| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 075244 | A. Building<br>B. Wing | 07/22/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Avon Health Center | 652 West Avon Rd<br>Avon, CT 06001 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | 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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46046<br><br>Based on clinical record reviews, facility policy and interviews for 2 of 2 residents (Residents # 8 and #405) reviewed for Advanced Directives, the facility failed to ensure the facility advanced directive election form was completed with the resident/responsible party signatures after verbal consent was obtained to change the election and ensure a physician order written. The findings included.<br><br>1. Resident #8's diagnoses included atrial fibrillation and a benign neoplasm.<br><br>A physician's progress note dated [DATE] at 7:02 PM indicated staff spoke with Resident #8's responsible party who indicated the Advanced Directive wishes were to no Cardiopulmonary Resuscitation (CPR).<br><br>A physician's order dated [DATE] at 1:24 PM directed to provide Advanced directives to include Do Not Resuscitate (DNR,) Do Not Intubate (DNI) and Nurse may pronounce.<br><br>The care plan labeled advanced directives effective [DATE] indicated Resident #8 Code status interventions included to receive all appropriate medical treatments excluding CPR.<br><br>The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #8 was cognitively intact.<br><br>The care plan labeled Advanced Directives with no change in interventions was reviewed on [DATE].<br><br>On [DATE] a review of the clinical record identified an advanced directive election form dated [DATE] in which Resident #8 elected and signed for Cardiopulmonary Resuscitation (CPR) to be provided in the event needed.<br><br>On [DATE] at 1:20 PM an interview with the Director of Nursing Services (DNS) indicated he/she would attempt to locate the advanced directive sheet signed by the resident reflecting the physician's order for DNR.<br><br>(continued on next page) |



| 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 |
|---|---|---|---|
| | 075244 | A. Building<br>B. Wing | 07/22/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Avon Health Center | 652 West Avon Rd<br>Avon, CT 06001 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | An interview and facility document review with the DNS on [DATE] at 11:41 AM indicated another staff member was checking in medical records to see if the form was accidentally removed from the chart. A review of facility policy identified the policy did not include information regarding the election form. The DNS further indicated if a resident or responsible party elected a change in their advanced directives, s/he would have expected a new election form be completed and signed by all parties including the type of advanced directive the resident/responsible party had elected.<br><br>On [DATE] at 1:00 PM an interview and record review with Registered Nurse (RN #3) indicated although a physician progress note was written on [DATE] and a physician order for DNR s/he was unable to explain why a new election form was not signed by the resident indicating the advanced directive wishes. RN #3 further provided a new election form awaiting signature dated [DATE] indicating confirmation via telephone call with the Power of Attorney (POA)for Resident #8 on [DATE] verifying the current order for DNR, DNI, and No Tube feeding reflect Resident #8's wishes, and the form was flagged to be signed.<br><br>2. Resident #405 's diagnoses included unspecified dementia, hypothyroidism, and contracture.<br><br>The care plan dated [DATE] identified Advanced Directives. Interventions included Do not Resuscitate (DNR), Do No Intubate (DNI) and Registered Nurse may pronounce (RNP).<br><br>The admission Minimum Data Set assessment dated [DATE] identified Resident # 405 as cognitively impaired and required extensive assistance with bed mobility, transfers and eating.<br><br>A physician's order dated [DATE] directed DNR, DNI and RNP<br><br>The nursing notes dated [DATE] through [DATE] did not mention the advance directive.<br><br>Observation of the facility's CPR/DNR Discussion form on [DATE] and 7/ ,d+[DATE] indicated the form should be signed and dated by a representative of the facility. The Advance Directives form for Resident # 405 was observed to have family's/ responsible party signature and date.<br><br>Interview with DNS on [DATE] at 11:55 AM indicated Advance Directives should be signed upon admission or within 24- 48 hours. The DNS also indicated s/he was unable to provide an explanation of why the form was not signed by the facility representative.<br><br>The facility policy labeled Admission Procedures; Advanced Directives dated ,d+[DATE] indicated in part the advanced directive status of each resident would be reviewed at the resident's care conference. The policy does not specify if/ when advance directive needs to be signed.<br><br>49100 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 075244 | A. Building<br>B. Wing | 07/22/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Avon Health Center | 652 West Avon Rd<br>Avon, CT 06001 |

