STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075243	A. Building B. Wing	11/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pierce Memorial Baptist Home, Inc.	44 Canterbury Road Brooklyn, CT 06234

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** 31310 Based on clinical record reviews, facility documentation, policy, and interviews for one of three sampled residents (Residents #1) who were reviewed for multiple falls, the facility failed to review and revise the plan of care to determine new interventions after Resident #1 sustained a fall to prevent further falls. The findings include: Resident #1's diagnoses included aphasia, anxiety, and history of falls. The Fall assessment dated [DATE] identified Resident #1 was a high risk for falls. The admission Minimum Data Set assessment dated [DATE] identified Resident #1 required total assistance with getting in and out of the bed and chair, toilet use, personal hygiene, and extensive assistance with turning and repositioning while in bed, and had no falls since admission, entry or reentry or the prior assessment. The Facility Reported Incident form dated 7/24/23 at 12:05 PM identified Resident #1 was observed sitting on his/her buttock on the floor mat with their back resting against the bed and holding onto the side rail with his/her left hand, and no injuries were noted. The Resident Care Plan dated 7/26/23 identified Resident #1 was at risk for falls related to deconditioning, gait and balance problems, incontinence, and poor communication and comprehension. Interventions directed to be sure Resident #1's call light was within reach, Resident #1 needed prompt response to all requests for assistance, encourage Resident #1 to be in common areas for supervision, out of bed for all meals, every two (2) hour toileting while awake, every fifteen (15) minutes checks, and bed against the wall. The Facility Reported Incident form dated 7/30/23 at 6:45 PM identified Resident #1 was observed sitting on the floor mat at his/her bedside and no injuries were noted. The Facility Reported Incident form dated 8/3/23 at 1:30 AM identified it was noted on the video monitor that Resident #1 was restless, and although staff quickly responded Resident #1 was observed lying on the floor mat at the bedside when the nurse entered the room and the skin tear to the left upper extremity reopened. (continued on next page)

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Facility Reported Incident form dated 8/8/23 at 7:30 AM identified Resident #1 was lowered to the floor at 7:30 AM by a nurse aide and although there were no obvious injuries at the time, later in the evening Resident #1 developed bruising to the left great toe. Review of the clinical record failed to provide documentation Resident #1's care plan was reviewed and/or revised after each fall on 7/24, 7/30, 8/3 and 8/8/23 to determine new interventions. Interview and review of the clinical record with the Director of Nursing (DON) on 11/3/23 at 11:40 AM identified Resident #1's care plan was not reviewed and revised after the falls on 7/24, 7/30, 8/3 and 8/8/23. The DON indicated the Minimum Data Set Coordinator was responsible to review and/or revise Resident #1's care plan after each fall. Interview with Minimum Data Set Coordinator, Licensed Practical Nurse (LPN) #1, on 11/3/23 at 12:30 PM identified she was responsible to review and revise Resident #1's care plan, however it was not only her responsibility, but all nurses were responsible to review and revise a resident's care plan. The Comprehensive Care Plan policy directed the comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly assessment. The comprehensive care plan will include measurable objectives and time frames to meet the resident's needs as identified in the residence comprehensive assessment. The objectives will be utilized to monitor the resident's progress. Alternative intervention will be documented as needed.

