STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075238	A. Building B. Wing	05/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maple View Health & Rehabilitation Center	856 Maple St Rocky Hill, CT 06067

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48880 Based on observations, clinical record review, policy review and staff interviews for 1 of 1 resident reviewed for choices (Resident #71), the facility failed to honor a family member's choice regarding having the resident out of bed to a chair by 11:00 AM. The findings include: Resident #71's diagnoses included early-onset Alzheimer's disease and seizure disorder. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #71 with short-term and long-term memory impairments and noted dependence with eating, toileting, and transferring to and from a bed to a chair. The MDS further identified Resident #71 as incontinent of bladder and bowel. The care plan dated 4/22/24 identified Resident #71 had little, or no group activity involvement related to dementia and behaviors. Interventions included: assisting/escorting to activity functions and indicated resident preferred socializing with nursing staff and spouse. The care plan also noted at risk for Activities of Daily Living (ADL) self-care performance deficit related to dementia. Interventions included: transferring the resident out of bed with the assistance of two staff members and a mechanical lift. The care plan for communication problems related to dementia. Interventions included anticipating and meeting the residents' needs. A psychiatric follow-up note dated 5/1/24 identified Resident #71 was non-verbal and did not respond to his/her name or to family. Additionally, the psychiatric follow-up indicated that the resident's spouse visits daily. On 5/7/24 at 3:00 PM, an interview with (Person # 3) identified the resident does not get out of bed in the morning. Person # 3 further indicated s/he would like Resident # 71 to be get out of bed in the morning by 11:00 AM so s/he could take the resident outside for a walk when s/he visits 11:30 AM to 1:30 PM. Person #3 indicated s/he have complained and spoken to staff about this concern and the resident is still not consistently out of bed by the time s/he arrives to visit. On 5/8/24 at 9:34 AM, an observation identified the resident in bed with a gown on. An observation at 11:29 AM identified Resident # 71 in bed and dressed. An observation at 11:35 AM was made of Nurse Aide (NA#2) pushing a mechanical lift into the resident's room. (continued on next page)

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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A follow-up interview with Person # 2 on 5/8/24 at 11:40 AM indicated s/he arrived to visit Resident # 71 at 11:15 AM and found the resident in bed. Person # 3 further indicated that it takes time for staff to transfer the resident using the mechanical lift, which takes time away from the time s/he could spend visiting with the resident. On 5/8/24 at 2:18 PM, an interview with NA #1 indicated staff tried to put the resident in the chair at the same time every day. NA#1 indicated that around 11:00 AM the resident is regularly incontinent of urine and stool, so staff will wait for the incontinent episode before moving the resident to the chair. NA#1 further indicated if the resident is transferred to the chair before the resident's incontinent episode, the staff would have to use the mechanical lift to transfer the resident back to the bed to be cleaned and then once again to the chair. On 5/8/24, an interview with NA #2 identified NA#2 was new to the facility and unaware Resident # 71 had a specific time to get up. NA#2 indicated she started getting things ready to get the resident up out of bed when Person # 3 arrived and told her the resident should be taken out of bed to chair. NA#2 also indicated that part of her workflow is to help the residents who are ambulatory to get out of bed first and then the residents who require assistance from another staff member but have no set time to get up. On 5/8/24 at 2:31 PM, an interview with LPN#3 indicated Person # 3 arrives to visit every day around 11:00 AM or 11:15 AM and when it is warm outside, Person # 3 would take the resident outside and sit on a bench. Additionally, LPN#3 indicated the resident tends to be incontinent of stool around 11:00 AM, and if staff were to get the resident up before then the resident would be incontinent of stool while in the chair. Additionally, LPN#3 indicated when Person # 3 arrives and notices that the resident is incontinent of stool while on the chair, Person # 3 complains about the resident being cleaned. On 5/13/24 at 10:00 AM, an interview with the Director of Nursing Services (DNS) indicated staff take Resident #71 out of bed every day and staff know the resident should be out of bed before Person # 3 arrives and if Resident # 71 is still in bed with Person # 3 arrives s/he becomes upset.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. 