPN #3 further identified he was a new nurse and a new to the long-term care facility and was told not to administer medications in the dining room and not to wake some of the residents. He identified on 11/2/24, that he had administered the incorrect dose of Lorazepam by giving 0.5mg instead of 1mg and had told someone, however, was unable to recall who he told, nor did he document in the progress note. LPN #3 indicated he was not familiar with the computerized MAR to document when he did not administer the medication, nor did he write a note, nor did he report the issue to the supervisor or DNS. He indicated that he is aware that if the resident refused or did not take the medication, he was to document refusal and to notify the supervisor, however in these cases he failed to do such. LPN #3 further added that he did administer Resident #17's schedule medication maybe late, but the controlled drugs were not administered.</p> <p>Interview with the Supervising Pharmacist Consultant (Pharmacist #3) on 11/18/24 at 2:00 PM identified when Resident #17 missed his/her scheduled Lorazepam dosage or receive less than the amount prescribed it would cause an adverse reaction of increase withdrawal with symptoms such as having a headache due to the resident not getting the medication. Pharmacist #3 identified if Resident #17 received an increase dose of Lorazepam it could cause increase sedation.</p> <p>Interview with the DNS on 11/18/24 at 4:00 PM identified that LPN #3 did not receive any medication competency on orientation nor does the facility has an orientation checklist. The DNS indicated that orientation training was scheduled based on the nurse's experience and their verbalization of needing additional training in which she was not aware by LPN#3 he needed/required additional orientation.</p> <p>Interview with LPN #3 on 11/19/24 at 11:57 AM identified he was only on orientation for a day and half, a nurse observed him administering medications for only half of a shift and he did not receive any medication competency training on orientation. LPN #3 indicated he did not make the facility aware he needed any assistance with the computer because he thought that he did not have an issue until recently.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075232	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2024
NAME OF PROVIDER OR SUPPLIER Cobalt Lodge Health Care and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 29 Middle Haddam Rd Cobalt, CT 06414	
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)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with the MD #1 on 11/19/24 at 9:03 AM identified he was not informed/notified that Resident #17 was not receiving his/her schedule Lorazepam as prescribed until today. MD #1 expects when medications are prescribed that they are administered as such and if the nurse is unable to that the medical provider is notified, and a note is written. MD #1 further identifies he review nursing notes at least monthly and cannot recall seeing a note regarding Resident #17 refusal or not getting his/her medication, nor did the resident express that he/she was not getting the medication. MD #1 identified that if Resident #17 received an increase dose of Lorazepam (1mg) it could cause over sedation; received decrease Lorazepam dose (0.5mg) will cause increase anxiety and if the medication was not administered could cause increase in agitation and anxiety.</p> <p>Review of the Administration of Controlled Medications policy identified administer medications only as prescribed in the resident's care plan and medical orders, which includes administering the correct drug, dose, route, and time.</p> <p>Review of the Controlled Medications policy identified that controlled substance would only be administered according to a physician's order, and each administration must be documented on the Medication Administration Record (MAR). The policy further identified that for schedule II medications, additional documentation is required in a controlled substance log known as a count sheet, which includes: the resident's name, name of the medication, dose administered, time and date of administration, amount remaining in the stock and signatures of the staff involved in the administration and documentation.</p> <p>2. Resident #26 was admitted to the facility in October of 2024 with diagnoses that included acute respiratory failure with hypoxia, dependence on supplemental oxygen, congestive heart failure and Alzheimer's disease.</p> <p>The admission MDS assessment dated [DATE] identified Resident #26 had moderately impaired cognition, utilized a walker, was taking an anticoagulant (blood thinner), a diuretic, and an opioid (pain medication), and was receiving continuous oxygen.</p> <p>The care plan dated 11/6/24 identified Resident #26 had impaired cognitive function related to dementia with interventions to administer medications as ordered and monitor for side effects and effectiveness.</p> <p>The monthly physician's orders for November 2024 directed to apply Oxygen at 2 Liters per minute via nasal cannula continuous every shift related to acute respiratory failure with hypoxia, change and date oxygen tubing and humidifier as applicable, and to change the storage bag every week on Sunday 11-7 shift. Additionally, the physician's orders directed to write a progress note every shift regarding pain, behaviors, mental status, respirations, lung sounds, bilateral lower extremity edema, wounds, mental status, vital signs, and fluid restriction.</p> <p>A physician's order dated 11/16/24 identified Resident #26 was taking antibiotics for pneumonia.</p> <p>Nursing progress note dated 11/5/24 at 1:58 PM identified a stat chest Xray was ordered, and the resident was encouraged to do incentive spirometer.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075232	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2024
NAME OF PROVIDER OR SUPPLIER Cobalt Lodge Health Care and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 29 Middle Haddam Rd Cobalt, CT 06414	
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)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The nursing note dated 11/15/24 at 10:03 PM identified the results of the chest Xray were shared with the on call APRN who ordered antibiotics and added an extra 20 mg of Lasix in the afternoon for 3 days, and as needed nebulizer treatments. The note further indicated Resident #26 was short of breath during ambulation, but vital signs were stable and pulse oximetry was within normal limits.</p> <p>Review of the nursing notes for 11/15, 11/16, 11/17, and 11/18/24 failed to identify documentation of lung assessments.</p> <p>Review of the MAR for the month of November 2024 identified vital signs, including blood pressure, temperature, pulse, respirations, oxygen saturation for each shift were documented as ordered, but failed to include documentation of lung sounds.</p> <p>Observation on 11/17/24 at 7:45 AM identified Resident #26 was seated in a recliner with nasal cannula in place. The oxygen tubing was connected to the oxygen condenser which was approximately 6 feet away from the resident. The oxygen condenser was set at 3 liters.</p> <p>Review of the MAR for the month of November 2024 identified oxygen was checked for accuracy on 11/18/24 at 8:22 AM by RN #4.</p> <p>Observation on 11/18/24 at 9:31 AM identified Resident #26 had a nasal cannula in place attached to the oxygen condenser that was set to 3 liters. There was a piece of tape with the date 11/18/24 written on it, which Resident #26 did not notice. The resident was seated in the recliner approximately 6 to 8 feet from the oxygen condenser unit. There was a tray table in front of the resident and a walker to the side of the resident.</p> <p>Interview on 11/18/24 at 9:39 AM with RN #4 identified that she had marked off that the oxygen was checked for accuracy that morning. Additionally, she identified that she may have checked quickly and did not notice the 3 liters. She adjusted the flow to 2 liters. RN #4 identified that she checked lung sounds if the resident complained of breathing difficulty or if she noticed breathing difficulties.</p> <p>Interview on 11/18/24 at 12:47 PM with the Medical Director identified he expected orders to be carried out as they are written. The Medical Director identified that oxygen should be applied at the dose ordered and can adversely affect a resident with ongoing respiratory issues when not set at the appropriate level. The Medical Director indicated that lung sounds should be part of any respiratory assessment or ongoing monitoring and should be documented in the chart.</p> <p>The facility oxygen policy identified the policy of the facility was to provide supplemental oxygen in accordance with a physician's order and indicated the tubing would be changed weekly on 11-7 shift for prolonged use.</p> <p>47900</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075232	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2024
