STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075236	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Noble Horizons	17 Cobble Rd Salisbury, CT 06068

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48792 Based on observations, facility policy and interviews for 8 out of 11 sampled residents, (Residents #5, # 8, #13, # 25, # 29, #31, #35, and # 38) observed eating lunch in the [NAME] dinning/activity room, the facility failed to ensure the residents experienced a dignity dining by not serving food on a dietary tray. The findings include: Observation of the noon meal service on 3/13/24 at 12:15 PM identified 8 residents (Residents #5, # 8, #13, # 25, # 29, #31, #35, and # 38) were served their meal on a dietary tray. The residents' food and drink items remained on the dietary tray and not on the dining table. Interview on 3/19/24 at 9:35 AM with Nurse Aide (NA#1) identified food remain on the tray because residents spill their food and drink therefore causing a mess. The dietary tray helps to contain the mess. Interview on 3/19/24 at 9:50 with Assistant Director of Nursing Services (ADNS) identified drink and food items should be removed from the dietary tray and set in front of the resident. The ADNS also indicated she was unsure why the facility policy was not being followed and she was going to investigate it. Review of the Dietary Services Policy dated 7/28/21 directed, in part, the philosophy of the dietary department is to provide meals emphasizing resident rights, choice, and quality of life.

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075236	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Noble Horizons	17 Cobble Rd Salisbury, CT 06068

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48950 Based on clinical record review, facility policy, and staff interviews for 1of 1 resident (Resident # 57) reviewed for Advanced Directive, the facility failed to ensure that an updated code status form was signed by the resident and physician to reflect Resident #57 wishes and physician's orders. The findings include: Resident #57 was admitted to the facility on [DATE] with diagnoses that included venous insufficiency, urinary tract infection, and anxiety. The Minimum Data Set (MDS) assessment dated [DATE] identified Resident #57 cognitively intact, requires supervision assistance for bed mobility, and personal hygiene, independent for toileting, transfer, and eating. Review of the clinical record identified Resident #57 had a signed Advanced Directive form on 4/17/23 from her/himself along with the physician which identified Resident #57 was a full code. Further review identified a physician's order dated 5/1/23 directed Do Not Resuscitate (DNR). However, the clinical record failed to provide evidence that reflected Resident #57 consented to the DNR. Interview on 3/14/24 at 12:07PM with Registered Nurse (RN#1) and Licensed Practical Nurse (LPN #1) identified that an updated code status form was not signed by the resident or the physician to reflect the change in the code status from a full code status to a DNR. RN #1 was unsure of the policy for the Do Not Resuscitate Order. The facility policy for Do Not Resuscitate order notes after consultation with the resident of health care agent the physician will write a Do Not Resuscitate Order on the physician's order form or complete the Advance Directive form, when a resident can express his/her own judgment, the Do Not Resuscitate decision should be reached consensually by the resident and the attending physician. An Advance Directive, previously made by the resident, must be used in making the decision. The nurse managers are responsible for assuring the accuracy of these forms. After surveyor's inquiry, the facility provided an updated Code status form signed and dated by the resident and physician on 3/14/24.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075236	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Noble Horizons	17 Cobble Rd Salisbury, CT 06068

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37721 Based on clinical record reviews, facility documentation, facility policy and interviews for 1 of 5 residents, (Resident #52) reviewed for medication administration, the facility failed to ensure the physician was notified of a medication refusal. The findings include: Resident #52's diagnoses included type II diabetes mellitus and heart failure. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #52 as cognitively intact, independent with bed mobility, supervision with transfer, toileting, and ambulation. The Resident Care Plan Dated 2/29/24 identified Resident #52 as type II diabetes mellitus. Interventions directed to monitor diet, laboratory values, glucose monitoring and the physician/Nurse Practitioner would review Resident #52's diabetic medications, sliding scale orders, Accu-Check (blood glucose monitoring) schedule, diet, and individualized orders for glycemic management accordingly. The physician's orders dated 3/1/24 directed Humalog insulin (fast acting hormone used in the treatment of diabetes mellitus) to be administered based on a sliding scale (parameters that determine dosage based on blood sugar reading) four times a day. The sliding scale directed the following dosage based on blood sugar reading at 7:30 AM, 11:30 AM, 4 :30 PM and 8:00 PM: If Blood Sugar is less than 60, call MD. If Blood Sugar is 0 to 150, give 0 Units. If Blood Sugar is 151 to 200, give 2 Units. If Blood Sugar is 201 to 250, give 4 Units. If Blood Sugar is 251 to 300, give 6 Units. If Blood Sugar is 301 to 350, give 8 Units. If Blood Sugar is 351 to 400, give 10 Units. If Blood Sugar is 401 to 450, give 12 Units. If Blood Sugar is greater than 450, give 14 Units. If Blood Sugar is greater than 450, call the physician. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075236	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Noble Horizons	17 Cobble Rd Salisbury, CT 06068

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Medication Administration History dated 3/11/24 identified the prescribed (6 units) of insulin was not administered with a notation that read, 'Resident insisted on 4 units only, not 6 per sliding scale. A nurse's note completed by Licensed Practical Nurse, LPN #4 dated 3/12/24 at 7:43 AM identified at 8:00 PM (on 3/11/24), Resident #52's blood sugar was 300 milligrams per deciliter, mg/dl (normal 80-100), requiring 6 units of insulin. Resident #52 refused and requested 4 units of Humalog insulin, stating s/he did not want the blood sugar level to be low during night. Patient teaching provided; 6 units were encouraged. Blood sugar at 12:00 AM (on 3/12/24) was 212. The blood sugar early morning 397. Resident #52 was asymptomatic. The supervisor was notified. A re-check of the blood sugar at 5:45 AM was 432 and 12 units of Humalog (insulin) were given per Advanced Practice Registered Nurse (APRN) order. Resident #52's next recorded blood sugar at 7:30 AM was 283 with 6 units of insulin administered with no other documented intervention. An interview with LPN #4 on 3/18/24 at 9:42 AM identified she was the assigned charge nurse working 7:00 PM - 7:00 AM from 3/11/24 to 3/12/24. LPN #4 reported she checked Resident #52's blood sugar at 8:00 PM and determined s/he would require 6 units of insulin. Resident #52 refused the 6 units but agreed to receive 4 units which she administered. LPN # 4 reported she did not notify the evening/night shift supervisor, or the physician, further stating she should have notified them. LPN #4 did report to the day shift nurse manager, Registered Nurse #1 prior to leaving on the morning of 3/12/24. An interview with the Director of Nursing, DNS on 3/18/24 at 10:01 AM identified she was unaware the medication error had occurred. The DNS indicated nurses should not change medications dosages without first notifying the physician. An interview with APRN #1 identified that she provided routine medical services to Resident #52. APRN #1 indicated she was not notified at any time Resident #52 refused the prescribed dose of insulin and was instead administered a reduced dose. APRN #1 indicated she would expect to be notified if a resident refused a prescribed medication. An interview with RN #1 on 3/18/24 10:14 AM identified LPN #4 reported to her Resident #52 did not receive a full dose of insulin and that she could not recall notifying APRN #1 of the medication error but would have documented the event in the clinical record. An interview with APRN #2 on 3/21/24 at 12:36 PM identified she was the afterhours provider on call on 3/12/24 who did not provide routine services to Resident #52 and could not recall being contacted by the facility the night of the incident. APRN #2 identified nursing staff should be contacting a provider for orders if the resident was preferring a reduced dose. A review of the facility policy for Notification of Change in Resident Condition dated 12/16/22 directed changes in a resident's condition, medications, treatments, and plan of care are reported timely to the resident's physician/ nurse practitioner and resident representative.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075236	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Noble Horizons	17 Cobble Rd Salisbury, CT 06068