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 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Develop and implement policies and procedures to prevent abuse, neglect, and theft.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48880<br><br>Based on resident interview, clinical record review, review of facility documentation, review of policy and staff interviews for 1 of 3 residents reviewed for abuse (Resident #98), the facility failed to implement the facility's abuse policy for an allegation of abuse. The findings include:<br><br>Resident #98 was admitted on [DATE] with diagnoses that included heart disease, respiratory failure, and diabetes mellitus.<br><br>The admission MDS assessment dated [DATE] identified Resident #98 had moderate cognitive impairment and did not exhibit disorganized thinking, altered level of consciousness, or rejection of care. Additionally, Resident #98 required substantial assistance with toileting and personal hygiene.<br><br>A care plan dated 5/3/2024 indicated Resident #98 did not have a history of dementia but had some short/long-term memory deficit. Interventions included encouraging the resident to participate in activities and providing cues and supervision. A care plan dated 6/28/2024 further indicated Resident #98 received palliative care. Interventions included offering the resident and family support.<br><br>A review of the internal investigation dated 7/2/2024 identified Person #1 reported to social work that a nursing aide had slapped Resident #98. The internal investigation identified Resident #98 had indicated that s/he wanted to help the aide when getting cleaned up after a bowel movement, but the aide slapped her/his hand away. The internal investigation also indicated that when Resident #98 was asked for a return demonstration by the DNS, Resident #98 indicated NA #7 did not slap her/him hard and indicated NA #7 pushed his/her hand away.<br><br>A review of the facility nursing schedule from 6/29/2024 through 7/9/2024 identified NA #7 was assigned to care for Resident #98 on Saturday, 7/6/2024.<br><br>In an interview on 7/16/2024 at 12:12 PM, Resident #98 indicated that a few weeks ago in the evening, Nurse Aide (NA#7) had slapped his/her hand while providing care and indicated NA # 7 said s/he had her/his own way of doing things. Resident #98 indicated NA#7 was by her/himself when providing care. Resident #98 also indicated s/he had not told staff about the incident but told (Person #1) the next day. Person #1 was in the room during the surveyor's interview and further indicated the incident had occurred on the weekend after the July 4 the holiday (7/6 or 7/7/2024). Person #1 also indicated that s/he had spoken to the resident's day nurse the following day but were unsure what the date or the nurse's name was. Additionally, Person #1 indicated s/he had spoken to the Social Worker (SW) about 48 hours after Resident #98 had complained about the incident. Person #1 also indicated that s/he received a phone call from the Director of Nursing Services (DNS) regarding the incident.<br><br>A review of the medical record, including nursing and social services progress notes from 6/26/2024 through 7/17/2024, did not identify any notes addressing the incident or any allegation of abuse. The facility was unable to provide an Accident/Incident report (A&I) addressing the incident or an allegation of abuse. Additionally, no report of the incident or allegation of abuse was noted in the state agency's online Reportable Event portal.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 075244 | A. Building<br>B. Wing | 07/22/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Avon Health Center | 652 West Avon Rd<br>Avon, CT 06001 |

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 0607<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | On 7/18/2024 at 11:37 AM, an interview with the Director of Social Services (Social Worker #1) identified that Person #1 had informed her in the morning of 7/8/2024 or 7/9/2024 (Social Worker #1 could not recall the exact date) that a staff member had slapped Resident #98's hand over the weekend. Social Worker #1 further indicated that after being informed of the incident, she immediately notified the DNS. Social Worker #1 was unable to provide any documentation or evidence in the clinical record the date of the allegation of abuse to reported to her and was unable to explain why.<br><br>On 7/18/2024 at 1:45 PM, an interview with the DNS identified on 7/2/2024, she was notified by Social Worker #1 that Person #1 had told her (Social Worker #1), Resident #98 had complained about being slapped Saturday night (6/29/2024). The DNS indicated s/he initiated an internal investigation and evaluated the resident's hands. After the internal investigation, the DNS determined that NA#7 had not slapped Resident #98. However, the DNS indicated s/he did not interview other staff members or potential witnesses since s/he was able to corroborate the incident with the interviews of NA# 7 and Resident #98. The DNS indicated that the incident was not recorded in the electronic medical record because there was no change to the plan of care.