NAME OF PROVIDER OR SUPPLIER Cobalt Lodge Health Care and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 29 Middle Haddam Rd Cobalt, CT 06414	
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)		
<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47900</p> <p>Based on observations, review of the clinical record, review of facility documentation, review of facility policy and interviews for one sampled resident (Resident #20) reviewed for range of motion and splint usage, the facility failed to ensure the splint was applied according to physician's orders. The finding include:</p> <p>Resident #20's diagnoses included dementia, delusional disorders and dysthymic disorders.</p> <p>The quarterly MDS assessment dated [DATE] identified Resident #20 had severely impaired cognition, was dependent for toileting hygiene, dressing, personal hygiene, transfers, was non-ambulatory and had functional limitations in range of motion to bilateral upper and lower extremities.</p> <p>The care plan dated 10/31/24 identified Resident #20 was at risk for contractures to the left upper extremity (LUE) with interventions that included monitor skin integrity of LUE with each splint application and removal for the presence of any redness, skin breakdown and resting hand splint on left arm to be on at all times except for ADL's (activity of daily living) and patient care.</p> <p>The physician's order dated 11/19/24 with an origination date of 6/24/24 directed left resting hand splint on for PM and AM hours, off for ADL's and patient care, monitor for skin integrity with each application and removal every shift for splint application and removal.</p> <p>Observation on 11/17/24 at 7:45 AM identified Resident #20 lying supine on his/her bed without the application of a resting hand splint to the left extremity.</p> <p>Observation on 11/17/24 at 12:45 PM identified Resident #20 seated in his/her wheelchair in the dining room being fed by a nurse aide. The resident did not have the splint on the left extremity.</p> <p>Observation on 11/18/24 at 8:28 AM identified Resident #20 seated in his/her wheelchair in the dining rooms in his/her wheelchair being fed breakfast by the DNS without the application of a resting hand splint to the left extremity.</p> <p>Review of the Treatment Administration Record (TAR) with the Charge Nurse (LPN #1) on 11/18/24 at 2:18 PM identified the physician's order which directed splint: (left resting hand splint on for PM and AM hours, off for ADL's and patient care, monitor for skin integrity with each application and removal) every shift for splint application and removal was signed off for 11/18/24 by LPN #1 as having been completed. LPN #1 identified she had completed the treatment as it involved checking the resident's skin integrity and did not included application of a splint on the day shift.</p> <p>Observation on 11/18/24 at 2:18 PM with the LPN #1 identified Resident #20 was in the recreational activity room seated in his/her wheelchair without the application of a resting hand splint to the left extremity. LPN #1 then found Resident #20's splint in the top drawer of his/her nightstand.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075232	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2024
NAME OF PROVIDER OR SUPPLIER Cobalt Lodge Health Care and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 29 Middle Haddam Rd Cobalt, CT 06414	

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)
<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with the LPN #1 on 11/18/24 at 2:18 PM identified she was the regular day shift nurse for that unit since October 2024 and thought the resident wore the splint at night and it was removed during the day where she would check the resident's skin integrity. LPN #1 read the order over and she clarified the order with the occupational therapist who identified that the splint to left hand was to be worn at all times except for patient care and ADL's. LPN #1 identified that the nurse would apply the splint, and the nurse aides could remove the splint for care. She identified that she had checked Resident #20's skin integrity earlier, when the nurse aide supposedly had removed the splint.</p> <p>Interview with the NA #3 on 11/18/24 at 2:24 PM identified that he did not remove a splint off Resident #20's left hand, nor did he apply a splint to the left extremity that morning. NA #3 further identified he recently started working at the facility about 3 months ago and did not receive any training on splint application for Resident #20.</p> <p>Review of Resident #20's resident care card as of 11/19/24 identified resting hand splint on left arm on at all times except for ADL's and patient care.</p> <p>Interview with the Occupational Therapist (OT #1) on 11/18/24 at 2:25 PM identified Resident #20 should have the splint to the left hand applied in the AM, PM and at mealtimes, and only removed for care and skin checks. OT #1 identified that Resident #20 requires the splint due to his/her contracture of the metacarpal phalangeal joint (MCP) of the left hand and if not worn will increase the risk of more contractures. OT #1 further identified she had last seen the resident last week (11/12/24) with the splint to the left hand and did not identify any increased contractures to the left hand. OT #1 identified that training was provided to the staff on the initiation of the splint on June 25, 2024, added to the care plan and the resident care card as the nurse aide can apply the splint as they were trained.</p> <p>Review of the Splinting policy and procedure under the therapy section identified that splints, either custom made or prefabricated are used to provide contracture management or reduction. The policy and procedure further identified once the wearing schedule is established; the physician's clarification order should specify the type of splint where it is to be applied, and the wearing schedule and the treating therapist is to provide instruction to the nursing staff regarding the wearing schedule.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075232	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2024
NAME OF PROVIDER OR SUPPLIER Cobalt Lodge Health Care and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 29 Middle Haddam Rd Cobalt, CT 06414	

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)
<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46117</p> <p>Based on clinical record review, facility policy review, and interviews for one of three residents (Resident #31) reviewed for nutrition, the facility failed to ensure that the dietician and/or physician assessed the resident for significant weight loss timely. The findings include:</p> <p>Resident #31 's diagnoses included congestive heart failure, disorder of kidney and ureter, depression, anxiety, atrial fibrillation.</p> <p>Physician's orders dated 5/15/24 directed to check weight three times per week and notify physician for weight gain or loss equal to 3 pounds(lbs.).</p> <p>Physician's orders dated 8/26/24 directed for Resident #31 to have regular diet of regular texture, thin liquid and fluid restriction of 1500 Milliliters(ml) per day.</p> <p>Review of the weight and vital summary identified Resident #31 was weighed on 9/25/24 at 11:20 AM with a weight of 238.6 pounds.</p> <p>The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #31 had intact cognition and dependent assistance with bed mobility, toileting, hygiene, transfer, and non-ambulatory. The assessment further identified Resident #31 was independent with eating with set-up assistance and did not identify a weight loss within the past six months.</p> <p>Further weight record reviewed identified Resident #31 was weighed on 10/3/24 at 2:31 PM with a weight of 223.4 lbs. (weight loss of 6.4 percent from 9/25/24), on 10/14/24 at 12:34 PM with a weight of 219.6 lbs. (weight loss of 7.9 percent from 9/25/24), and on 11/1/24 at 7:32 AM with a weight of 220 lbs. (weight loss of 7.8 percent from 9/25/24).</p> <p>The Resident Care Plan (RCP) dated 10/10/24 identified Resident #31 had the potential for nutritional risk related to depression, anxiety, and obesity. Care plan interventions included: provide and serve diet as ordered, monitor intake and record each meal, dietician to evaluate and make diet recommendations as needed weight at the same time of the day and record.</p> <p>Review of dietician #1 notes from 9/25/24 through 11/1/24 failed to identify Resident #31 was assessed for weight loss.</p> <p>Reviewed of physician progress notes from 9/25/24 through 11/1/24 failed to identify Resident #31 was assessed for weight loss.</p> <p>Review of nurse's notes from 9/25/24 through 11/1/24 failed to identify that the nursing staff identified that Resident #31 had a significant weight loss from his/her previous weight.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075232	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2024