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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** 31310 Based on clinical record reviews, facility documentation, policy, and interviews for one of three sampled residents (Resident #1) who had potential for impairment to skin integrity, the facility failed to document that a complete assessment was conducted to identify the exact location and set a baseline when areas of discoloration were identified on admission and after Resident #1 sustained falls with injuries and failed to ensure a Registered Nurse assessment was conducted when abrasions were identified to right lower extremity. The finding include: Resident #1's diagnoses included aphasia, anxiety, and history of falls. A Fall assessment dated [DATE] identified Resident #1 was a high risk for falls. The admission Minimum Data Set assessment dated [DATE] identified Resident #1 required total assistance with transfer, toilet use, personal hygiene, and extensive assistance with bed mobility, and had no falls since admission, entry or reentry or the prior assessment. The Resident Care Plan dated 7/26/23 identified Resident #1 had potential for impairment to skin integrity, was at risk for pressure sores due to decreased mobility, fragile skin, and incontinence. Interventions directed to keep skin clean and dry, use house lotion with personal care. a. The admission nursing assessment dated [DATE] identified Resident #1 had an alteration in skin integrity. Resident #1 had scattered bruising on abdomen, bilateral arms. Review of the clinical record failed to reflect documentation that a complete assessment, i.e., size color and exact location, of the discolorations had been conducted when an area was first identified on 6/29/23 to establish a baseline description of the area for further evaluation to determine if there was an improvement or decline of the discolorations. b. The nurse's note dated 7/10/23 at 6:30PM identified a nurse was walking by Resident #1's room and saw Resident #1 lying on stomach in front of his/her recliner chair. A small bruise measuring 1. 0 centimeter (cm) to the left wrist and a small bruise to lower lip were identified. No open areas or other new bruises were noted. Review of the clinical record failed to reflect documentation that a complete assessment, i.e., size color and description of the discolorations had been conducted when the areas were first identified on 7/10/23 to establish a baseline description of the area for further evaluation to determine if there was an improvement or decline of the discolorations and weekly thereafter. c. The nurse's note dated 8/3/23 at 2:58AM identified at 1:30AM noted on the video monitor Resident #1 was restless, and there was a pillow on the floor. The nurse quickly responded, upon entering the room Resident #1 was lying on the floor mat at bedside on his/her back, an old skin tear to left upper extremity was noted to be bleeding, the area was cleansed, and a border foam dressing was applied. Resident #1 stated no pain. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the clinical record failed to reflect documentation that a complete assessment, i.e., size color and description of the skin tear had been conducted when the area was first identified on 8/3/23 to establish a baseline description of the area for further evaluation to determine if there was an improvement or decline of the discolorations and weekly thereafter. d. Interview with Person #1 on 11/2/23 at 10:05 AM identified on 8/8/23 Person #1 noticed a series of five (5) puncture marks to Resident #1's right leg just above the ankle and no one was able to provide an answer as to how Resident #1 acquired these marks. Person #1 stated another series of the same marks appeared on Resident #1's leg again on 8/15/23 alongside the other puncture wounds. The weekly evaluation of alteration in skin integrity dated 8/9/23 identified a bruise to left great toe, small, scattered bruising to the bilateral lower and upper extremities. No other skin issues observed. Interview with the 7AM-3PM, nurse aide, Nurse Aide (NA) #1, on 11/3/23 at 9:30AM identified she did care for Resident #1 on 8/8/23 and she did not notice any puncture marks to Resident #1's right lower extremity. NA #1 stated she was Resident #1's regular nurse aide during the 7AM-3PM shift, and she did not notice any puncture marks to the right lower extremity while caring for Resident #1. Interview with the Director of Nursing (DON) on 11/3/23 at 10:50AM identified she was not aware of the puncture marks to Resident #1's right lower extremity. The DON indicated if a resident sustained an injury from a fall like a bruise, skin tear or any skin altercation, the Registered Nurse was responsible to complete skin assessment and the assessment was to include the location, size of the bruise, skin tear or any skin deformities and to obtain treatment when necessary. The DON stated the areas of skin altercations were to be assessed and documented weekly thereafter. The non-pressure skin condition policy directed the license nurse to document in nurses' notes description of non-pressure skin condition. The weekly skin evaluation policy directed the license nurse to complete the weekly skin evaluation. If a new area was discovered, the charge nurse was responsible to start appropriate documentation. The weekly skin evaluation of alterations in skin integrity instructions directed that this form should be completed on all bruises, skin tears, abrasions on a weekly basis until resolved. Be sure to document in the description what the altercation was- bruise or skin tear or abrasion.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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** 31310 Based on clinical record reviews, facility documentation and interviews for one of three sampled residents (Resident #1) who were reviewed for falls, the facility failed to consistently document Resident #1's location on the resident observation sheets while on every fifteen (15) minute monitoring. The findings include: Resident #1's diagnoses included aphasia, anxiety, and history of falls. A Fall assessment dated [DATE] identified Resident #1 was a high risk for falls. The admission Minimum Data Set assessment dated [DATE] identified Resident #1 required total assistance with transfer, toilet use, personal hygiene, and extensive assistance with bed mobility, and had no falls since admission, entry or reentry or the prior assessment. The nurse's note dated 7/22/23 at 11:27 PM identified at 7:05 PM Resident #1 was noted sitting on floor mat with his/her back against the bed and the legs extended in front of him/her. Resident #1 was placed on every fifteen (15) minute monitoring. The Resident Care Plan dated 7/26/23 identified Resident #1 was at risk for falls related to deconditioning, gait/balance problems, incontinence, poor communication/comprehension. Interventions directed to be sure the call light was within reach, Resident #1 needed prompt responses to all requests for assistance, encourage Resident #1 to be in common areas for supervision, out of bed for all meals, every two (2) hours toileting while awake, every 15 minutes checks, bed against the wall. A review of nurse's note from 7/22/23 through 8/17/23 identified Resident #1 continued every fifteen (15) minute monitoring. Review of the resident observation sheet, every fifteen (15) minute monitoring form from 7/22/23 through 8/17/23 failed to provide documentation Resident #1 was consistently monitored on 8/15, 8/14, 8/10, 8/8, 8/5, 8/4, and 8/1/23 during the 7AM-3PM, 3-11PM and 11PM-7AM shifts while on every fifteen (15) minute monitoring. Interview with the Director of Nursing (DON) on 11/3/23 at 10:20 AM identified the nurse aides were responsible to monitor Resident #1 and document on every fifteen (15) minute monitoring form. The DON indicated she was unaware of every fifteen (15) minute monitoring form not being consistently documented. The DON identified there was no policy regarding every fifteen (15) minute monitoring.