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46046 Based on clinical record review, review of facility documents, review of policy and staff interviews for 1 of 5 residents reviewed for accidents (Resident # 40), the facility failed to assess the use of full siderails at night to ensure the resident was free from a physical restraint and failed to obtain a consent for the utilization of the siderails. The findings include: Resident #40 was readmitted to the facility on [DATE] after hospitalization for surgical repair of a hip fracture sustained after having a fall. Resident # 40's diagnosis included aftercare following a joint replace with presence of an artificial hip joint after fracture of part of the neck of the femur, cognitive communication deficit and Alzheimer's disease. A Side Rail Assessment and consent dated 2/22/2024 with no time, indicated Resident # 40 returned from the hospital after having hip surgery had poor safety awareness and family member requested to have 2 full siderails in place. The reason for use indicated for safety with risks and benefits explained to the family member. The Side Rail Assessment and consent did not contain an assessment as to identify that the side rails were not considered a physical restraint. A physician's order dated 2/22/2024 at 6:25 PM directed to have 2 full side rails up while in bed at night for safety per family request. The Significant Change Minimum Data Set (MDS) dated [DATE] indicated Resident #40 was cognitively impaired, required partial assistance for going from lying to sitting at the edge of the bed and substantial assistance from sitting at edge of bed to standing. The assessment noted the utilization of a walker and wheelchair and indicated the resident was able to walk 10 feet with supervision or touching assistance. The MDS further indicated side rails were used daily as a restraint. The Care Plan dated 3/5/2024 indicated physical restraints, 2 side rails up at night for safety when in bed at night related to recent fall with hip fracture as requested by a family member. Interventions included checking on resident every 2 hours while in bed, keeping bedroom door open when resident in bed, inform resident family of risk and benefits of use and to obtain a signed consent before applying a restraint. On 3/20/2024 at 12:35 PM interview and record review with RN #1(unit manager), indicated Resident #40 was unable to remove the siderails or put them up or down independently making them a restraint. RN#1 was unable to provide evidence of an evaluation of the siderails to determine whether they were a restraint or any plans to monitor and evaluate in the future. Review of the care plan indicated 2 full siderails were in place but did not indicate they were a restraint. Interview and review of the facility's Side Rail Policy with the DNS on 3/20/24 at 12:42 PM indicated a form labeled Consent to use Restraints should be used. The DNS indicated the side rail form was always used and s/he was unable to provide a copy of the consent for use of a restraint form as indicated in the facility policy. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075236	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Noble Horizons	17 Cobble Rd Salisbury, CT 06068

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Although a copy of the side rail policy was requested one was not provided.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075236	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Noble Horizons	17 Cobble Rd Salisbury, CT 06068

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46046 Based on clinical record review and staff interview for 1 of 3 resident (Resident # 47) with a change in condition, the facility failed to ensure a comprehensive resident assessment was completed timely after a significant change in condition was identified and for 1 of 2 residents at risk for weight loss for (Resident 38), the facility failed to complete a significant change of condition for the resident's weight loss. The findings included: 1. Resident #47's diagnosis included fracture of the right femur, pressure ulcer of the sacrum, deep tissue damage of the left hip and right heel. The Admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #47 had no pressure ulcers. The care plan dated 3/8/2024 indicated Resident #47 was at risk for unavoidable pressure or currently has an unavoidable pressure injury(ulcer) related to poor nutrition, immobility, and incontinence. Interventions included to provide stage appropriate wound care and controlled risk factors for prevention of additional ulcers, pain management and pressure reduction such as specialty mattress, chair cushions, heel protectors, incontinence products/supplies and nutritional supplements. A physician's progress note dated 3/15/2024 at 6:42 PM indicated in part on 3/1 2024 identified the resident had a right heel deep tissue injury with declining nutrition and mobility. On 3/8/2024 a new left hip deep tissue injury and coccyx pressure ulcer stage 1. The progress notes on 3/15/2024 indicated the coccyx wound progressed to a stage 2 pressure ulcer. On 3/19/2024 at 10:50 AM an interview and record review with the MDS Coordinator (LPN #7) indicated the Admission MDS assessment was completed on 2/27/2024 indicated Resident #47 had no pressure ulcers. The pressure ulcer was noted on 3/1/2024 (18 days ago) Resident #47 was found to have a pressure ulcer. However, LPN#7 was unable to provide indication the MDS department was monitoring Resident #47's condition for up to 14 days to determine if Resident #47 had a significant change in condition (even though on 3/8/24 the development of two new pressure ulcers occurred and on 3/15/24 the coccyx wound declined to a stage 2 pressure ulcer). LPN #7 further indicated Resident #47 developed 3 pressure ulcers, most likely had weight loss. LPN # 7 also indicated according to the Resident Assessment Instrument guidelines the completion of a significant change MDS assessment should have been done and he/she would schedule a significant change MDS for completion. 2. Resident #38's diagnoses included dysphagia, dementia, and nutritional deficiency. The care plan dated 1/25/24 identified Resident #38 as at risk for nutritional decline related to an advancing dementia diagnosis. Interventions included meals to be served with supervision, to encourage completion of at least 75% of each meal, utilization of adaptive devices, and to monitor weights. A physician's order dated 1/25/24 directed to weigh daily for 3 days. A physician's order dated 2/7/24 directed to administer Boost or Ensure twice daily. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075236	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Noble Horizons	17 Cobble Rd Salisbury, CT 06068

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The admission Minimum Data Set assessment dated [DATE] identified Resident #38 was moderately cognitively impaired and required set up assistance for eating, substantial assistance for hygiene and showering/bathing. A dietician note dated 2/7/24 at 2:25 PM identified Resident #38 had a weight loss of 19 lbs. in one week. An Occupational Therapy note dated 2/26/24 at 12:09 PM identified an OT assessment was completed due to maximum assistance needed for eating. Further, the note states that resident has had mental status changes and falls in February. A Vital Sign Report for the period of 1/24/24 through 3/19/24 identified a weight loss trend: 2/12/24 weight was 179.8 lbs., 2/20/24 weight was 173.4 lbs., 2/28/24 weight was 177.4 lbs., 3/6/24 weight was 169 lbs., 3/12/24 weight was 168.4 lbs., and 3/19/24 weight was 163.6 lbs. A dietician note dated 3/19/24 at 4:12 PM identified Resident #38 had a 5.6% weight loss in one month. Review of the MDS assessments identified that a significant change in condition assessment was not completed. In an interview and clinical record review with LPN #7, MDS Coordinator on 3/19/24 at 11:50 AM identified an MDS Assessment for a significant change should have been completed for the significant weight loss. Review of the Notification of Change in Resident Condition policy dated 12/16/22 directed, in part, that a change in resident condition is defined as, Resident change from baseline including physical, cognitive behavior, and ADL status. Review of Long Term-Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual dated October 2023 identified in part, a significant change is a major decline or improvement in a resident's status that: 1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, the decline is not considered self-limiting. 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan. A Significant Change in Status Assessment is appropriate when: 1. There is a determination that a significant change in a resident's condition from their baseline has occurred as indicated by comparison of the resident's status to the most recent comprehensive assessment and any subsequent quarterly assessments; and 2. The resident's condition is not expected to return to baseline within two weeks. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075236	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Noble Horizons	17 Cobble Rd Salisbury, CT 06068

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	48792

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075236	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Noble Horizons	17 Cobble Rd Salisbury, CT 06068

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident's assessment is updated at least once every 3 months. 46117 Based on clinical record reviews, facility policy review, and interview for 4 of 4 residents (Residents #12, #32, #53, #56) reviewed for Resident Assessment, the facility failed to ensure the residents quarterly assessments were completed timely. The findings included: Clinical record review of the following completion of the Minimum Data Set (MDS) assessments identified: 1. Resident #12's quarterly MDS assessment with Assessment Reference Date (ARD) of 2/1/24 was due on 2/15/24. However further review identified the resident's quarterly assessment was not completed as of 3/19/24. (33 days late) 2. Resident #32's quarterly MDS assessment with ARD of 1/8/24 was due on 1/22/24. However further review identified the resident's quarterly assessment was not completed as of 3/19/24. (57 days late) 3. Resident #53's quarterly MDS assessment with ARD of 2/6/24 was due on 2/20/24. However further review identified the resident's quarterly assessment was not completed as of 3/19/24. (28 days late) 4. Resident #56's annual MDS assessment with ARD of 2/1/24 was due on 2/15/24. However further review identified the resident's quarterly assessment was not completed as of 3/19/24. (33 days late). Interview with LPN #7 (MDS Coordinator) on 3/19/24 at 12:30 PM identified s/he was responsible for completing and submitting the MDS assessment. LPN # 7 also identified that s/he needs to complete the MDS assessment 14 days after it set ARD. S/he acknowledged s/he was late completing Resident # 12, # 32, # 53 and #56 quarterly assessments because s/he was the only staff in the MDS office and could not catch up. The facility policy title Resident Assessment identified a quarterly assessment will be completed every 92 days from admission to provide for revision of the care plan as necessary.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075236	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Noble Horizons	17 Cobble Rd Salisbury, CT 06068

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. 46117 Based on clinical record review and interviews for 4 of 4 residents (Residents #12, #32, #53, #56) reviewed for Resident's Assessment, the facility failed to ensure the residents assessment were submitted timely. The findings included: Clinical record review of the following completion of the Minimum Data Set (MDS) assessments identified: 1. Resident #12's quarterly MDS with Assessment Reference Date (ARD) of 2/1/24 was due on 2/15/24 and required submission on 2/29/24; however, Resident #12's assessment was not submitted as of 3/19/24. (19 days late) 2. Resident #32's quarterly MDS with ARD of 1/8/24 was due on 1/22/24 and required submission on 2/5/24; however, Resident #32's assessment was not submitted as of 3/19/24 (43 days late) 3. Resident #53's quarterly MDS with ARD of 2/6/24 was due on 2/20/24 and required submission on 3/5/24; however, Resident #53's assessment was not submitted as of 3/19/24. (14 days late) 4. Resident #56's annual MDS with ARD of 2/1/24 was due on 2/15/24 and required submission on 2/29/24; however, Resident #56's assessment was not submitted as of 3/19/24 (19 days late). Interview with LPN #7 (MDS Coordinator) on 3/19/24 at 12:30 PM identified she was responsible for completing and submitting the MDS assessment. She also identified she need to complete the MDS assessment within 14 days after it set ARD and submit within 14 days after completion. LPN # 7 acknowledged that she was late with completing the MDS assessment and not able to transmit the MDS in timely manner because she was the only one in the MDS office and was not able to catch up with the timeframe of completing the MDS assessment. The Resident Assessment Instrument 3.0 user manual 10/2023 identified that to be considered timely the ARD of the quarterly assessment must be completed within 14 days and submitted within 14 days after its completion.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075236	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Noble Horizons	17 Cobble Rd Salisbury, CT 06068