NAME OF PROVIDER OR SUPPLIER Cobalt Lodge Health Care and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 29 Middle Haddam Rd Cobalt, CT 06414	

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)
<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview with MD #1 on 11/19/24 at 8:45 AM identified that the dietician would be responsible to follow through of any resident's weight loss. He also identified that the facility would notify the dietician and the physician when there is a weight loss for any resident. He identified that the facility would follow it policy in addressing of a resident weight loss. He identified that he would typically evaluate the root cause of the resident weight loss whether it was lack of eating or an acute illness. He further identified that he was not notified when Resident #31 had a weight loss of more than 5 percent, but he would expect the facility would notify the physician when it identified the weight loss.</p> <p>Interview with DNS on 11/19/24 at 9:20 AM identified that Dietician #1 would be responsible for assessing resident for weight loss. She identified that she was not sure what the facility policy for significant weight loss, but she would follow what indicated in the policy for identifying a significant weight loss. She also identified that she had not conducted any at risk meeting at the facility since she started her position at the facility. She further identified that Dietician #1 and MD #1 should had assessed Resident #31 for a significant weight loss in one month.</p> <p>Interview with LPN #1 on 11/19/24 at 1:00 PM identified that NA would obtain the resident weight and the nurse would record the weight in the electronic record. She identified that she was not sure what is the facility policy of reporting weight loss. She identified that she was not trained on what a significant weight loss and when to report the weight loss to the dietician and physician. She further identified that she would document in the nurse notes when there is a significant change of condition with the resident such as a weight loss for a resident.</p> <p>Attempts to interview Dietician #1 were unsuccessful.</p> <p>The Weight Loss policy identified that all weight loss would be medically appropriate and safe in accordance with each individual resident to prevent malnutrition, unintentional weight loss and other weight loss complication. The threshold for a significant unplanned weight loss would be greater than 5 percent in 1 month and greater than 10 percent in 6 months.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075232	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2024
NAME OF PROVIDER OR SUPPLIER Cobalt Lodge Health Care and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 29 Middle Haddam Rd Cobalt, CT 06414	
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)		
<p>F 0726</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.</p> <p>47402</p> <p>Based on review of facility documentation, review of facility policy/procedures and interviews for four of five sampled nursing staff (NA #4, NA #6, LPN #4 and RN #8) the facility failed to ensure staff competencies were completed. The findings included:</p> <p>Review of NA #4's personnel file identified she was hired in November of 2022. NA #4's personnel file did not contain documentation of competencies.</p> <p>Review of NA #6's personnel file identified she was hired in July of 1980. NA #6's personnel file did not contain documentation of competencies.</p> <p>Review of LPN #4's personal file identified he was hired in September of 2024. LPN #4's personnel file did not contain documentation of competencies.</p> <p>Review of RN #8's personnel file identified she was hired in August of 2024. RN #8's personnel file did not contain documentation of competencies.</p> <p>Interview with Business Office Staff #1 on 11/19/24 at 7:45 AM identified she was responsible for a portion of the employee file however did not retain the training or competencies and the competencies would be completed by the nursing department.</p> <p>Interview with the DNS on 11/19/24 at 9:58 AM identified she could not locate competencies completed for the staff requested and identified she had completed some random observation when staff didn't know she was looking, however when requested documentation of these competencies were written.</p> <p>Review of the Staff competencies policy effective 11/19/24 identified it is the policy of the facility to ensure that all staff possess the necessary competencies to deliver high-quality, safe, and effective care to our residents. New hires will complete an initial competency assessment upon employment.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075232	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2024
NAME OF PROVIDER OR SUPPLIER Cobalt Lodge Health Care and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 29 Middle Haddam Rd Cobalt, CT 06414	
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)		
<p>F 0730</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Observe each nurse aide's job performance and give regular training.</p> <p>47402</p> <p>Based on review of facility documentation, review of facility policy/procedures and interviews for three of three sampled nurse aides (NA #4, #6, #8), the facility failed to ensure performance reviews were completed. The findings included:</p> <p>Review of personnel records indicated NA#4 started on 11/16/22, NA #8 started on 7/11/24, and NA #6 started in 7/1980, and did not contain and performance evaluations for 2024, 2023, or 2022.</p> <p>Interview with Business office #1 on 11/19/24 at 7:45 AM identified she was responsible for a portion of the employee file however did not retain the training or competencies and the competencies would be completed by the nursing department.</p> <p>Interview with DON on 11/19/24 at 9:58 AM identified performance reviews were not being completed and could not be located from before she started as well.</p> <p>Review of the Performance Review policy directed all new employees will receive a performance review at the end of their probationary period. All employees will undergo a formal performance review annually, unless otherwise required by state or federal regulations or contractual obligations.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075232	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2024
NAME OF PROVIDER OR SUPPLIER Cobalt Lodge Health Care and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 29 Middle Haddam Rd Cobalt, CT 06414	