<br><br>On 7/22/2024 at 10:44 AM, an interview with NA #7 identified s/he had only taken care of Resident #98 once and had not taken care of the resident since the incident secondary to being a floating NA. NA #7 further indicated s/he was currently assigned to another unit. However, NA #7 could not recall what Saturday s/he had taken care of Resident #98. NA #7 indicated s/he did not slap or push Resident #98's hand but was helping Resident #98 wash his/her hands with a washcloth because Resident # 98 had gotten soiled when the resident was trying to help NA# 7 get cleaned.<br><br>A follow-up interview with Social Worker #1 on 7/22/2024 at 12:22 PM indicated that for any allegation of abuse, the social worker's responsibility is to follow up with the resident for three days to monitor for any emotional or mood changes. Social Worker #1 indicated that s/he followed up with Resident #98 the next day, but the resident was sleeping. However, SW #1 indicated the follow-up was not related to the reported incident but rather regarding the resident's clinical status.<br><br>A follow-up interview with the DNS on 7/22/2024 at 1:05 PM identified s/he had mistakenly written the wrong date on the internal investigation. The incident had occurred on the night of 7/6/2024, and Person #1 had reported the incident to Social Worker #1 on 7/9/2024 in the morning.<br><br>A review of the facilities Abuse Policy identified that the facility has trained employees to identify potential and actual occurrences of abuse. The policy also indicated the facility should investigate an allegation and report the allegation by following federal and state guidelines. Additionally, the facilities Abuse Observation and Recording Policy indicated that all allegations and/or reports of any type of abuse toward a resident would be thoroughly investigated, documented, and reported according to procedure. The procedure outlined in the policy included interviewing the alleged perpetrator, all staff, residents and visitors who could have knowledge of the event. The procedure also indicated that a thorough account of the investigation should be documented, all witnesses should sign their individual statements, and all notifications will be noted on the Accident/incident report (A&I) and/or Narrative Nurses Note. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 075244 | A. Building<br>B. Wing | 07/22/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Avon Health Center | 652 West Avon Rd<br>Avon, CT 06001 |

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 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48880<br><br>Based on resident interview, clinical record review, review of facility documentation, review of the facility policy and staff interviews for 1 of 3 residents reviewed for abuse (Resident #98), the facility failed to report an allegation of potential abuse to the state agency. The findings include:<br><br>Resident #98 was admitted on [DATE] with diagnoses that included heart disease, respiratory failure, and diabetes mellitus.<br><br>The admission MDS assessment dated [DATE] identified Resident #98 had moderate cognitive impairment and did not exhibit disorganized thinking, altered level of consciousness, or rejection of care. Additionally, Resident #98 required substantial assistance with toileting and personal hygiene.<br><br>A care plan dated 5/3/2024 indicated Resident #98 did not have a history of dementia but had some short/long-term memory deficit. Interventions included encouraging the resident to participate in activities and providing cues and supervision. A care plan dated 6/28/2024 further indicated Resident #98 received palliative care. Interventions included offering the resident and family support.<br><br>A review of the internal investigation dated 7/2/2024 identified Person #1 reported to social work that a nursing aide had slapped Resident #98. The internal investigation identified Resident #98 had indicated that s/he wanted to help the aide when getting cleaned up after a bowel movement, but the aide slapped her/his hand away. The internal investigation also indicated that when Resident #98 was asked for a return demonstration by the DNS, Resident #98 indicated NA #7 did not slap her/him hard and indicated NA #7 pushed his/her hand away.<br><br>A review of the facility nursing schedule from 6/29/2024 through 7/9/2024 identified NA #7 was assigned to care for Resident #98 on Saturday, 7/6/2024.