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37721 Based on observation, clinical record, facility policy and staff interview for 1 of 3 sampled residents (Resident #52) reviewed for accidents, the facility failed to ensure the care plan was comprehensive and individualized for a resident who did not require a safety device. The findings include: Resident #52's diagnoses included type II diabetes mellitus and heart failure. The Admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #52 as cognitively intact, required partial assistance of one with transfers and ambulation and did not require any electronic devices that monitor movement. The Resident Care Plan dated 8/25/23 identified Resident #52 as at risk for falls and took chances transferring him/herself. Interventions directed use of alarms to notify staff that the resident had needs and required assistance, do not leave the resident alone on the toilet during the time the safety device was in use and re-evaluate the need for bed/chair alarms. An observation on 3/18/24 at 7:34 AM identified that there was no visible use of safety devices in Resident #52's room. An interview with Licensed Practical Nurse, LPN #7 on 3/19/24 at 9:14 AM identified nursing staff was responsible for the completion of initial care planning while she was responsible for overseeing the care plan cumulatively. LPN #7 identified Resident #52 never had any alarms and that nursing staff may have likely inadvertently indicated the resident had. LPN #7 further identified she should have removed the information when reviewing the care plan and did not. An interview with Registered Nurse, RN #1 on 3/19/24 at 10:12 AM identified she placed interventions regarding the use of alarms in the event their use would ever be required. RN #1 further identified Resident #52 never had any motion detection alarms and would require an order and consent to implement their use. An interview with the Director of Nursing, DNS on 3/19/24 at 12:03 PM identified the Resident Care Plan should accurately reflect individualized resident need. A review of the facility policy for Resident care Plan directed the Resident Care Plan developed by the resident, family and staff shall ensure the maintenance of high quality, individualized care. The Interdisciplinary Plan of Care is developed and implemented within 21 days of admission. 46046

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075236	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Noble Horizons	17 Cobble Rd Salisbury, CT 06068

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37721 Based on observations, clinical record reviews, facility documentation, facility policy and interviews for 2 of 3 residents reviewed for accidents for (Residents # 11 and # 38), the facility failed to revise the care plan after after the resident experienced falls and for 1 of 5 sampled resident, (Resident# 57) reviewed for care planning, the facility failed to ensure the care plan was revised to reflect a resident who frequently refused a daily treatment and for 1 of 3 residents reviewed for accidents, the facility failed to revise the care plan after several falls. The findings included: 1. Resident #11 was admitted to the facility on [DATE]. The resident's diagnoses included heart failure, generalized muscle weakness, and repeated falls. The care plan dated 6/28/23 identified Resident #11 as at risk for falls related to a history of multiple falls. Interventions included arranging the resident's room so that necessary items are kept accessible, remind the resident to use the call bell, ensuring adequate lighting, performing safety checks per policy, reviewing medications if needed, and re-evaluating the need for bed/chair alarms. A quarterly fall risk assessment dated [DATE] identified Resident #11 as not at risk for falling, with a fall risk score of 7 on a scale where a score of 10 or higher represents a high risk for falls. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified the resident was cognitively intact and independent in toileting, dressing, and ambulating. The MDS also identified Resident #11 had no falls since admission. A facility Incident Report and investigation dated 8/13/23 indicated on 8/13/23 at 1:30 PM, Resident #11 was found lying on the floor in front of a chair. Resident #11 reported to facility staff that he/she had missed the chair when attempting to sit. The Incident Report further indicated the resident was alert, oriented, and independent with care at the time and was assisted back to the room. A post-fall observation assessment dated [DATE] indicated the resident did not require any post-fall interventions therefore no changes to the resident care plan were made. A review of RCP did not identify any new interventions or care plan edits secondary to the 8/13/23 fall. Additionally, the care plan was last reviewed on 6/28/23 before the fall. The last time an intervention was added to the fall care plan before the fall 8/13/23 was 1/12/23. A quarterly fall risk assessment dated [DATE] identified Resident #11 was not at risk for falling with a fall risk score of 9 on a scale where a score of 10 or higher represents a high risk for falls. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075236	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Noble Horizons	17 Cobble Rd Salisbury, CT 06068

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. A facility Incident Report and investigation dated 9/24/23 identified on 9/24/23 at 6:45 PM, Resident #11 was found lying on the floor. Resident #11 reported to facility staff that s/he had lost his/her balance when reaching to wash his/her hands. The incident report further indicated that the resident was alert, oriented, and independent with care at the time. A post-fall observation assessment in the medical record dated 9/24/23 indicated a potential factor that could have contributed to the fall was poor placement on the walker in front of the sink. The post-fall observation does not identify any measures taken to prevent further falls. A review of the resident care plan did not identify any new interventions or care plan revisions related to the 9/24/23 fall. b. A facility Incident Report and investigation dated 9/26/23 identified on 9/26/23 at 6:00 AM, Resident #11 was found lying on the floor next to the bed. Resident #11 reported to facility staff that he/she was getting up to go to the bathroom, slipped, and fell . The Incident Report further indicated the resident was educated on the importance of using the nursing call light for assistance. A review of the resident care plan identified the resident was care planned to be reminded to use the call bell from 1/12/23 (prior to the resident's admitted). A revision to the care plan indicated that the most recent fall was dated 9/26/23; however, no new interventions were noted related to the 9/26/23 fall. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified that the resident was cognitively intact and independent in toileting, dressing, and ambulating. The MDS dated [DATE] also identified Resident #11 had experienced one fall with injury and two falls with no injury since the prior MDS assessment. c. A facility Incident Report and investigation dated 10/1/23 identified on 10/1/23 at 7:00 PM, Resident #11 was found sitting on the floor leaning against their recliner. The resident reported to staff that he/she had missed the chair when attempting to sit and slid to the floor. A post-fall observation assessment dated [DATE] indicated Resident #11 was educated to feel the edge of any seat with the back of his/her legs before sitting down. A review of the resident's care plan identified a revision on 10/1/23 to indicate that the resident had fallen. However, no new interventions were noted in the care plan to address the fall on 10/1/23, and there was no revision to the care plan indicating that the resident should be reminded to feel the edge of any seat before sitting down. d. A facility Incident Report and investigation dated 10/16/23 identified on 10/16/23 at 6:30 PM, Resident #11 was found sitting on the floor in his/her room. The resident reported to staff that he/she was getting up to get his/her cell phone when he/she lost his/her balance and fell in front of the recliner. A post-fall observation assessment dated [DATE] indicated Resident #11 was educated on proper stance and securing balance with the walker. A review of the resident care plan identified that the care plan had been revised on 10/16/23 to indicate that the resident had fallen; however, no new interventions were noted in the care plan because of the 10/16/23 fall. Additionally, the care plan indicated that it had been reviewed/revised on 10/17/23. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075236	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Noble Horizons	17 Cobble Rd Salisbury, CT 06068