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)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47900</p> <p>Based on observation, review of facility documentation, review of facility policy and interviews, the facility failed to ensure that controlled medications were periodically reconciled to ensure against diversion of medication. The findings include:</p> <p>Interview with the DNS on [DATE] at 1:05 PM identified she had stored the returned/unused controlled substances in the DNS's office in a drawer which has not been reconciled, as the previous DNS left without them reconciling the controlled drugs together. The DNS identified she started working at the facility in August of 2024 and had not destroyed or reconciled any of the controlled drugs. The DNS identified on her a desk a folder with Controlled Substance Disposition Records which comes in a duplicate form, a yellow sheet kept by the DNS and the white sheet used on the unit. She identified there is a folder filled with both yellow and white copy of the Controlled Drug Disposition Records that has not been reconciled, by matching the yellow copy with the white copy together.</p> <p>Observation of the locked storage drawer located in the DNS's office for returned unused controlled substances with the DNS on [DATE] at 1:05 PM identified the storage drawer contained an over-flowing contents of blister packets, controlled substance patches, and bottles containing liquid controlled substances which did not allow for easy opening of the drawer along with the white copy of the Controlled Substance Disposition Records.</p> <p>Review of the white copy of the Controlled Substance Disposition Records located in the drawer identified the following controlled substance categories of medications:</p> <p>One white copy of patch Analgesic Opioid medication sheet</p> <p>Two white copies of tablet form of Sedative -hypnotic medication sheets</p> <p>One white copy of capsule form of Anticonvulsant medication sheet</p> <p>Fourteen white copies of tablet form of Antianxiety medication sheets</p> <p>Twenty-eight white copies of tablet form of Analgesic Opioid medication sheets</p> <p>Ten white copies of liquid form of Analgesic Opioid medication sheets</p> <p>Nine white copies of liquid form Antianxiety medication sheets</p> <p>Review of the controlled destruction records with the DNS on [DATE] at 1:05 PM identified the following:</p> <p>On [DATE] the facility destroyed a total of 12 controlled drugs.</p> <p>On [DATE] the facility destroyed a total of 13 controlled drugs.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075232	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2024
NAME OF PROVIDER OR SUPPLIER Cobalt Lodge Health Care and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 29 Middle Haddam Rd Cobalt, CT 06414	
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)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview with the DNS on [DATE] at 1:05 PM identified that audits of the controlled substance on the unit should be completed monthly, however since employed at the facility she has yet to complete any or locate any that were completed by the previous DNS. The DNS further identified she had not located the yellow copy of the returned/unused controlled substance disposition record as she was waiting to reconcile with another nurse and the Administrator since the previous DNS left without them reconciling the medications. The DNS identified the returned/unused controlled substances should be destroyed and reconcile at least monthly, but she has not done so due to her workload.</p> <p>Review of the Controlled Medications policy and procedure identified all controlled substance transactions orders, receipt, administration, and disposal must be thoroughly documented. Also, monitoring and disposal of controlled substances that unused, expired, or discontinued controlled medications must be securely disposed of in accordance with the Drug Enforcement Agency's secure and responsible drug disposal act and any applicable state laws. The policy and procedure further identified prevention of drug diversion that the facility would implement safeguards to prevent the diversion of controlled substances which includes regular audits of controlled substances to ensure proper inventory management, monitoring of narcotic administration practices, including verification of signatures and any discrepancies, random or schedule checks of medication storage areas by supervisory staff.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075232	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2024
NAME OF PROVIDER OR SUPPLIER Cobalt Lodge Health Care and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 29 Middle Haddam Rd Cobalt, CT 06414	
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)		
<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17723</p> <p>Based on review of the clinical record, review of facility documentation, review of facility policy/procedures and interviews for 1 of 5 sampled residents (Resident #5) reviewed for unnecessary medications, the facility failed to ensure medication reviews were provided to the provider and action taken. The findings included:</p> <p>Resident #5's diagnoses included long term use of anticoagulants, bipolar II disorder, and anxiety disorder.</p> <p>The annual MDS assessment dated [DATE] identified Resident #6 was cognitively intact, had no behaviors, required maximal assistance with bed mobility, transfers, dressings and personal hygiene. The assessment further identified that the resident could ambulate a short distance with maximal assistance and utilized a wheelchair for mobility.</p> <p>The care plan dated 9/30/24 identified Resident #6 was at risk for altered cardiovascular status related to elevated blood pressure and chest pain secondary to angina, hypertension with interventions that included assess for chest pain, enforce the need to call for assistance if pain starts. Vital signs, notify MD of significant abnormalities.</p> <p>Physician's order dated 8/19/24 directed to administer 5mg of Eliquis every 12 hours by mouth.</p> <p>The Pharmacy Consultant #1's medication regimen review dated 10/4/24 identified recommendations to monitor for bruising, bleeding, and to monitor for signs/symptoms of thromboembolism (blood clot) due to the resident being on an anticoagulant.</p> <p>A review of Resident #5's clinical record failed to identify that the Pharmacy Consultants recommendations had been incorporated into the resident's plan of care, or a rationale as to why the monitoring was not necessary.</p> <p>Review of the MAR (medication administration record) and TAR (treatment administration record) TAR for the month of October 2024 failed to identify that the recommendations from Pharmacy Consultant #1 was added to the MAR or TAR.</p> <p>Interview on 11/17/24 at 1:11PM with the DNS identified she had not been receiving pharmacy recommendations since she started in August 2024, and she could not locate previous pharmacy recommendations that had been made. The facility started with a new pharmacy in November 2024 and had recently had a discussion with the provider regarding the recommendations.</p> <p>Interview on 11/18/24 at 11:36 AM with Pharmacy Consultant #1 identified she completed the monthly medication regimen reviews until the new pharmacy started on 11/2/24. The charts were reviewed monthly, and recommendations were entered into a report and sent to the DON or nurse supervisor that was covering the facility, the Social Worker is always copied on the medication recommendations due to the fact she is a constant in the building and could receive them due to the nursing (DNS) turnover.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075232	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2024
NAME OF PROVIDER OR SUPPLIER Cobalt Lodge Health Care and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 29 Middle Haddam Rd Cobalt, CT 06414	

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)
<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 11/19/24 at 8:31 AM with MD#1 identified he did recall receiving the pharmacy recommendation for Resident #5 from 10/4/24. The medication regimen review process would include the pharmacy consultant sending to the facility the medication reviews once completed, and the facility would disseminate to the provider.</p> <p>Review of the Pharmacy Recommendations policy dated 9/9/24 identified each recommendation made by the pharmacy team will be documented in the resident's medical record and communicated to the attending physician and nursing team. Upon receiving the recommendation, the attending physician or medical director will review it in the context of the resident clinical condition and make the final decision whether to implement the suggestion. If the physician agrees with the recommendation, they will adjust the resident's medication orders as appropriate. If the physician disagrees with the recommendation, they will document the rationale for not following the advice.</p> <p>Based on review of the clinical record, review of facility documentation, review of facility policy/procedures and interviews for 1 of 5 sampled residents (Resident #5) reviewed for unnecessary medications, the facility failed to ensure medication reviews were provided to the provider and action taken. The findings included:</p> <p>Resident #5's diagnoses included long term use of anticoagulants, bipolar II disorder, and anxiety disorder.