<br><br>In an interview on 7/16/2024 at 12:12 PM, Resident #98 indicated that a few weeks ago in the evening, Nurse Aide (NA#7) had slapped his/her hand while providing care and indicated NA # 7 said s/he had her/his own way of doing things. Resident #98 indicated NA#7 was by her/himself when providing care. Resident #98 also indicated s/he had not told staff about the incident but told (Person #1) the next day. Person #1 was in the room during the surveyor's interview and further indicated the incident had occurred on the weekend after the July 4 the holiday (7/6 or 7/7/2024). Person #1 also indicated that s/he had spoken to the resident's day nurse the following day but were unsure what the date or the nurse's name was. Additionally, Person #1 indicated s/he had spoken to the Social Worker (SW) about 48 hours after Resident #98 had complained about the incident. Person #1 also indicated that s/he received a phone call from the Director of Nursing Services (DNS) regarding the incident.<br><br>A review of the medical record, including nursing and social services progress notes from 6/26/2024 through 7/17/2024, did not identify any notes addressing the incident or any allegation of abuse. The facility was unable to provide an Accident/Incident report (A&I) addressing the incident or an allegation of abuse. Additionally, no report of the incident or allegation of abuse was noted in the state agency's online Reportable Event portal.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 075244 | A. Building<br>B. Wing | 07/22/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Avon Health Center | 652 West Avon Rd<br>Avon, CT 06001 |

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 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | On 7/18/2024 at 11:37 AM, an interview with the Director of Social Services (Social Worker #1) identified that Person #1 had informed her in the morning of 7/8/2024 or 7/9/2024 (Social Worker #1 could not recall the exact date) that a staff member had slapped Resident #98's hand over the weekend. Social Worker #1 further indicated that after being informed of the incident, she immediately notified the DNS. Social Worker #1 was unable to provide any documentation or evidence in the clinical record the date of the allegation of abuse to reported to her and was unable to explain why.<br><br>On 7/18/2024 at 1:45 PM, an interview with the DNS identified on 7/2/2024, she was notified by Social Worker #1 that Person #1 had told her (Social Worker #1), Resident #98 had complained about being slapped Saturday night (6/29/2024). The DNS indicated s/he initiated an internal investigation and evaluated the resident's hands. After the internal investigation, the DNS determined that NA#7 had not slapped Resident #98. However, the DNS indicated s/he did not interview other staff members or potential witnesses since s/he was able to corroborate the incident with the interviews of NA# 7 and Resident #98. The DNS indicated that the incident was not recorded in the electronic medical record because there was no change to the plan of care. Additionally, The DNS indicated the incident was not reported to the state agency because the facility did not consider it an allegation of abuse.<br><br>A review of the facilities Abuse Policy identified that the facility has trained employees to identify potential and actual occurrences of abuse. The policy also indicated the facility should investigate an allegation and report the allegation by following federal and state guidelines. Additionally, the facilities Abuse Observation and Recording Policy indicated that all allegations and/or reports of any type of abuse toward a resident would be thoroughly investigated, documented, and reported according to procedure. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 075244 | A. Building<br>B. Wing | 07/22/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Avon Health Center | 652 West Avon Rd<br>Avon, CT 06001 |

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 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Respond appropriately to all alleged violations.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48880<br><br>Based on resident review of the clinical record review, review of facility documentation, review of facility policy for 1 of 3 residents reviewed for abuse (Resident #98), the facility failed to initiate and complete a thorough investigation for an allegation of abuse and failed to maintain documentation that the alleged abuse was thoroughly investigated. The findings include:<br><br>Resident #98 was admitted on [DATE] with diagnoses that included heart disease, respiratory failure, and diabetes mellitus.<br><br>The admission MDS assessment dated [DATE] identified Resident #98 had moderate cognitive impairment and did not exhibit disorganized thinking, altered level of consciousness, or rejection of care. Additionally, Resident #98 required substantial assistance with toileting and personal hygiene.<br><br>A care plan dated 5/3/2024 indicated Resident #98 did not have a history of dementia but had some short/long-term memory deficit. Interventions included encouraging the resident to participate in activities and providing cues and supervision. A care plan dated 6/28/2024 further indicated Resident #98 received palliative care. Interventions included offering the resident and family support.