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	e. A facility Incident Report and investigation dated 11/1/23 identified on 11/1/23 at 12:00 PM, Resident #11 fell on his/her right side while independently walking to the dining room. A post-fall observation assessment dated [DATE] indicated that a gait belt would be utilized by staff during ambulation if the resident feels weak. A review of the resident care identified that the resident care was planned for gait belt use on 1/12/23. The care plan was revised on 11/1/23 to indicate the resident had fallen; however, no new interventions were noted in the care plan due to the 11/1/23 falls until after the 11/26/24 when the care plan was revised to reflect to encourage the resident to wear adequate footwear. f. A facility Incident Report and investigation dated 12/8/23 identified on 12/8/23 at 3:07 PM, Resident #11 was found sitting on the floor. The resident reported to staff that he/she fell when trying to reach for an envelope from the nightstand. A post-fall observation assessment dated [DATE] indicated Resident #11 was educated on using the walker for support. A review of the resident's care plan identified the care plan was revised on 12/8/23 to indicate the resident had fallen; however, no new interventions were noted in the care plan because of the 12/8/23 fall. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified the resident as cognitively intact and independent in toileting, dressing, and ambulating. A quarterly fall risk assessment dated [DATE] identified Resident #11 was at a high risk for falling. g. A facility report and investigation dated 1/12/24 identified on 1/12/24 at 10:15 AM, Resident #11 was found sitting on the floor in the resident's bathroom. Resident #11 reported to staff that he/she missed the toilet, slipped, and fell . The report further identified Resident #11 was not wearing shoes or socks. A post-fall observation assessment in the medical record dated 1/12/24 indicated that Resident #11 was educated on wearing proper footwear. A review of the resident care plan identified the resident care was planned to encourage the resident to wear adequate footwear on 11/26/23. No new interventions were identified related to the 1/12/24 (before the resident's admission). h. A facility Incident Report and investigation dated 1/18/24 identified on 1/18/24 at 9:45 AM, Resident #11 was found sitting on the floor next to the bed. The resident reported to staff that he/she was trying to pull the recliner away from the wall and fell backward. A post-fall observation assessment in the medical record dated 1/18/24 indicated Resident #11 was educated on using the nursing call bell. A review of the resident care plan identified no new interventions related to the 1/18/24 fall, and no care plan was noted to address the resident not moving furniture. i. A facility Incident Report and investigation dated 2/1/24 identified that on 2/1/24 at 1:45 PM, Resident #11 was found sitting on the floor with his/her back against the bed. Resident #11 reported to staff that he/she was trying to move his/her recliner and fell backward. The report further indicated Resident #11 suffered a left arm skin tear that measured 3 centimeters (cm) by 0.1 cm and required treatment with a dressing. A post-fall observation assessment dated [DATE] indicated Resident #11 was reminded not to move furniture. A review of the RCP identified no new interventions related to the 2/1/24 fall. Additionally, no interventions in the care plan addressed that the 2/1/24 fall which was the second time Resident # 11 had fall related to attempting to move furniture. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075236	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Noble Horizons	17 Cobble Rd Salisbury, CT 06068

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	j. A facility Incident Report and investigation dated 2/26/24 identified on 2/26/24 at 7:45 PM, Resident #11 was found on his/her knees by the bed without shoes or socks. The resident reported to staff that he/she lost his/her balance taking off his/her jacket. The report further indicated that the resident suffered a right second toe abrasion that measured 1.5 cm by 1.5 cm. A post-fall observation assessment dated [DATE] indicated Resident #11 was not wearing footwear at the time of the fall. The assessment further indicated that measures to prevent further falls were to continue safety checks and anticipate resident needs. A review of the resident care plan identified the resident care was planned to encourage the resident to wear adequate footwear on 11/26/23. No new interventions were identified related to the 2/26/24 fall. k. A facility Incident and Report and investigation dated 3/5/24 identified on 3/5/24 at 3:05 PM, Resident #11 was found sitting on the floor in the resident's bathroom. The resident reported to staff he/she misjudged the distance when transferring from the toilet to the rollator. A post-fall observation assessment dated [DATE] did not identify any potential factors that may have contributed to the failure to identify any measures taken to prevent future falls. A review of the RCP failed to identify any new interventions or care plan revision related to the 3/5/24 fall. l. A facility Incident Report and investigation dated 3/13/24 identified on 3/13/24 at 8:50 PM, Resident #11 was found sitting on the floor in the resident's bathroom. The resident reported to staff that he/she reached over his/her walker to reach his/her pajamas, lost his/her balance, and fell backward, hitting his/her head. A post-fall observation assessment dated [DATE] identified the resident did not have shoes or socks on at the time of the fall. The assessment further indicated that physical therapy was ordered, and that the resident would likely need increased supervision in performing activities of daily living. A review of the resident care plan did not identify any of the new interventions related to the 3/13/24 fall in the RCP. An interview with the DNS on 3/20/24 at 11:00 AM indicated that a new intervention for falls would be added if therapy was not already working on the issues that caused the resident's fall or if there was not done, such as not having the resident's call bell in reach. The DNS also indicated that educating and reminding the resident on how to properly feel a chair behind him/her before sitting down was not added to the care plan because the supervisor may have thought educating the resident immediately post-fall was enough. Additionally, the DNS could not identify why no education or care planning was done regarding moving furniture when the resident fell moving his/her recliner on 1/18/24. The DNS further identified the MDS Coordinator, nursing supervisors, and nurse managers can update the care plan and the MDS Coordinator and nurse managers oversee the care plans. An interview with the MDS Coordinator on 3/20/24 at 2:20 PM identified she was unsure why Resident #11's care plan was initiated in January 2023 when the resident's admission was in March 2023 and indicated it could be because the resident's care plan was not discontinued when the resident was discharged from a previous admission to the facility. The MDS Coordinator also identified the care plan from the previous admission should have been discontinued and a new care plan initiated for the March 2023 admission. The MDS Coordinator further indicated the admitting nurse initiates the care plan on admission and nurses, managers, and the MDS Coordinator can put in new interventions. The MDS Coordinator indicated the care plan should be updated with each fall and be personalized to the resident. Additionally, the MDS Coordinator could not identify why Resident #11 was not care planned for non-compliance with certain fall-prevention interventions. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075236	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Noble Horizons	17 Cobble Rd Salisbury, CT 06068

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2.Resident #38's diagnoses included muscle weakness, dementia, and abnormalities of gait and mobility. A physician's order dated 1/26/24 directed to place motion sensor for patient safety in the room. The admission Minimum Data Set assessment dated [DATE] identified Resident #38 was moderately cognitively impaired and required set up assistance for eating, substantial assistance for hygiene and showering/bathing. The Resident Care Plan dated 1/25/24 identified Resident #38 as at risk for falls due to moderate dementia, behaviors, and poor safety awareness. Interventions included a comprehensive medication review, increased staff supervision, and placing the resident in the lounge if resident allow, as well as use of a Tab alarm. A nurse's note dated 2/11/24 at 3:30 AM identified Resident #38 was found on the floor mat next to his/her bed after calling out for help. No injuries noted. An observation note dated 2/11/24 at 5:09 AM did not include measures to be taken to prevent further falls. There were no revisions to the care plan noted. The state agency Reportable Event Form dated 2/11/24 identified Resident #38 had fallen without major injury. APRN notified. A nurse's note dated 2/13/24 at 6:46 AM identified Resident #38 was found sitting on floor mat next to his bed after motion detector alarmed. No injuries noted. An observation note dated 2/13/24 at 1:45 AM did not include measures to be taken to prevent further falls. There were no revisions to the care plan noted. A nurse's note dated 2/21/24 at 7:05 AM identified Resident #38 was found sitting on his floor mat next to his bed. No injuries noted. The state agency Reportable Event Form dated 2/21/24 identified Resident #38 had fallen without major injury. MD notified. Further, the form indicated that an addendum to the care plan was completed, however there was no care plan revision noted. However, review of risk for falls due to moderate dementia, behaviors, and poor safety awareness noted revisions to the care plan on 2/27/24 which included, the resident would not go to bed earlier than 8:00 PM, ambulated in the hall at least 3 times per day. A care plan revision on 3/6/24 included a perimeter mattress, low bed, and floor mats. A care plan revision on 3/8/24 included praying with the resident before bed. Interview and clinical record review with the DNS on 3/20/24 at 10:15 AM identified the supervisor, manager, and MDS Coordinator update the care plan with changes. The only time that the care plan gets updated after a fall is if there is a change to be made. The DNS also indicated interventions are not always to add to the care plan. The nursing team has vigorous conferences after falls to determine if there are any further interventions that can be instituted. They are verbal conferences, nothing is documented. Resident # 11 is impulsive and has advanced dementia. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075236	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Noble Horizons	17 Cobble Rd Salisbury, CT 06068

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Resident #57 had diagnoses included muscle weakness, osteoarthritis, and localized swelling to the left lower limb. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #57 as cognitively intact, required set up assist with eating, showering and supervision with dressing. The Resident Care Plan dated 1/31/24 identified Resident #57 required assistance with activities of daily living (ADL) and had a potential for weight fluctuations related to 3-4+ bilateral edema of the lower extremities. Interventions directed to provide supervision for walking, provide fluids with and between meals and monitor for signs of dehydration. The physician's orders dated 1/31/24 directed use of six-inch ACE bandages to wrap legs foot to knee every morning before getting out of bed and remove at bedtime. Observations made on 3/13/24 at 12:39 PM, 3/18/24 at 8:28 AM and 3/18/24 at 10:55 AM identified Resident #57 was out of bed with marked edema and without the benefit of ACE wraps. A review of the Medication Administration Record (MAR) dated 2/19/24 through 3/18/24 identified Resident #57 refused the ACE wraps on 33 occasions. An interview with Licensed Practical Nurse, LPN #2 on 3/18/24 at 10:55 AM identified Resident #57 often refused the ACE wraps to the bilateral lower extremities, and she was unsure what to do for refusals. LPN #2 identified she had not re-approached Resident #57 since h/her initial refusal to encourage h/her to have the wraps applied. An interview with the Director of Nursing (DNS) on 3/19/24 at 12:21 PM identified staff was aware that Resident #57 frequently refused h/her ACE wraps and that the care plan should have been revised to reflect this need. The care plan failed to identify a concern related to resident refusal of an ACE wrap with interventions on best approaches to reduce future refusals. A review of the facility policy for Resident Care Plans directed that the Resident Care Plan developed by the resident, family and staff shall ensure the maintenance of high quality, individualized care. The Care Pan may be reviewed and revised at any time indicated by the changing needs of the resident. 48792 48880