</p> <p>The annual MDS assessment dated [DATE] identified Resident #6 was cognitively intact, had no behaviors, required maximal assistance with bed mobility, transfers, dressings and personal hygiene. The assessment further identified that the resident could ambulate a short distance with maximal assistance and utilized a wheelchair for mobility.</p> <p>The care plan dated 9/30/24 identified Resident #6 was at risk for altered cardiovascular status related to elevated blood pressure and chest pain secondary to angina, hypertension with interventions that included assess for chest pain, enforce the need to call for assistance if pain starts. Vital signs, notify MD of significant abnormalities.</p> <p>Physician's order dated 8/19/24 directed to administer 5mg of Eliquis every 12 hours by mouth.</p> <p>The Pharmacy Consultant #1's medication regimen review dated 10/4/24 identified recommendations to monitor for bruising, bleeding, and to monitor for signs/symptoms of thromboembolism (blood clot) due to the resident being on an anticoagulant.</p> <p>A review of Resident #5's clinical record failed to identify that the Pharmacy Consultants recommendations had been incorporated into the resident's plan of care, or a rationale as to why the monitoring was not necessary.</p> <p>Review of the MAR (medication administration record) and TAR (treatment administration record) TAR for the month of October 2024 failed to identify that the recommendations from Pharmacy Consultant #1 was added to the MAR or TAR.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075232	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2024
NAME OF PROVIDER OR SUPPLIER Cobalt Lodge Health Care and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 29 Middle Haddam Rd Cobalt, CT 06414	
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)		
<p>F 0756</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Interview on 11/17/24 at 1:11PM with the DNS identified she had not been receiving pharmacy recommendations since she started in August 2024, and she could not locate previous pharmacy recommendations that had been made. The facility started with a new pharmacy in November 2024 and had recently had a discussion with the provider regarding the recommendations.</p> <p>Interview on 11/18/24 at 11:36 AM with Pharmacy Consultant #1 identified she completed the monthly medication regimen reviews until the new pharmacy started on 11/2/24. The charts were reviewed monthly, and recommendations were entered into a report and sent to the DON or nurse supervisor that was covering the facility, the Social Worker is always copied on the medication recommendations due to the fact she is a constant in the building and could receive them due to the nursing (DNS) turnover.</p> <p>Interview on 11/19/24 at 8:31 AM with MD#1 identified he did recall receiving the pharmacy recommendation for Resident #5 from 10/4/24. The medication regimen review process would include the pharmacy consultant sending to the facility the medication reviews once completed, and the facility would disseminate to the provider.</p> <p>Review of the Pharmacy Recommendations policy dated 9/9/24 identified each recommendation made by the pharmacy team will be documented in the resident's medical record and communicated to the attending physician and nursing team. Upon receiving the recommendation, the attending physician or medical director will review it in the context of the resident clinical condition and make the final decision whether to implement the suggestion. If the physician agrees with the recommendation, they will adjust the resident's medication orders as appropriate. If the physician disagrees with the recommendation, they will document the rational for not following the advice.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075232	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2024
NAME OF PROVIDER OR SUPPLIER Cobalt Lodge Health Care and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 29 Middle Haddam Rd Cobalt, CT 06414	
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)		
<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17723</p> <p>Based on observation, review of the clinical record, review of facility documentation, review of facility policy/procedures and interviews for one sampled resident (Resident #6) reviewed for medication administration, the facility failed to ensure Metoprolol Succinate ER (extended release) was not crushed. The findings include:</p> <p>Resident #6's diagnoses included unspecified atrial fibrillation, dysphagia and long-term use of anticoagulants.</p> <p>The care plan dated 7/1/24 identified Resident #1 was at risk for hypertension and atrial fibrillation related to congestive heart failure with interventions that included give cardiac medication as ordered.</p> <p>The quarterly MDS assessment dated [DATE] identified Resident #6 was cognitively intact, required extensive assistance with bed mobility, transfers, dressings and personal hygiene. The assessment further identified that the resident required supervision for eating and had a mechanically altered therapeutic diet.</p> <p>The physician's order dated 11/12/24 directed to administer Metoprolol Succinate ER oral tablet (extended release 24 hour) 50mg twice a day for hypertension (high blood pressure) with directions to not crush or chew.</p> <p>Observation of LPN #1 during medication administration on 11/18/24 at 9:45 AM identified she crushed the Metoprolol Succinate ER in preparation to administer the medication to Resident #6.</p> <p>Interview with LPN #1 on 11/18/24 at 9:50 AM identified she had been crushing the Metoprolol Succinate ER for Resident #6 on a daily basis and realized after re-reading the blister pack that the medication is an extended-release medication that should not be crushed or chewed.</p> <p>Interview with MD#1 on 11/19/24 at 8:31 AM identified Metoprolol Succinate ER should not be crushed, and he would expect his orders to be followed. He further noted that crushing the medication could be dangerous because all the medication is administered all at once instead of over a period of time.</p> <p>According to the literature, crushing Metoprolol Succinate ER increases the risk of side effects inclusive of headache, feeling tired, dizzy or weak, stomach pain and cold hands or feet. The most serious side effect is that it could cause the heart rate to be too low and could worsen lung conditions.</p> <p>Review of the medication pass policy directed to remember the five rights of medication: the right resident, the right drug, the right dose, the right route, and the right time and to know the diagnosis and indication for every medication. A change in the form of medication requires a physician's order. Refusal or hold of high-risk medication to include cardiac medication warrants immediate notification to the provider.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075232	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2024
NAME OF PROVIDER OR SUPPLIER Cobalt Lodge Health Care and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 29 Middle Haddam Rd Cobalt, CT 06414	
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)		
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>47900</p> <p>Based on observations, review of facility policy and interviews for 1 of 2 medication storage rooms (Wing 2), the facility failed to ensure the medication storage room was secured. The findings included:</p> <p>Observation on 11/17/24 at 7:10 AM identified on Wing 2 a door labelled Medication Room opened greater than 12 inches containing:</p> <p>Upper cabinets without any securement device containing over the counter medications, overflow prescription medications, mask and treatment supplies.</p> <p>On the counters identified a sharp container that was filled with used needles and syringes.</p> <p>Lower cabinets without any securement device with labels on the doors indicating its content such as cups, spoons, straws, gloves, sharp containers, and another cabinet contained oxygen supplies and treatment supplies.</p> <p>Lower cabinet drawers without any securement device with labels on the drawers indicating its content such as batteries and syringes.</p> <p>Two refrigerators on the counter, with only one functioning, the functioning refrigerator was without any securement device, contained a locked box, tuberculin vial, unopened insulin vial, Tylenol suppository and Bisacodyl suppository.