<br><br>A review of the internal investigation dated 7/2/2024 identified Person #1 reported to social work that a nursing aide had slapped Resident #98. The internal investigation identified Resident #98 had indicated that s/he wanted to help the aide when getting cleaned up after a bowel movement, but the aide slapped her/his hand away. The internal investigation also indicated that when Resident #98 was asked for a return demonstration by the DNS, Resident #98 indicated NA #7 did not slap her/him hard and indicated NA #7 pushed his/her hand away.<br><br>A review of the facility nursing schedule from 6/29/2024 through 7/9/2024 identified NA #7 was assigned to care for Resident #98 on Saturday, 7/6/2024.<br><br>In an interview on 7/16/2024 at 12:12 PM, Resident #98 indicated that a few weeks ago in the evening, Nurse Aide (NA#7) had slapped his/her hand while providing care and indicated NA # 7 said s/he had her/his own way of doing things. Resident #98 indicated NA#7 was by her/himself when providing care. Resident #98 also indicated s/he had not told staff about the incident but told (Person #1) the next day. Person #1 was in the room during the surveyor's interview and further indicated the incident had occurred on the weekend after the July 4 the holiday (7/6 or 7/7/2024). Person #1 also indicated that s/he had spoken to the resident's day nurse the following day but were unsure what the date or the nurse's name was. Additionally, Person #1 indicated s/he had spoken to the Social Worker (SW) about 48 hours after Resident #98 had complained about the incident. Person #1 also indicated that s/he received a phone call from the Director of Nursing Services (DNS) regarding the incident.<br><br>A review of the medical record, including nursing and social services progress notes from 6/26/2024 through 7/17/2024, did not identify any notes addressing the incident or any allegation of abuse. The facility was unable to provide an Accident/Incident Report (A&I) addressing the incident or an allegation of abuse.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 075244 | A. Building<br>B. Wing | 07/22/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Avon Health Center | 652 West Avon Rd<br>Avon, CT 06001 |

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 0610<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | On 7/18/2024 at 11:37 AM, an interview with the Director of Social Services (Social Worker #1) identified that Person #1 had informed her in the morning of 7/8/2024 or 7/9/2024 (Social Worker #1 could not recall the exact date) that a staff member had slapped Resident #98's hand over the weekend. Social Worker #1 further indicated that after being informed of the incident, she immediately notified the DNS. Social Worker #1 was unable to provide any documentation or evidence in the clinical record the date of the allegation of abuse to reported to her and was unable to explain why.<br><br>On 7/18/2024 at 1:45 PM, an interview with the DNS identified on 7/2/2024, she was notified by Social Worker #1 that Person #1 had told her (Social Worker #1), Resident #98 had complained about being slapped Saturday night (6/29/2024). The DNS indicated s/he initiated an internal investigation and evaluated the resident's hands. After the internal investigation, the DNS determined that NA#7 had not slapped Resident #98. However, the DNS indicated s/he did not interview other staff members or potential witnesses since s/he was able to corroborate the incident with the interviews of NA# 7 and Resident #98. The DNS indicated that the incident was not recorded in the electronic medical record because there was no change to the plan of care.<br><br>On 7/22/2024 at 10:44 AM, an interview with NA #7 identified s/he had only taken care of Resident #98 once and had not taken care of the resident since the incident secondary to being a floating NA. NA #7 further indicated s/he was currently assigned to another unit. However, NA #7 could not recall what Saturday s/he had taken care of Resident #98. NA #7 indicated s/he did not slap or push Resident #98's hand but was helping Resident #98 wash his/her hands with a washcloth because Resident # 98 had gotten soiled when the resident was trying to help NA# 7 get cleaned.<br><br>A follow-up interview with the DNS on 7/22/2024 at 1:05 PM identified s/he had mistakenly written the wrong date on the internal investigation. The incident had occurred on the night of 7/6/2024, and Person #1 had reported the incident to Social Worker #1 on 7/9/2024 in the morning.<br><br>A review of the facilities Abuse Policy identified that the facility has trained employees to identify potential and actual occurrences of abuse. The policy also indicated the facility should investigate an allegation and report the allegation by following federal and state guidelines. Additionally, the facilities Abuse Observation and Recording Policy indicated that all allegations and/or reports of any type of abuse toward a resident would be thoroughly investigated, documented, and reported according to procedure. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 075244 | A. Building<br>B. Wing | 07/22/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Avon Health Center | 652 West Avon Rd<br>Avon, CT 06001 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46046<br><br>Based on clinical record reviews, review of facility policy and staff interviews and for 1 of 1 resident, (Resident #18), reviewed for nutrition, the facility failed to provide supervision with meals according to the plan of care and for 1 of 1 resident reviewed for pain (Resident # 24) the facility failed to ensure the resident's care plan included nonpharmaceutical interventions for pain relief and for 1 of 5 residents (Resident #70) reviewed for unnecessary medications, the facility failed to ensure a resident care plan addressed resident specific behaviors and interventions. The findings included.<br><br>1. Resident #18 had diagnoses included Alzheimer's disease, dysphagia (swallowing difficulties), and dyskinesia of esophagus (disorder of esophageal sphincters).<br><br>On 4/22/24 The Advanced Practicing Registered Nurse (APRN) order directed a dysphagia advanced diet with thin liquids and no straws. An additional order on the same date and time directed aspiration precautions, 90 degrees with anything by mouth and to maintain 90 degrees for 30 minutes after eating, encourage small sips, small bites, slow pace, alternate liquids and solids.<br><br>An APRN progress note on 5/3/24 at 9:09 A.M. identified a 10.1% weight loss in 6 months.<br><br>A Speech Therapy Daily Treatment note dated 5/17/24 identified Resident #18's intake amounts increased by 25% - 50% with cueing.<br><br>An APRN progress note on 5/20/24 at 9:41 A.M. identified Resident #18 required more cueing with meals<br><br>The quarterly MDS assessment dated [DATE] identified Resident #18 as moderately impaired in cognitive function and requiring supervision or touching assistance with eating.<br><br>On 7/16/24 at 9:25 A.M. and on 7/16/24 at 12:45 P.M., Resident #18 was observed in his her/room eating a meal independently with no staff present.<br><br>Interview and clinical record review with LPN #4 on 7/16/24 at 12:52 P.M. identified Resident #18's level of assistance with meals was supervision and Resident #18 should not have been eating unsupervised.<br><br>Interview and review of the electronic Nurse's Aide (NA) care card with NA #2 on 7/16/24 at 2:15 P.M. identified Resident #18 required supervision with meals. NA #2 stated s/he did not serve Resident #18 his/her meal trays and did not know who did.<br><br>After surveyor inquiry on 7/16/24, the Speech Therapist (ST #1) reevaluated Resident # 18 for the need for assistance with meals, and the 7/17/24 Treatment Encounter note reflected a change from supervision to assistance as needed with meals.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 075244 | A. Building<br>B. Wing | 07/22/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Avon Health Center | 652 West Avon Rd<br>Avon, CT 06001 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | An interview with ST #1 on 7/19/24 at 11:35 AM indicated the meaning of supervision with meals as 100% supervision from the time the resident receives his/her meal tray until the meal tray is removed. ST #1 identified Resident #18 received supervision with meals to monitor and increase meal consumption by providing assistance and verbal cues. She/he further stated the level of assistance is no longer beneficial to Resident #18 or to the staff based on the documented resident meal consumption. ST #1 identified s/he does not have access to review flow sheets where level of assistance is documented but trusts interventions are followed once initiated.<br><br>Review of the 7/1/24 through 7/22/24 NA flow sheets identified missing documentation for feeding assistance and amount consumed for 36 out of 64 meals. Of the documented meals, the NA's documented set up only assistance for 7 meals and no set up or physical help from staff for 1 meal. Remaining documented meals indicated one-person physical assist and no documentation indicated supervision.<br><br>An interview with the DNS on 7/19/24 at 12:45 P.M. indicated the NA care card is an extension of the care plan and the instructions on the care card should be followed. The DNS further indicated a resident requiring supervision with meals should not be left unattended with a meal tray,<br><br>The facility Feeding Policy states, in part, its purpose is to ensure that all residents receive appropriate and safe assistance with feeding promoting their nutritional well-being, dignity, and social engagement. The Feeding Policy further states provide appropriate assistance based on each residents feeding plan and record all assistance provided during mealtimes in the residents' medical record.