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075236	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Noble Horizons	17 Cobble Rd Salisbury, CT 06068

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48880 Based on clinical record review, review of facility documentation, review of facility policy, and staff interviews for 1 of 5 sampled residents (Resident #11) reviewed for accidents, the facility failed to ensure that neurological checks were completed to professional standards after a resident's unwitnessed falls per facility policy. The findings include: Resident #11 was admitted on [DATE] with a diagnosis that included heart failure, generalized muscle weakness, and repeated falls. The care plan dated 6/28/23 identified Resident #11 as at risk for falls related to a history of multiple falls. Interventions included arranging the resident's room so that necessary items are kept accessible, reminding the resident to use the call bell, ensuring adequate lighting, performing safety checks per policy, reviewing medications if needed, and re-evaluating the need for bed/chair alarms. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified the resident as cognitively intact and independent in toileting, dressing, and ambulating. The MDS also identified Resident #11 as having no fall since admission. a.A facility Incident and Report and investigation dated 8/13/23 indicated on 8/13/23 at 1:30 PM, Resident #11 experienced an unwitnessed fall. Resident #11 was found lying on the floor in front of a chair. Resident #11 reported to facility staff that he/she had missed the chair when attempting to sit. A 24-hour neurological checks Flowsheet was completed post-fall, however, a neurological check for 8/14/23 at 9:15 AM and for 1:15 PM was not completed. b. A facility Incident and Report and investigation dated 9/24/23 identified on 9/24/23 at 6:45 PM, Resident #11 experienced an unwitnessed fall and was found lying on the floor in the resident's bathroom. Resident #11 reported to facility staff that he/she had lost his/her balance when reaching to wash his/her hands. A 24-hour neurological checks Flowsheet was completed post-fall; however, a neurological check for 9/25/23 at 2:15 PM and for 6:15 PM was not completed. c. A facility Incident Report and investigation dated 9/26/23 identified on 9/26/23 at 6:00 AM, Resident #11 experienced an unwitnessed fall and was found lying on the floor next to their bed. Resident #11 reported to facility staff that he/she was getting up to go to the bathroom, slipped, and fell . A 24-hour neurological checks Flowsheet was completed post-fall; however, neurological checks for 9/26/23 at 5:45 PM and for 9:45 PM were not completed. d. A facility Incident Report and investigation dated 1/18/24 identified on 1/18/24 at 9:45 AM, Resident #11 experienced an unwitnessed fall and was found sitting on the floor next to the bed. The resident reported to staff that he/she was trying to pull the recliner away from the wall and fell backward. A 24-hour neurological checks Flowsheet was not completed post-fall. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075236	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Noble Horizons	17 Cobble Rd Salisbury, CT 06068

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	e. A facility Incident Report and investigation dated 2/26/24 identified on 2/26/24 at 7:45 PM, Resident #11 experienced an unwitnessed fall and was found on his/her knees by the bed without shoes or socks. The resident reported to staff that he/she lost his/her balance taking off his/her jacket. The report further indicated the resident suffered a right second toe abrasion that measured 1.5 cm by 1.5 cm. A 24-hour neurological checks Flowsheet was completed post-fall; however, a neurological check for 2/27/24 at 3:30 PM and 7:30 PM was not completed. An interview and record review with the DNS on 3/20/24 at 11:00 AM identified the facility performed a neurological assessment for all unwitnessed falls. Additionally, the DNS identified that during the 11:00 PM to 7:00 AM shift, Resident #11 does not like being disturbed if he/she is sleeping and during that time, he/she will refuse an assessment. The DNS further indicated staff should still have attempted neurological assessments post-fall and documented any refusals. When a resident refuses a neurological check post-fall, the refusal would be documented in the nursing progress notes or directly on the 24-hour neurological check Flowsheet. No nursing progress notes were identified that indicated Resident #11 had refused neurological checks for 8/14/23 at 9:15 AM and 1:15 PM, 9/25/23 at 2:15 PM and 6:15 PM, 9/26/23 at 5:45 PM and 9:45 PM, or 2/27/24 at 3:30 PM and 7:30 PM. Additionally, the DNS could not identify why a neurological check Flowsheet was not completed post-fall on 1/18/24. The Neuro-check Policy for the facility indicated the policy's objective was to ensure appropriate monitoring of residents following a head injury or suspected head injury. The policy further indicated that the neurological assessments are documented on a paper Flowsheet for 24 hours. The assessments are done every 15 minutes for one hour, then every hour for 3 hours, and finally every 4 hours for 20 hours.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075236	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Noble Horizons	17 Cobble Rd Salisbury, CT 06068

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46046 Based on clinical record review and staff interview for 1 of 2 residents (Resident # 47) reviewed for at risk for pressure ulcer, the facility failed to consistently document turning and repositioning of the resident in accordance with facility practice. The findings include: Resident #47's diagnosis included fracture of the right femur, pressure ulcer of the sacrum, deep tissue damage of the left hip and right heel. The Admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #47 had no pressure ulcers. The care plan dated 3/8/2024 indicated Resident #47 was at risk for unavoidable pressure or currently has an unavoidable pressure injury(ulcer) related to poor nutrition, immobility, and incontinence. Interventions included to provide stage appropriate wound care and controlled risk factors for prevention of additional ulcers, pain management and pressure reduction such as specialty mattress, chair cushions, heel protectors, incontinence products/supplies and nutritional supplements. A review of the progress notes dated 3-15-24 identified the following for the resident's wound assessment: Wound #1 Right Heel is a Deep Tissue Pressure Injury Persistent non-blanchable deep red, maroon or purple discoloration Pressure Ulcer and has received a status of Not Healed. Subsequent wound encounter measurements are 2.5 cm length x 5.5 cm width x 0 cm depth, with an area of 13.75 sq cm and a volume of 0 cubic cm. There was no drainage noted. Wound bed has 76-100% epithelialization. There is no change noted in the wound progression. Wound #2 Left Hip is a Deep Tissue Pressure Injury Persistent non-blanchable deep red, maroon or purple discoloration Pressure Ulcer and has received a status of Not Healed. Subsequent wound encounter measurements are 0.5cm length x 0.5cm width x 0 cm depth, with an area of 0.25 sq cm and a volume of 0 cubic cm. There was no drainage noted. Wound bed has 76-100% epithelialization. There is no change noted in the wound progression. The peri wound skin texture is normal. The peri wound skin moisture is normal. The peri wound skin color is normal. Wound #3 Coccyx is a Stage 2 Pressure Injury Pressure Ulcer and has received a status of Not Healed. Subsequent wound encounter measurements are 2cm length x 2cm width x 0.1 cm depth, with an area of 4 sq cm and a volume of 0.4 cubic cm. There was no drainage noted. The wound is deteriorating. A physician's progress note dated 3/15/2024 at 6:42 PM indicated in part on 3/1 2024 identified the resident had a right heel deep tissue injury with declining nutrition and mobility. On 3/8/2024 a new left hip deep tissue injury and coccyx pressure ulcer stage 1. The progress notes on 3/15/2024 indicated the coccyx wound progressed to a stage 2 pressure ulcer. A review of the clinical record from 2/27/24 through 3/7/24 failed to reflect turning and repositioning of the resident in the clinical record per facility practice. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075236	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Noble Horizons	17 Cobble Rd Salisbury, CT 06068

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DNS on 3/19/24 at 10:00 AM identified the facility software did not include a section for the Nurse Aides to document turning and repositioning. The DNS indicated she would add a section in the software and educate staff. On 3/19/2024 at 10:50 AM an interview and record review with the MDS Coordinator (LPN #7) indicated the Admission MDS assessment was completed on 2/27/2024 indicated Resident #47 had no pressure ulcers. The pressure ulcer was noted on 3/1/2024 (18 days ago) Resident #47 was found to have a pressure ulcer. On 3/8/24 the development of two new pressure ulcers occurred and on 3/15/24 the coccyx wound declined to a stage 2 pressure ulcer). LPN #7 further indicated Resident #47 developed 3 pressure ulcers, most likely had weight loss. Interview with the DNS on 3/19/24 at 10:00 AM identified the facility software did not include a section for the Nurse Aides to document turning and repositioning. The DNS indicated she would add sections in the software and educate staff.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075236	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Noble Horizons	17 Cobble Rd Salisbury, CT 06068