49100 Based on observations, review of the facility grievance file, facility policy and interviews, the facility failed to ensure grievances were responded to in a timely manner regarding appropriate food temperatures for consumption. The findings include: Review of the Resident Council Minutes for 2/21/24 and 3/25/24 identified residents' reported concerns that meals were not served at the appropriate temperature. Inservice education on 4/2/24 indicated Nursing staff are aware to reheat food in the microwave when residents request or complain their food is cold or not warm enough. No plan was discussed for non-verbal residents. Interview with a resident on 5/8/24 at 1:30 PM identified food continues to arrive to units cold. Residents attribute the cold food temperatures to the delay in staff passing out the food. Observation on 5/9/24 at 12:00 PM of food identified food arriving on 2nd floor unit. Observation On 5/9/24 at 12:38 PM identified the last meal given to the resident on the 2nd floor. A temperature check of the last try was completed at 12:40 PM by surveyor and Registered Nurse (RN #3). The temperature of the meal served to a resident on 2nd floor identified the following: 123.8 degrees Fahrenheit (Normal Range Holding Food 135 degrees Fahrenheit; RN #3 temperature indicated 120 degrees Fahrenheit. On 5/9/24 at 12: 55 PM Interview with RN #3 indicated for non-verbal/ cognitively impaired residents, the facility should be able to tell if the food is cold by looking at it or hovering hand over meal to feel for temperature. On 5/9/24 at 1:15 PM Interview with Director of Nursing Services (DNS) indicated staff are responsible for ensuring foods are at the correct temperature prior to serving residents. She indicates for nonverbal/ cognitively impaired residents' staff should be able to tell if the food is at the appropriate temperature prior to serving. Interview on 5/13/24 at 10:14AM with Grievance Officer (Administrator) indicated he was aware of the concerns regarding the food temperature, and conducted an in service, on what to do for residents who complain. He indicated for non-verbal/ cognitively impaired residents, food temperatures are checked based on the temperatures of the plate or hovering their hand over it. Facility policy notes the appropriate method of testing temperatures, includes using various types of thermometers (Bimetallic Stemmed Thermometer, Thermistors, and thermocouples Thermometer) Etc. Facility policy Grievances notes in part the Grievance Officer is responsible for ensuring that all grievances are responded to in a timely manner.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37721 Based on review clinical records, facility documentation, facility policy, and interviews for 2 of 3 residents (Resident # 160 and Resident #259) reviewed for abuse, the facility failed to report allegations of abuse to other regulatory agencies. The findings included: 1. Resident #160's diagnoses included pancytopenia (significant reduction in the number of almost all blood cells), alcoholic cirrhosis of liver with ascites (abnormal fluid in the abdomen) and dementia. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #160 as cognitively intact, requiring one person to assist with bed mobility, transfers, and personal care. The RCP dated 4/17/23 identified Resident #160 as dependent on staff for meeting emotional, intellectual, physical, social needs and noted cognitive dysfunction. Interventions directed to ensure activities are compatible with physical/mental capabilities, provide assist of one with activities of daily living and to monitor report changes in cognitive function. A facility Reportable Event dated 4/22/23 at 3:29PM identified on 4/22/23 at 1:30PM Resident #160 reported to Registered Nurse, RN #4, that the charge nurse, Licensed Practical Nurse, LPN #6 last evening during the 3:00 PM-11:00 PM shift, LPN #6 told Resident #160 she wished s/he would fall, crack her/his head, and die. A nurse's note dated 4/22/2023 at 4:06 PM identified Resident #160 reported the nurse told him/ her that she wished the resident would fall and crack his/her head and die. The state agency, local law enforcement, Conservator of Estate and Advanced Practice Registered Nurse (APRN) were notified. The APRN ordered urinalysis due to confusion to rule out a urinary tract infection (UTI). A Reportable Event Summary dated 4/24/23 identified Resident #160 alleged on 4/22/23 LPN #6 threatened him/her and was verbally abusive. Resident #160 was confused, anxious and paranoid at the time. Resident # 160 verbalized all the other residents on the unit were dead. Investigation initiated immediately. LPN #6 was removed from the schedule. LPN #6 denied any verbal abuse. Resident's laboratory results revealed critical levels and abuse was not substantiated. A review of the investigative report did not include documented notification to other regulatory agencies. An interview with Person #3 at 5/10/24 at 10:14 AM identified that although allegations of abuse submitted for residents in long term care were referred to state agency for investigation, all allegations of potential abuse were required to be reported to other regulatory agencies when an incident occurs. An interview with the Director of Nursing Services (DNS) on 5/13/24 at 11:25 AM other regulatory agency was only notified if an allegation of abuse was substantiated. In the case of Resident #160, abuse was not substantiated. Rather, a symptom of a medical condition. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility policy for Abuse dated 12/2023 directed the Administrator, DNS or designee assume the responsibility for notification of the incident and preliminary internal investigation results to include the state agency and other regulatory agencies per individual state reporting requirements. Attempts to interview RN #4 and LPN #6 were unsuccessful. 2. Resident #259's diagnoses included dementia, visual hallucinations, and major depressive disorder. The care plan dated 8/30/22 identified Resident # 259 as cognitively impaired, impaired thought process related to dementia. Interventions included cueing, reorienting, and supervising as needed, keeping the resident's routine consistent, and providing as consistent caregivers as possible. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #259 with moderate cognitive impairment and noted the resident required extensive assistance from one person for dressing and personal hygiene. The resident was independent with ambulation. A facility Reportable Event dated 9/10/22 identified at 10:30 PM, Resident #259 alleged (Nurse Aide (NA#4) was rough with her/him and called the resident names during care. The Reportable Event indicated the facility notified the local police, immediately suspended NA#4 pending the investigation, consulted psychiatry, performed a body audit, and ensured two staff members provided care to the resident. The incident was reported to the state agency on 9/11/22 at 12:00 AM, within the two-hour mandatory window for initial reporting of alleged abuse. The facility's summary of the investigation dated 9/12/22 identified the facility did not have a reasonable cause to suspect abuse had occurred. A nursing progress note by the nursing supervisor (RN#5) dated 9/11/22 at 12:41AM indicated a body assessment was performed, and no injuries were noted. Additionally, the progress note indicated that police arrived, the resident's provider and family were notified, and the facility DNS was notified. On 5/9/24 and 5/10/24, attempts to contact NA#4 during the survey were unsuccessful. On 5/9/24 and 5/10/24 attempts to contact RN#5 were unsuccessful. An interview with the DNS on 5/9/24 at 2:00 PM indicated NA#4 was sent home when the allegation was first known. Additionally, the DNS indicated the allegation was not reported to other regulatory agency because the facility did not substantiate the allegation as an incident of abuse and the facility would only report to the other regulatory services if the facility's investigation concluded that abuse may have occurred. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/10/24 at 10:14 AM, an interview with Person #3 indicated the allegation of abuse for Resident #259 was the other regulatory agencies at Department of Social Services on 9/12/22 by the local police department. Person #3 indicated long-term care facilities are expected to report allegations of abuse within 24 hours to the other regulatory agency. A review of facility policy for abuse identified the facility would notify the state agency immediately but no later than 2 hours to report allegations of abuse. The facility abuse policy further indicated that staff would need to see state-specific guidelines for verbal notification of all abuse (alleged or confirmed) to the state health department and other regulatory agencies per individual state reporting requirements. 48880

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48792 Based on observations, clinical record reviews, facility policy and interviews for the 2 of 2 residents (Resident # 77 and Resident #80) reviewed for oxygen, the facility failed to administer oxygen as prescribed. The findings included: 1. Resident #77 's diagnoses included Chronic Obstructive Pulmonary Disease (COPD) with (acute) exacerbation, dysphagia, and anxiety. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #77 as cognitively intact and required two persons to assist in bed mobility, transfers and one person assist with eating. The MDS also indicated Resident #77 experience shortness of breath/ trouble breathing when lying flat and required oxygen therapy. The Resident care plan dated 4/13/24 for chronic respiratory failure with hypoxia. Interventions included oxygen via nasal cannula at 2-3 L per minute and to monitor for respiratory distress. A physician's order dated 4/13/24 directed oxygen at 2 or 3 liters per minute continuous via nasal cannula. Observation on 5/08/24 at 9:08 AM identified Resident # 77 in the room with nasal cannula in, however, tube was not connected to the oxygen machine. The oxygen machine was 4 liters. Interview with LPN #1 on 5/8/24 at 9:15 AM indicated Resident # 77 was connected to her/his oxygen machine when LPN # 1 did her rounds at 7:30 AM. However, LPN #1 could not explain why the resident was connected to the oxygen. LPN #1 was unable to explain why Resident# 77 oxygen was set at 4 litter. LPN #1 also indicated nursing supervisor/ APRN are allowed to set litter per physician's order. During the interview Resident #77 expressed she was experiencing shortness of breath (SOB). LPN #1 indicated when resident expresses SOB, there is an as needed order for a nebulizer to assist. After inquiry, the resident's orders were revised on 5/8/24 to reflect oxygen 4 liters when needed, titrate up as needed up to 5 liters and to keep oxygen saturation greater than 93 percent. 2. Resident #80's diagnoses included Chronic Diastolic Hear Failure, hypertensive heart disease with heart failure, and Chronic Obstructive Pulmonary Disease (COPD). A physician's order dated 3/5/24 directed to administer oxygen at 2 liters per minute via nasal cannula for shortness of breath or oxygen saturation levels of less than 90%. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #80 as severely cognitively impaired and required extensive assistance with transfers, eating and toileting. The Resident Care Plan updated on 3/19/24 identified Resident #80 had altered respiratory status/difficulty breathing. Interventions included oxygen settings via nasal cannula as ordered. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observation on 5/08/24 09:55 AM identified Resident # 80's oxygen liter flow rate was set at 4 liters. Interview and observation with LPN #2 on 5/8/24 at 10:00 AM identified Resident # 80's oxygen set at 4 liters and the order was for 2 liters. LPN #2 also was unable to explain why the oxygen level was set at 4 liters. After inquiry, LPN #2 set the resident's oxygen flow rate at 2 liters. Although requested, a facility policy for Oxygen was not provided. The Administrator indicated they do not have a policy for oxygen, the staff are directed to follow the physician's order for oxygen flow rate. 49100