<br><br>2. Resident #24's diagnosis include chronic pain.<br><br>The physician's orders dated 4/19/2024 at 11:33 PM directed to provide Resident #24 Oxycontin 10 Milligrams (MG), crush resistant, extended-release tablet by mouth every 12 hours and to provide Oxycodone 5 MG tablet by mouth every 6 hours as needed for breakthrough pain.<br><br>The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #24 was cognitively intact, received scheduled and as needed (PRN) medication for pain and did not receive non medication interventions for pain.<br><br>The care plan dated 6/13/2024 indicated in part Resident #24 had alteration in pain. Interventions included: to administer medications as ordered, complete a pain assessment every shift and to notify the provider if pain medication was ineffective.<br><br>An Advanced Practice Registered Nurse (APRN) progress note dated 7/3/2024 indicated chronic pain and resident complaint of pain all over with opioid use and opioid constipation further indicating to continue the current medication regime and laxative.<br><br>A follow up APRN progress note dated 7/5/2024 indicated Resident # 24 reported fair effect from current regimen and the PRN Oxycodone was utilized 1-2 x daily with good effect and prescriptions for refills for pain medications were provided.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 075244 | A. Building<br>B. Wing | 07/22/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Avon Health Center | 652 West Avon Rd<br>Avon, CT 06001 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview and record review with the DNS on 7/22/2024 at 10:46 AM with the Administrator present indicated Resident #24 had been living at the facility for several years and prior to being admitted to the facility had been on opioid pain medications. The DNS further indicated that although s/he was unable to easy access the exact date, approximately 6 months ago upon return from the hospital Resident #24 returned on no opioid medications but was restarted on the medication several days after readmission due to pain. After surveyor inquiry, the DNS indicated 1:1 visit by recreational staff and diversional activities including watching television were nonpharmaceutical interventions provided to Resident #24. The DNS further indicated s/he was not aware if therapy had been consulted regarding alternative pain relief interventions other than opioid medications or if nursing had requested any other possible alternatives. The DNS further indicated the APRN follows Resident #24 closely for pain as the resident was subject to opioid constipation. During further review of the clinical record, the DNS was unable to locate any non-pharmaceutical interventions utilized in addition to the pain medication in Resident #24's care plan.<br><br>The facility policy labeled pain management dated 6/2024 indicated in part the facility is committed to assist each resident to attain or maintain the resident's highest practicable mental and psychosocial well-being by assessing pain and using interventions to prevent pain from interfering with the quality of life.<br><br>3 Resident #70's diagnoses include traumatic cerebral hemorrhage and anxiety.<br><br>The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #70 was cognitively intact and received antianxiety and antidepressant medications and had no behavioral symptoms displayed during the 7-day lookback period.<br><br>The physician's orders dated 6/13/2024 at 5:58PM directed to monitor and documents target behaviors every shift for use of Klonopin for antianxiety/restlessness and to document outcomes of interventions used for the behaviors and if worsened improved or unchanged every shift. The physician's order also directed to monitor for side effects related to the use of Klonopin every shift and to monitor for target behaviors every shift for use of Melatonin for insomnia/poor sleep.<br><br>An interview and record review on 7/22/24 at 9:34 AM with MDS Nurse, RN #1 indicated<br><br>Resident #70 had a diagnosis of anxiety and orders for behavioral monitoring. However, RN #1 was not able to find a care plan addressing the behaviors and interventions utilized to manage the behaviors and s/he further indicated there should be a care plan.<br><br>An interview and record review with LPN #3 on 7/22/24 at 10:05 AM indicated s/he was speaking with RN #1 and identified the behavioral care plan must have been missed and should have been added to the care plan. After surveyor inquiry, a behavior care plan was added. LPN #3 further indicated without the behavioral care plan interventions used cannot be evaluated for effectiveness.<br><br>The facility policy labeled Resident Care Plan indicated in part the goal is to achieve optimal physical, psychosocial, and functional status by initiating an interdisciplinary care plan on admission with reviews quarterly and as needed. The policy further indicated the care plan would be maintained in the medical record, updated as needed and reviewed quarterly.