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48792 Based on clinical record reviews , facility documentation, facility policy and interviews for the 2 of 5 sampled resident reviewed for accidents for (Resident # 10), the facility failed to ensure that staff conducted safety checks as directed by the manufacture to ensure the alarm was functional and for (Resident # 11), the facility failed to ensure fall assessment was completed after every fall per facility policy. The findings included: 1. Resident #10 's diagnoses included dementia, abnormalities of gait, and rheumatoid arthritis. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #10 as severely cognitively impaired and required moderate assistance for toilet transfer, maximal assistance for showering, and moderate assistance for upper body dressing. A physician's order dated 8/25/23 directed to use a Tab alarm for safety when the resident was unattended. The Resident Care Plan dated 8/25/23 identified falls as a problem. Interventions included use of a Tab alarm, to anticipate resident needs, and to complete safety checks per policy. A nurse's note dated 10/2/23 at 6:45 AM identified Resident #10 was found lying on the floor with a complaint of right hip pain. Resident # 10 was noted lying on her/his back with her/his head and shoulders up against the dresser. Review of the state agency Reportable Event line Summary Report dated 10/7/23 identified the Resident # 10's Tab alarm did not sound. Review of flow sheets for the period of 10/1/23 through 10/31/23 failed to identify functionality checks for the Tab alarm as directed by manufacturer. Interview with DNS and RN #1 on 3/18/24 at 11:20 AM identified: Resident #10 fell shortly after safety rounds. The Nurse Aide (NA) was in the room at 5:00 AM and the resident fell at 6:45 AM. The Tab alarm was in place but malfunctioned that night. The Tab alarm is magnetic and is supposed to detach from resident and it did not at the time of the floor. They were unsure if Resident # 10 was holding the alarm, not sure where the alarm was found in relation to the resident. The NAs are supposed to check functionality and complete safety rounds at the beginning and the end of each shift. The checks are not logged. The charge nurse will ask the nurse aides if safety checks were completed. The DNS was unsure if they were completed the night in question. Resident #10 fell immediately after safety rounds. The DNS indicated the Tab alarm continues to be used by Resident #10. The DNS was also unsure if checking the Tab alarm was on the care card. The DNS indicated care cards are discarded weekly and the facility has no history of the information. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075236	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Noble Horizons	17 Cobble Rd Salisbury, CT 06068

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with LPN #5 on 3/19/24 at 1:51 PM (charge nurse) at the time of the fall identified the NA went to get the LPN as Resident #10 was on the floor. LPN #5 went into the room and found the resident lying on the floor. LPN #5 could not recall where the alarm was located at the time of the fall. LPN #5 identified that safety check forms are in the NA books, and they should be checking off on them. Currently the nurse aides are signing off on a paper form to indicate that the alarm was checked for functionality. The oncoming and off going NAs check the functionality together. LPN #5 is not sure if this system was in place in October 2023 when the resident fell . Interview with the DNS 3/19/24 at 2:10 PM to review the Tab alarm manufacturer's guidelines which state to test the Tab alarm before each use. Further, the DNS identified this task was done by the NAs, however at the time of Resident #10's fall they were not documenting the checks. Currently the system is for the NAs to document the checks on a paper log, the DNS will review to ensure they were done and then throws the paper away. A telephone interview with NA #2 on 3/20/24 at 11:23 AM identified s/he was working the night of the fall but doesn't remember if s/he was assigned to the resident. NA # 2 further indicated s/he knew the resident had fallen while attempting to go to the bathroom. Resident #10 was on the floor when NA #2 entered the room. NA # 2 stated the Tab alarm was still attached to Resident # 10 but was alarming if s/he remembered correctly. A telephone interview with NA #3 on 3/20/24 at 2:30 PM identified Resident #10 did not fall any time s/he cared for the resident. NA # 3 indicated s/he did not remember the events on 10/2/24 related to Resident #10. Review of the Safety Device/Monitoring policy dated 1/10/21 directed, in part, Aide will complete every shift walking rounds to check the functioning of safety devices. Review of the Manufacturer's guidelines for the [NAME] Magnetic Pull-Cord Alarm recommendations include testing the alarm to determine that the system is operating correctly, and that the battery is charged before each use. 2. Resident #11 was admitted on [DATE] with a diagnosis that included heart failure, generalized muscle weakness, and repeated falls. The care plan dated 6/28/23 identified Resident #11 as at risk for falls related to a history of multiple falls. Interventions included arranging the resident's room so that necessary items are kept accessible, reminding the resident to use the call bell, ensuring adequate lighting, performing safety checks per policy, reviewing medications if needed, and re-evaluating the need for bed/chair alarms. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified the resident as cognitively intact and independent in toileting, dressing, and ambulating. The MDS also identified Resident #11 as having no fall since admission. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075236	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Noble Horizons	17 Cobble Rd Salisbury, CT 06068

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. A facility Incident and Report and investigation dated 8/13/23 indicated on 8/13/23 at 1:30 PM, Resident #11 experienced an unwitnessed fall. Resident #11 was found lying on the floor in front of a chair. Resident #11 reported to facility staff that he/she had missed the chair when attempting to sit. A review of clinical record and facility documentation failed to identify a new fall risk assessment was completed for the 8/13/23 fall. b. A facility Incident and Report and investigation dated 9/24/23 identified on 9/24/23 at 6:45 PM, Resident #11 experienced an unwitnessed fall and was found lying on the floor in the resident's bathroom. Resident #11 reported to facility staff that he/she had lost his/her balance when reaching to wash his/her hands. A review of clinical record and facility documentation failed to identify a new fall risk assessment was completed for the 9/24/23 fall. c. A facility Incident Report and investigation dated 9/26/23 identified on 9/26/23 at 6:00 AM, Resident #11 experienced an unwitnessed fall and was found lying on the floor next to their bed. Resident #11 reported to facility staff that he/she was getting up to go to the bathroom, slipped, and fell . A review of clinical record and facility documentation failed to identify a new fall risk assessment was completed for the 9/26/23 fall. d. A facility Incident Report and investigation dated 1/18/24 identified on 1/18/24 at 9:45 AM, Resident #11 experienced an unwitnessed fall and was found sitting on the floor next to the bed. The resident reported to staff that he/she was trying to pull the recliner away from the wall and fell backward. A review of clinical record and facility documentation failed to identify a new fall risk assessment was completed for the 1/18/24 fall. e. A facility Incident Report and investigation dated 2/26/24 identified on 2/26/24 at 7:45 PM, Resident #11 experienced an unwitnessed fall and was found on his/her knees by the bed without shoes or socks. The resident reported to staff that he/she lost his/her balance taking off his/her jacket. The report further indicated the resident suffered a right second toe abrasion that measured 1.5 cm by 1.5 cm. A review of clinical record and facility documentation failed to identify a new fall risk assessment was completed for the 2/26/24 fall. f. A facility report and investigation dated 3/5/24 identified that on 3/5/24 at 3:05 PM, Resident #11 was found sitting on the floor in the resident's bathroom. The resident reported to staff that he/she misjudged the distance when transferring from the toilet to the rollator. A post-fall observation assessment in the medical record dated 3/5/24 did not identify any potential factors that may have contributed to the fall and did not indicate any measures taken to prevent future falls. A review of the clinical record and facility documentation failed to identify a new fall risk assessment was completed for the 3/5/24 fall. g. A facility report and investigation dated 3/13/24 identified that on 3/13/24 at 8:50 PM, Resident #11 was found sitting on the floor in the resident's bathroom. The resident reported to staff that he/she reached over his/her walker to reach his/her pajamas, lost his/her balance, and fell backwards, hitting his/her head. A post-fall observation assessment dated [DATE] identified the resident did not have shoes or socks. A review of the clinical record and facility document did not identify a new fall risk assessment was completed for the 3/13/24 fall. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075236	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Noble Horizons	17 Cobble Rd Salisbury, CT 06068

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview and policy review with the DNS on 3/18/24 at 12:13 PM identified that fall risk assessments are completed on admission, quarterly, and with significant changes. The DNS also indicated that a fall risk assessment is not completed after every fall because once a resident is a fall risk, they remain a fall risk. The DNS further indicated that there must have been an error in the policy because staff will only complete the fall observation, which is the post-fall assessment, and that the current policy is the most updated. The facility's current Fall Prevention Policy (with revision date 6/2019) indicated that a fall risk assessment is completed quarterly, annually, and whenever a resident has experienced a fall. Additionally, the policy indicated that the fall risk assessment was in addition to the fall assessment following a fall. 48880

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075236	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Noble Horizons	17 Cobble Rd Salisbury, CT 06068

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. 37721 Based on facility documentation review, facility policy and interviews, the facility failed to ensure nurses were assessed to be competent in intravenous (IV) therapy. The findings include: A review of the nursing IV competencies identified that the last review was completed on 12/23/22. An interview with the Staff Educator on 3/19/24 at 9:59 AM identified she was responsible for ensuring IV competencies are provided annually. The Staff Educator became aware that IV competencies were outdated sometime after July 2023 when she became employed at the facility. The Staff Educator felt she herself needed training in IV certification before educating staff and discussed the concern with the Director of Nursing Services who indicated the need would be addressed. The Staff Educator further identified she had not yet received training. An interview with the DNS on 3/19/24 at 11:16AM identified IV competencies should be completed according to policies. A review of the facility policy for Skills Assessment/Continued Competencies directed all employees will have specific skills assessed to assure competency. The skills are to be assessed each year and reported to the Governing Board by the Administrator at least annually and kept in the employee's personnel file.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075236	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Noble Horizons	17 Cobble Rd Salisbury, CT 06068