</p> <p>Observation on 11/17/24 at 7:20 AM identified Resident #32 who resides on Wing 2 ambulating in the hallway while the Charge Nurse was in the hallway with the medication cart administering medication to the residents.</p> <p>Observation and interview on 11/17/24 at 7:26 AM with the Nursing Supervisor (RN #5) identified the medication storage room was left opened and unsecured. She identified that the medication storage room should be kept closed and then proceeded to close the door.</p> <p>Interview with the night shift Nursing Supervisor (RN #6) on 11/17/24 at 7:28 AM identified that he last went into the medication room at 6:15 AM to place a list of over-the-counter medications on the cabinet and left the door opened. He identified that he could not recall closing the medication storage room door as he was seated at the nursing station.</p> <p>Interview with the DNS on 11/18/24 at 7:35 AM identified the medication room should be kept close at all times and both nurses have a key to the medication storage room which is kept with them at all times. The DNS identified the medication room should be kept close even if seated at the nursing station in case of an emergency and the nurse needed to attend to the situation.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075232	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2024
NAME OF PROVIDER OR SUPPLIER Cobalt Lodge Health Care and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 29 Middle Haddam Rd Cobalt, CT 06414	

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)
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Review of the Medication Storage policy identified all medication storage areas must be locked when not in use.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075232	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2024
NAME OF PROVIDER OR SUPPLIER Cobalt Lodge Health Care and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 29 Middle Haddam Rd Cobalt, CT 06414	
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)		
<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47402</p> <p>Based on observation, review of facility documentation, review of facility policies/procedures and interviews for two sampled residents (Resident#1, and Resident #24) reviewed for food, the facility failed to post accurate menus and failed to post and or announce changes to the daily menu. The findings include:</p> <p>Resident #1's diagnoses included chronic obstructive pulmonary disease, unspecified, age-related osteoporosis without current pathological fracture, and hyperlipidemia.</p> <p>The care plan dated 9/3/24 identified Resident #1 was at risk for weight loss related to esophageal stricture with interventions that included no added salt diet, regular texture.</p> <p>The annual MDS assessment dated [DATE] identified Resident #1 was cognitively intact, had no behaviors, was independent with bed mobility, transfers, and required supervision with dressings and set up clean up assist with personal hygiene. The assessment further identified that the resident ambulated and utilized a walker and a wheelchair.</p> <p>Resident #24's diagnosis included type 2 diabetes, gastroesophageal reflux disease without esophagitis, and chronic obstructive pulmonary disease.</p> <p>The care plan dated 7/22/24 identified Resident #24 had the potential nutritional problem related to diabetes, asthma, and dementia with interventions that included provide, serve diet as ordered. Registered dietician to evaluate and make diet change recommendations as needed.</p> <p>The quarterly MDS assessment dated [DATE] identified Resident #24 was cognitively intact, had no behaviors, utilized supervision for bed mobility, transfers, and required supervision with dressing and hygiene. The assessment further identified that the resident ambulated and utilized a walker.</p> <p>Observation of lunch service on 11/17/24 at 12:30 PM identified lunch being served was pulled pork, noodles, carrots and teriyaki chicken and roll. Menu posted on the wall said Sunday lunch should include garlic cheddar chicken, broccoli, pasta, and roll. No measured serving utensils were being utilized for service on the unit, and food was being served from a rolling steam table. No announcement of menu changes were made or written on the menu posted.</p> <p>Interview on 11/17/24 at 8:00 AM with Resident #1 identified the menu was not being followed and that food was being run out of before arrival to Resident #1's room, and that mashed potatoes were being served frequently.</p> <p>Interview on 11/17/24 at 8:10 AM with Resident #24 identified the menu was not being followed and that food was run out of before getting to Resident #24's room.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075232	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2024
NAME OF PROVIDER OR SUPPLIER Cobalt Lodge Health Care and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 29 Middle Haddam Rd Cobalt, CT 06414	
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)		
<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Interview on 11/17/24 at 12:40 PM with Head Cook, indicted the use of current slotted spoons, and tongs was how the staff was taught to plate the foods at meals times. No scoops, or portion size utensils (measuring cups) identified as being used during any food service. This is how the staff was taught, not sure about scoops or portion control amounts to delineate calories. These are the utensils that are used and we provide large portions sizes. The facility does not use chafing lids to cover the chafing dishes on the steam table. Tin foil is used to cover the chafing dishes and was torn open on the top when the lunch service began. No cover placed on the dishes as Buddy moved the steam table to a different area on the unit or new unit.</p> <p>Interview on 11/18/24 at 9:04 AM with [NAME] President/owner identified, that the chicken teriyaki was substituted for the garlic chicken yesterday, as it was probably more popular than the garlic chicken. Utilizing scoops or cups was never stressed with the cooks, so they use the utensils available, and provide large servings. Half a cup or 4 ounces are small servings, the cooks give larger servings. Buddy has worked as a cook for many years and provides large servings. When there is a change to the menu it is announced overhead for the residents. The current menu is on week 3.</p> <p>Interview on 11/18/24 at 12:29 PM with [NAME] President/owner identified the week 2 menu posted on unit 1 and unit 2., and week 3 menu will be posted. Not sure why the wrong menu is posted.</p> <p>Interview on 11/18/24 at 12:59 PM with [NAME] President/owner indicated the head cook orders all the food and to his knowledge the facility has not ever run out of food. The residents are offered 2 different entree's/selections and sandwiches are also available for substitution, if the entree's isn't wanted.</p> <p>Interview on 11/19/24 at 8:12 AM with Person #2, the [NAME] President/owner, indicated food is ordered according to resident census and experience, experience knowing how much food is needed to accommodate the resident population/nutritional needs. Meadow Meat is the company used to order meat. For example, for 30 resident's we would order 5 pounds of meat. If chicken was on the menu 5 times during the week, then we would order the meat accordingly. For a census of 38, it would be more than 5lbs of meat. New cooks order more than what's needed usually. When they become more familiar with the facility and residents, the order becomes more accurate. Trial and error. The menu's provided yesterday, were one of the cycles of menus. It was the last menu signed off on by the Dietician. The facility has 3 menu cycles. The first menu provided to surveyors on Sunday 11/17/24, are the menu's being utilized currently at the facility.</p> <p>Interview on 11/19/24 at 9:42 AM with the cook, indicated the ingredients for the chicken cordon bleu were not available today, so Chicken Ala King will be served instead. [NAME] #2 was hired 2 weeks ago and has had to change the entree selection (s) at lunch time, due to not having all the needed ingredients. He/she was unsure as to how many times this had occurred in the last 2 weeks.</p> <p>Interview on 11/18/24 at 1:11 PM with the Dietician for the facility, indicated she works 3 hours per week and is onsite at the facility every other week. Staff contact the dietician via email with any consults or new doctor's orders/changes. The Maryland Diet Manual for long term care residents is used to determine dietary requirements. An in-service was provided to the 2 new cooks by the dietician at the facility, to ensure/review the Maryland Diet Manual along with therapeutic diets, and what a therapeutic diet should include. The vice president is the Food Service</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075232	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2024