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 46046 Based on observations of facility posted staffing ratios and interviews, the facility failed to ensure the daily census was written on the 24-hour nurse staffing sheet posted in the lobby for the view of the residents and the public. The findings included: An observation on 3/13/2024 at 9:05 AM of the daily 24-hour nurse staffing sheet posted in the lobby of the facility noted no resident census written on the space in the right upper hand corner of the form. On 3/20/2024 at 9:00 AM the posted 24-hour nurse staffing in the front lobby was missing the census in the space provided in the right upper corner of the form. An interview with Receptionist #1 at the time of the observation indicated the scheduler completed the forms in advance and provided several days at a time and the receptionist posts the form daily. On 3/20/2024 at 9:05 AM an interview with the Scheduler over the phone indicated initially it was the receptionist's responsibility to write in the census on the form before posting then indicated it was his/her own responsibility to have added the census to the form. On 3/20/2024 at 9:06 AM an interview with the receptionist indicated s/he was never told to write the census on the form and further indicated if there was a change needed the scheduler would come and adjust the form for the day. An interview on 3/20/2024 at 9:20 AM with the DNS and the scheduler indicated they were currently working on revising the procedure for completion and posting of the 24-hour nurse staffing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075236	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Noble Horizons	17 Cobble Rd Salisbury, CT 06068

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37721 Based on clinical record reviews, facility documentation, facility policy and interviews for 1 of 5 residents, (Resident #38) reviewed for unnecessary medications, the facility failed to respond to pharmacy recommendations for a resident receiving psychotropic medications. The findings include: Resident #38 had diagnoses that included anxiety disorder and depression. The admission MDS assessment dated ,d+[DATE] 24 identified Resident #38 was moderately cognitively impaired and dependent with ADL assist. The RCP dated 2/7/24 identified Resident #38 utilized psychotropic drugs related to anxiety, depression, and dementia. Interventions directed to attempt gradual dose reductions as prescribed and refer to APRN (psychiatric) consults. The physician's orders dated 2/24/24 directed Trazadone 50 mg every 8 Hours PRN (as needed) for agitation with no identified date of discontinuation. A Pharmacy Consult dated 3/4/24 recommended including a 'stop' date for the PRN use of Trazadone with no documented provider response. An interview with the DNS on 3/20/24 at 1:13 PM identified all pharmacy recommendations that should have been responded to by the provider. After surveyor inquiry, the Pharmacy Consult dated 3/4/24 included a documented signature from the provider (no date). A review of the facility policy for Pharmacy Consults directed that monthly pharmacy consults were to be submitted by the pharmacy before the end of each month and reviewed by the practitioner to identify irregularities in medication regime and review recommendations. The practitioner may choose to fill out the sheet pharmacy consult and/or write an order in the chart.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075236	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Noble Horizons	17 Cobble Rd Salisbury, CT 06068

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46046 Based on observation, review of the clinical record, facility policy and interviews for 1 of 4 residents reviewed for medication administration opportunities (Resident #57), the facility failed to ensure medications were administered timely and medication errors did not exceed 5%. The findings include. Resident #57's diagnosis included localized swelling and edema, vitamin deficiency and left knee effusion (excess fluid buildup in the knee joint). The physician's order dated 4/17/2023 directed vitamin C 250 mg tablet to be administered orally once daily at 8:00AM. The physician's order dated 11/2/2023 directed Vitamin D3 capsule (600 international units) be given orally daily at 8:00 AM. The physician's order dated 12/19/2023 directed Hydrochlorothiazide 25 mg tablet one orally be given once daily at 8:00 AM for edema. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated in part Resident #57 was cognitively intact. The care plan dated 1/31/2024 indicated Resident #57 with increased weight with potential for weight fluctuations related to bilateral lower leg edema. Interventions including in part, a low sodium diet. On 3/19/2024 at 9:30 AM an observation medication administration was made with LPN # 2 for Resident #57. The medications administered were Hydrochlorothiazide (a diuretic) 25 milligrams, one whole tablet administered by mouth, Vitamin C 25 mg one tablet by mouth and Vitamin D3, 3 half tablets of 10 mcg (400 iu, international units), to make 600 iu, given by mouth. An interview and record review of the medication administration history with the DNS on 3/19/2024 at 10:35 AM indicated the hydrochlorothiazide, vitamin C and Vitamin D3 were administered 30 minutes late. The DNS indicated the medications were administered outside the allotted time (1 hour before and 1 hour after the scheduled time). An interview with LPN #2 would be needed to determine the reason. An interview with LPN #2 indicated the reason medications for Resident #57 were administered 30 minutes late because he/she was unable to administer medications for 30 residents safely in the time given. The DNS indicated he/she would look at adjusting the medication administration times to make the administration times for the nurses manageable. The facility policy labeled Medication Administration dated 1/2024 indicated in part, all medications are properly administered and documented via the Electronic Medication Administration Record (EMAR) per the physician or nurse practitioners' orders and medications administered following the five rights of Medication Administration, right drug, right dose, right resident, right route, and right time.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075236	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Noble Horizons	17 Cobble Rd Salisbury, CT 06068

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37721 Based on clinical record reviews, facility documentation, facility policy and interviews for of 1 of 5 residents, (Resident #52) reviewed for medication administration, the facility failed to ensure a resident was free from a significant medication error following the administration of an unprescribed reduced dose of insulin. The findings include: Resident #52's diagnoses included type II diabetes mellitus and heart failure. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #52 as cognitively intact, independent with bed mobility, supervision with transfer, toileting, and ambulation. The Resident Care Plan Dated 2/29/24 identified Resident #52 as type II diabetes mellitus. Interventions directed to monitor diet, laboratory values, glucose monitoring and the physician/Nurse Practitioner would review Resident #52's diabetic medications, sliding scale orders, Accu-Check (blood glucose monitoring) schedule, diet, and individualized orders for glycemic management accordingly. The physician's orders dated 3/1/24 directed Humalog insulin (fast acting hormone used in the treatment of diabetes mellitus) to be administered based on a sliding scale (parameters that determine dosage based on blood sugar reading) four times a day. The sliding scale directed the following dosage based on blood sugar reading at 7:30 AM, 11:30 AM, 4 :30 PM and 8:00 PM: If Blood Sugar is less than 60, call MD. If Blood Sugar is 0 to 150, give 0 Units. If Blood Sugar is 151 to 200, give 2 Units. If Blood Sugar is 201 to 250, give 4 Units. If Blood Sugar is 251 to 300, give 6 Units. If Blood Sugar is 301 to 350, give 8 Units. If Blood Sugar is 351 to 400, give 10 Units. If Blood Sugar is 401 to 450, give 12 Units. If Blood Sugar is greater than 450, give 14 Units. If Blood Sugar is greater than 450, call the physician. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075236	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Noble Horizons	17 Cobble Rd Salisbury, CT 06068

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Medication Administration History dated 3/11/24 identified the prescribed (6 units) of insulin was not administered with a notation that read, 'Resident insisted on 4 units only, not 6 per sliding scale. A nurse's note completed by Licensed Practical Nurse, LPN #4 dated 3/12/24 at 7:43 AM identified at 8:00 PM (on 3/11/24), Resident #52's blood sugar was 300 milligrams per deciliter, mg/dl (normal 80-100), requiring 6 units of insulin. Resident #52 refused and requested 4 units of Humalog insulin, stating s/he did not want the blood sugar level to be low during night. Patient teaching provided; 6 units were encouraged. Blood sugar at 12:00 AM (on 3/12/24) was 212. The blood sugar early morning 397. Resident #52 was asymptomatic. The supervisor was notified. A re-check of the blood sugar at 5:45 AM was 432 and 12 units of Humalog (insulin) were given per Advanced Practice Registered Nurse (APRN) order. Resident #52's next recorded blood sugar at 7:30 AM was 283 with 6 units of insulin administered with no other documented intervention. An interview with LPN #4 on 3/18/24 at 9:42 AM identified she was the assigned charge nurse working 7:00 PM - 7:00 AM from 3/11/24 to 3/12/24. LPN #4 reported she checked Resident #52's blood sugar at 8:00 PM and determined s/he would require 6 units of insulin. Resident #52 refused the 6 units but agreed to receive 4 units which she administered. LPN # 4 reported she did not notify the evening/night shift supervisor, or the physician, further stating she should have notified them. LPN #4 did report to the day shift nurse manager, Registered Nurse #1 prior to leaving on the morning of 3/12/24. An interview with the Director of Nursing Services, DNS on 3/18/24 at 10:01 AM identified she was unaware the medication error had occurred. The DNS indicated nurses should not change medications dosages without first notifying the physician. An interview with APRN #1 identified that she provided routine medical services to Resident #52. APRN #1 indicated she was not notified at any time Resident #52 refused the prescribed dose of insulin and was instead administered a reduced dose. APRN #1 indicated she would expect to be notified if a resident refused a prescribed medication. An interview with RN #1 on 3/18/24 10:14 AM identified LPN #4 reported to her Resident #52 did not receive a full dose of insulin and that she could not recall notifying APRN #1 of the medication error but would have documented the event in the clinical record. An interview with APRN #2 on 3/21/24 at 12:36 PM identified she was the afterhours provider on call on 3/12/24 who did not provide routine services to Resident #52 and could not recall being contacted by the facility. APRN #2 indicated that although the short acting insulin would have been out of a resident's system in 4-6 hours, nursing staff should be contacting a provider for orders if the resident was preferring a reduced dose. A review of the facility policy for Medication Errors directed the medications are to be administered according to physician orders. All medication errors are to be reported to the supervisor, Director of Nursing and Assistant Director of Nursing and the attending physician will be notified. Examples of medication errors include the wrong dose or omission of an ordered dose. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075236	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Noble Horizons	17 Cobble Rd Salisbury, CT 06068