NAME OF PROVIDER OR SUPPLIER Cobalt Lodge Health Care and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 29 Middle Haddam Rd Cobalt, CT 06414	

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)
<p>F 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>director and handles any issues like menu changes or appropriate serving utensils. If the proper utensils for serving were not used, then the meal may not meet the requirement of a 1800-2200 calorie diet. Which can cause other issues, like weight loss. If a menu item is changed or swapped out for another entree, that would be something the food service director or the cook would handle. The last menu(s) that the dietician signed off on were in June of this year.</p> <p>Review of the Kitchen Food ordering and Supply policy dated 8/4/24 directed, in part, to always have an approved menu (by registered dietician) in place, to post menus in an area visible to residents, staff and visitors. Enough food will be ordered as needed to always ensure continued meal service. Substitutions or changes to the daily menu will be posted or announced before meal service. Any permanent changes to the menu will be approved by the registered dietician before its implementation.</p> <p>48335</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075232	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2024
NAME OF PROVIDER OR SUPPLIER Cobalt Lodge Health Care and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 29 Middle Haddam Rd Cobalt, CT 06414	

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)
<p>F 0812</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>48335</p> <p>Based on observations, review of facility policy and interviews, the facility failed to ensure food items were appropriately labeled and dated when opened. The findings include:</p> <p>Observation in the kitchen dry storage area on 11/17/24 at 9:19 AM with the Food Service Director, identified an opened large carton of dry mashed potato flakes without a label or date when opened. A box of cornstarch, canister of peanut butter, a cereal-like substance identified by the FSD as granola in a small chafing tray covered with plastic wrap that was not labeled or dated. The observation also identified chocolate baking chips and walnuts stored in the dry storage area, both open. Each had no label or date when opened. 4 butterfly crackers in small plastic cups covered with plastic wrap observed in 6 cups in total. 2 squeeze bottles, one almost empty and both with a brown like syrup, no labels or dates.</p> <p>Interview on 11/17/24 at 9:22 AM with the FSD, indicated spices can remain good for several months, everything should be labeled when opened. The FSD was unable to state what the facility policy was for labeling and dating foods. Everyone is responsible for labeling and dating foods once opened. The FSD is newly hired almost 3 months.</p> <p>Review of the kitchen policy dated 8/5/24 directed, in part, that all food be properly labeled and dated. Manufacturer's recommended use by dates, will be used for any products stored in the kitchen unopened.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075232	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2024
NAME OF PROVIDER OR SUPPLIER Cobalt Lodge Health Care and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 29 Middle Haddam Rd Cobalt, CT 06414	
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)		
<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p>47489</p> <p>Based on lack of facility documentation and interviews for the facility reviewed for quality and performance improvement, the facility failed to have written policies and procedures for feedback, data collections systems, and monitoring including adverse event monitoring. The findings included:</p> <p>Interview on 11/19/24 at 2:55 PM with one the [NAME] President and the DNS identified the facility had an anonymous suggestion box and a customer survey and identified the facility did not have written policies and procedures for feedback, data collections system and monitoring. He identified that the facility is a small facility, and residents and families address concerns in person. The VP identified that if a staff member identified a concern, or an error, the facility would address this in real time. There is not a system of tracking unless a pattern is noticed. The DNS identified that if a problem was identified, the facility would bring the problem to the QAA committee to address. The DNS identified the QAA committee met quarterly.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075232	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2024
NAME OF PROVIDER OR SUPPLIER Cobalt Lodge Health Care and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 29 Middle Haddam Rd Cobalt, CT 06414	

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)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>46117</p> <p>Based on review of facility documentation, review of facility, and interviews for infection surveillance, the facility failed to review the infection control program policies and procedures at least annually, the facility failed to ensure monthly environmental rounds was conducted in accordance with the facility practice, and failed to follow the policy and procedures measures developed by the facility to prevent growth of legionella and other water borne pathogens in the building water system. The findings include:</p> <p>1. Review of the facility Infection Control Program Policies and Procedure manual for the past three years (2022, 2023, and 2024) on 11/18/24 at 10:30 AM failed to identify that the policies and procedures manual was reviewed.</p> <p>Interview with Infection Preventionist (RN #1) on 11/18/24 at 10:40 AM identified that she unable to locate the documentation that the policy and procedures manual was reviewed for the year 2022, 2023, and 2024). She identified that she just started working as IP nurse at the facility on 11/13/24. She further identified that it would be responsibility of the IP nurse to ensure that the infection control policies and procedures were reviewed and signed off annually.</p> <p>Review of the Infection Prevention Program policy identified that infection control policies would be reviewed annually and signed off by the Medical Board.</p> <p>2. Review of the facility documentation of the monthly environmental round from May 2024 through November 2024 identified that the last monthly environmental was done on June 2024.</p> <p>Interview with IP nurse (RN #1) on 11/18/24 at 11:10 AM identified that she was not sure what is the facility policy for the environmental rounds; however, she identified that based on the facility documentation for environmental rounds that the facility practice was conducting a monthly environmental rounds. She identified that she just started working as IP nurse at the facility on 11/13/24 and the last documentation for environmental rounds that was given to her was on June 2024.</p> <p>Interview with DNS on 11/19/24 at 10:30 AM identified that she recently started her position of DNS 4 months ago and the previous IP left approximately 3 months ago. She identified that the IP nurse would be responsible for conducting the monthly environmental rounds. She was aware that environmental rounds was not being done because there was no IP nurse at that time. She further identified that the facility recently hired an IP nurse who would be responsible for conducting the monthly environmental rounds.</p> <p>Although requested, a policy for environmental rounds was not provided.</p> <p>3. The Facility Water Management Plan Policy identified that the facility would maintain a log that included the hot water heaters would be drained of sediment and recorded in a log twice a year, the pressure vessels to be drained of sediment and recorded as being done in a log twice a year, ice maker machine to be clean quarterly and sanitized yearly and log would be maintain, and shower head, hoses, eye wash station and aerators to be removed, cleaned, and soaked in chlorine bleach solution on a monthly basis and recorded that it being completed.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075232	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2024
NAME OF PROVIDER OR SUPPLIER Cobalt Lodge Health Care and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 29 Middle Haddam Rd Cobalt, CT 06414	

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)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Interview with the Director of Maintenance on 11/19/24 at 1:30 PM identified that he had no information or documentation of the facility water management plan. He could not identify if the facility had the water tested for the legionella. He further identified that the administrator was responsible for keeping the water management documentation.</p> <p>Interview with the administrator on 11/19/24 at 2:00 PM identified that the previous maintenance director took all the documents related to the water management plan and he could not find any maintenance that were completed related to the facility water management plan. He also could not identify when the facility undergoes water testing for legionella.</p> <p>Review of the Facility Water Management plan and policy identified that sampling, management plan and sampling result would be retained. The Water Management plan policy also identified that the facility was committed to the prevention, detection and control of water-borne contaminants and program log would be utilized and kept within the water management plan.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075232	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2024
NAME OF PROVIDER OR SUPPLIER Cobalt Lodge Health Care and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 29 Middle Haddam Rd Cobalt, CT 06414	
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)		
<p>F 0883</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop and implement policies and procedures for flu and pneumonia vaccinations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46117</p> <p>Based on review of the clinical records, review of facility documentation, facility policy, and interviews for two of five residents (Resident #33 and Resident #35) reviewed for immunizations, the facility failed to ensure that the pneumococcal vaccine was offered and/or assessed to resident. The findings include:</p> <p>1. Resident #33's was admitted to the facility on [DATE] with diagnosis that included Parkinson's disease, dementia, malnutrition, and neurocognitive disorder with Lewy bodies.</p> <p>The admission MDS assessment dated [DATE] identified Resident #33 had severe cognitive impairment. The assessment further identified that Resident #33 pneumococcal vaccination was not up to date.</p> <p>Review of Resident #33's immunization consents and records, along with the new admission consent documentation with Infection Preventionist (RN #1) on 11/18/24 at 1:30PM failed to identify that the pneumococcal vaccine was offered to the resident.</p> <p>2. Resident #35's was admitted to the facility on [DATE] with diagnosis that included major depression, dementia, and anxiety.</p> <p>The admission MDS assessment dated [DATE] identified Resident #35 had severe cognitive impairment. The assessment further identified that Resident #35 pneumococcal vaccination was not up to date.</p> <p>Review of Resident #35's immunization consents and records, along with the new admission consent documentation with Infection Preventionist (RN #1) on 11/18/24 at 1:30PM failed to identify that the pneumococcal vaccine was offered to the resident.</p> <p>Interview with the Infection Preventionist (RN#1) on 11/18/24 at 11:30 AM identified that she just started her position as Infection Preventionist at the facility and she was not sure who would be responsible of offering the resident vaccine when it due. She identified that she could not find the consent for Resident #33 and Resident #35 pneumococcal vaccine. She further identified that going forward it would be her responsibility to ensure all residents would be offered up to date vaccination.</p> <p>Review of Pneumococcal Vaccine identified that all residents would be offered pneumococcal vaccines to aid in preventing pneumonia infections. The policy also identified that all residents would be assessed for eligibility to receive the pneumococcal vaccine series when indicated within 30 days of admission to the facility unless medically contraindicated or the resident had completed the current recommendation of the vaccine series.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075232	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2024
NAME OF PROVIDER OR SUPPLIER Cobalt Lodge Health Care and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 29 Middle Haddam Rd Cobalt, CT 06414	

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)
<p>F 0887</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46117</p> <p>Based on review of the clinical records, review of facility documentation, facility policy, and interviews for one of five residents (Resident #33) reviewed for immunizations, the facility failed to ensure that the COVID-19 vaccination was offered and/or assessed to resident. The finding include:</p> <p>Resident #33's was admitted to the facility on [DATE] with diagnosis that included Parkinson's disease, dementia, malnutrition, and neurocognitive disorder with Lewy bodies.</p> <p>The admission MDS assessment dated [DATE] identified Resident #33 had severe cognitive impairment.</p> <p>Review of Resident #33's immunization consents and records, along with the new admission consent documentation with Infection Preventionist (RN #1) on 11/18/24 at 1:30PM failed to identify that the COVID-19 booster vaccine was offered to the resident.</p> <p>Interview with the Infection Preventionist (RN#1) on 11/18/24 at 11:30 AM identified that she just started her position as Infection Preventionist at the facility and she was not sure who would be responsible of offering the resident vaccine when it due. She identified that she could not find the consent for Resident #33 COVID-19 booster vaccine. She further identified that going forward it would be her responsibility to ensure all residents would be offered up to date vaccination.</p> <p>Review of COVID Vaccination identified that the facility would vaccinate its residents against certain preventable disease such as COVID-19 disease. Each resident would be offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident had already been immunized.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075232	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/19/2024
NAME OF PROVIDER OR SUPPLIER Cobalt Lodge Health Care and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 29 Middle Haddam Rd Cobalt, CT 06414	
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)		
<p>F 0947</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47402</p> <p>Based on review of facility documentation, review of facility policy/procedures and interviews for two of three sampled nurse aide (NA #4 and #6), the facility failed to ensure nurse aide in-services were completed. The findings included:</p> <p>Review of NA #4's personnel file identified she was hired in November of 2022. NA #4's personnel file did not contain documentation of required annual in-service training.</p> <p>Review of NA #6's personnel file identified she was hired in July of 1980. NA #6's personnel file did not contain documentation of required annual in-service training.</p> <p>Interview with Business Office Staff #1 on [DATE] at 7:45 AM identified in-service training and competencies were not maintained in the employee file records and noted they are completed and maintained by Nursing.</p> <p>Interview on [DATE] at 9:58 AM with the DNS identified annual in-service training had not been completed for the past year, she further noted she could not locate in-service records from before she started.</p> <p>Interview on [DATE] at 10:05 AM with Social Worker #1 identified she had been completing some of the initial in-service training for new hires, however no in-service training was found for NA #4 or NA #6.</p> <p>Review of the facility Training Policy identified all employees are required to complete annual in-service education to comply with state and federal regulations and ensure they remain up to date with best practices. Job specific training is based on their roles, for nurses and aides medication administration, wound care, care planning, CPR/first aid, and infection control practices.</p>		