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Efforts to interview the Medical Director were unsuccessful.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075236	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Noble Horizons	17 Cobble Rd Salisbury, CT 06068

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48792 Based on a tour of the kitchen, facility policy, and staff interview, the facility failed to ensure that expired food was discarded. The findings included: A tour of the kitchen on [DATE] at 10:30 AM with the Director of Dining Services identified the following in the dry storage room and the overflow dry storage room: a. 12- 6 lb. cans of beets expired [DATE]. b. ,d+[DATE] lb. cans of corn expired [DATE]. c. 3- 8.8 boxes of [NAME] Chickpea Rotini expired [DATE]. An interview with Director of Dining Services on [DATE] at 10:45 AM identified he checks the food storage monthly for expiration dates and discards outdated food. Further, all dietary staff should be checking dates. The Director of Dining Services could not explain why the expired foods were not discarded. Review of the Dietary Services policy dated [DATE] directs in part, all food must have a date when it is opened and dated when it is stored. Most recent dates are utilized first, and new orders are stocked to the back of the rotation to prevent expiration.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075236	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Noble Horizons	17 Cobble Rd Salisbury, CT 06068

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46046 A review of the Facility Assessment sheet failed to ensure the facility assessment included therapeutic facility pets and individualized resident pets to meet the needs of the residents and failed to ensure the therapy pets were up to date with vaccinations and veterinary visits per facility policy. The findings included: Interview and review of facility document with the Director of Recreation on 3/21/2024 at 10:50 AM indicated 2 cats live in the facility (Cat #1 and Cat #2) and are available to all residents one of which had documentation of up-to-date vaccination for rabies and wellness examination, no distemper (Cat #1) and the other (Cat #2)was overdue for Rabies vaccine since 2020(initial vaccine 11/4/2019 due for booster 10/4/2020(3 years 5 months ago) then the three year rabies vaccine was due 11/3/2022 (2 years 4 months ago). Further review of facility documentation identified Cat #2's last wellness exam was 11/4/2019 (3 years 5 months ago) and no evidence of a distemper vaccine. After surveyor inquiry, the Recreation Director indicated Cat #2 had an appointment scheduled with the veterinarian the of the interview. The Recreation Director further indicated one resident in the facility (Resident #58) was in possession of a pet cat (Cat#3) who lived in the resident's room whose family member cared for the cat's needs. An interview with the DNS on 3/21/2024 at 10:52 AM indicated Cat #3 was (older) and an emotional support pet for Resident #58. Cat 3 veterinarian visit was managed by the resident's family therefore the facility would not have any records of vaccination or health records. An interview with the Director of Recreation on 3/21/2024 at 11:00 AM indicated s/he would request the health record for Cat 3 from Resident # 58's family. After surveyor inquiry the documentation for Cat #3 was provided and noted as up to date with rabies vaccine and wellness exam, no evidence of a distemper vaccine. The facility policy labeled Pet Policy and Agreement dated 1/2024 indicated in part residents of the cottages or independent living apartments (no indication of pets kept in the skilled nursing facility) may keep a single pet subject to the regulations and procedures established by the facility owners and use of service or support animals is subject to the requirements of the Service and Support animal Policy. The policy further indicated in part, pets do not include Service or Support Animals and a pet cat must have current veterinary health record, distemper, and rabies shots. The facility policy labeled Service and Support animal Policy and Agreement indicated in part a support animal is an animal selected to play an integral part of a person's treatment process that demonstrates a good temperament and reliable predictable behavior. The animal is provided to the individual with a disability by a healthcare or mental health professional that is incorporated a treatment process to assist in alleviating symptoms of the individual's disability and further indicated a support animal is not a pet subject to the Pet Policy and agreement. The policy further indicated the resident must be responsible for the care of the animal, annual clean bill of health and immunized against diseases common to the type of animal. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075236	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Noble Horizons	17 Cobble Rd Salisbury, CT 06068

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility Recreation policy labeled Community Pets, dated 1/2024, indicated in part resident cats would be jointly cared for daily by the recreation staff and nursing staff. The policy further indicated the Recreation Director would be responsible for the cat's wellbeing, shots, and licenses. The Facility assessment dated ,d+[DATE], indicated in part it provided care and services for residents with psychiatric/mood disorders but made no mention of services and care offered based on resident needs as to support animals.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075236	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Noble Horizons	17 Cobble Rd Salisbury, CT 06068

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37721 Based on clinical record review, facility policy and staff interview for 1 of 5 residents reviewed for Unnecessary Medications, the facility failed to ensure clinical records were complete and accurate containing pharmacy recommendations. The findings include: Resident #32's diagnosis included dementia with psychotic disturbance, anxiety, and depressive episodes. The quarterly Minimum Data Set (MDS) dated [DATE] indicated Resident #32 was cognitively impaired and received antipsychotic and antidepressant medications. The care plan dated 1/23/2024 indicated resident received psychotropic medications including psychotropic Drugs. Interventions included: to monitor mood and response to the medications, consult with the psychiatric APRN, to conduct an Abnormal Involuntary Movement Scale assessment (AIMS) every 6 months and assess and record effectiveness and side effects of the medication. Interview and record review with the DNS on 3/20/2024 at 10:30 AM indicated a monthly pharmacy review was completed and a recommendation was made on 12/4/2024. However, the recommendation could not be found or evidence that the recommendation had been addressed by the physician. The facility policy labeled Medication Regimen dated 1/2024 indicated in part within 24 hours of the medication regimen review, the consultant pharmacist provides a written report to the physicians for each resident reviewed identified as having a non-life-threatening medication irregularity which includes the resident's name the name of the medication, the identified irregularity and the pharmacist's recommendation then provides the Director of Nursing Services and Medical Director a written signed, and dated copy of all medication regimen reports. The policy further indicated copies of medication regimen review reports, including the physicians' responses, are maintained as part of the permanent medical record. 46046

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075236	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Noble Horizons	17 Cobble Rd Salisbury, CT 06068

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly 46046 Based on review of facility documentation, interview, and facility policy, the facility failed to ensure the Medical Director attended Quality Assurance Performance Improvement (QAPI) meetings quarterly. The findings include: On 3/21/24 at 11:20 AM an interview and facility document review indicated QAPI meeting occurred every three months. Although, the Medical Director was on the list of members that were required to attend the QAPI meeting quarterly there was no evidence of the Medical Director's attendance at the QAPI meeting found from January 2023 through 3/21/2024(one year, 2 months). The DNS indicated the Medical Director is aware of his/her need to attend the meetings but may not have been able to attend the meeting. The Medical Director is updated at the medical staff meetings. Evidence of the medical staff meetings was requested but not provided. On 3/21/2024 at 11:44 AM attempts to reach the Medical Director via phone were unsuccessful. The facility policy labeled Quality Assurance Performance Improvement (QAPI) indicated in part the QAPI program is a comprehensive program designed to drive the decision making within the organization to promote excellence on quality of care, quality of life, resident choice, person driven care and resident transitions. The policy further indicated the QAPI Committee would consist of members including in part the Medical Director.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075236	A. Building B. Wing	03/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Noble Horizons	17 Cobble Rd Salisbury, CT 06068

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 37721 Based on review of the facility Infection Control Program, facility policy and interview, the facility failed to ensure infection control policies and procedures were reviewed annually. The findings include: A review of the facility's infection Control policies and procedures during the survey identified the facility failed to provide documented evidence that policies were reviewed annually. An interview and facility documentation review with the Director of Nursing Services on 3/13/24 at 1:00 PM identified the facility never previously required a documented review of current policies and procedures. Although requested, a policy for the review of policies and procedures was not provided.