<br><br>50890 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 075244 | A. Building<br>B. Wing | 07/22/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Avon Health Center | 652 West Avon Rd<br>Avon, CT 06001 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46046<br><br>Based on clinical record review, observation, review of facility policy and staff interviews for 1 of 7 residents (Resident #69) reviewed during medication administration, the facility failed to ensure staff disposed of a narcotic medication in an acceptable manner. The findings include.<br><br>Resident #69's diagnosis included essential hypertension, mood disorder and gastric esophageal reflux.<br><br>A physician's order dated 3//19/2024 at 11:07 PM directed to provide Propranolol 120 MG, 24 hour extended-release capsule by mouth daily at 9:00 AM for hypertension.<br><br>A physician's order dated 3//19/2024 at 11:07 AM directed to provide Duloxetine 60 MG capsule, delayed release by mouth daily at 9:00 AM for mood disorder.<br><br>The care plan dated 4/1/2024 indicated Resident #69 had dysphagia with swallowing difficulty and interventions included in part to provide speech therapy as needed.<br><br>The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #69 was severely cognitively impaired.<br><br>On 7/17/2024 at 8:42 AM observation and interview with LPN #6 during medication administration for Resident #69 LPN#7 indicated the need to dispose of the medications just poured (including a narcotic medication) before repouring the medications for Resident #69. LPN#6 and LPN#7 witnessed the discarded the unused medication for destruction of the crushed medications which included a narcotic. After the disposal was done and LPN #7 left further observations identified the cup of medications in applesauce with the spoon inside was on top of the uncovered small trash receptacle on the side of the medication cart. After surveyor inquiry, LPN #7 indicated the cup of crushed medications was the same cup of medications discarded (including the narcotic) and further indicated s/he did not know what the facility policy was for proper disposal of medications including narcotics but would contact the supervisor.<br><br>On 7/17/2024 At 9:01 AM RN #2 came to the medication cart and was updated by LPN #6. RN #2 identified the medication should be disposed in a bottle of Drug Buster (usually kept in a drawer of the medication cart and this cart must have run out of the Drug Buster. RN #2 indicated he/she would properly dispose of the medication along with LPN #6 and witness the discard on the narcotic sheet. RN #2 further indicated h/she would talk with LPN #7 regarding the proper procedure as well as inform the Staff Development nurse.<br><br>The facility policy labeled Controlled Substance Disposal dated 6/2024 indicated in part when a dose of a controlled medication is removed from the container for administration but refused by a resident or not given for any reason the medication will be destroyed in the presence of 2 licensed nurses. Although, the facility policy for the process used to dispose of narcotic medication was requested one was not supplied. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 075244 | A. Building<br>B. Wing | 07/22/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Avon Health Center | 652 West Avon Rd<br>Avon, CT 06001 |

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 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Provide activities to meet all resident's needs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50890<br><br>Based on clinical record, observations, facility documentation, and interviews for 1 of 1 resident (Resident #42) reviewed for activities, the facility failed to provide therapeutic recreation activities to meet the psycho-social needs of the resident. The findings include:<br><br>Resident #42's diagnoses included diabetes mellitus, pain and Alzheimer's disease.<br><br>The quarterly Minimum Data Set assessment dated [DATE] identified Resident #42 as severely cognitively impaired, non-verbal, and dependent for all aspects of care to include bed mobility, transfers, eating and hygiene.<br><br>The Resident Care Plan (RCP) last reviewed 7/16/24 identified interventions to inform, invite and escort Resident #42 to appropriate recreation programs, offer music in room, and 1:1 recreation visits to promote socialization.<br><br>During an observation on 7/16/24 at 11:08 A.M., Resident #42 was sitting in his/her wheelchair at the bedside, sleeping. During further observations at 11:35A.M., 12:15 P.M., 12:40 P.M., 1:04 P.M., 1:30 P.M., 1:53 P.M., 2:10 P.M., and 2:30 P.M., Resident #42 was observed in his/her wheelchair in the same position with no form of stimulation.<br><br>On 7/19/24 the Recreation Director indicated Resident #42 is brought to activities and is provided sensory forms of stimulation such as stuffed animals and music in his/her room.<br><br>Review of the Activity Progress Notes dated 7/14/24 through 7/21/24 identified Resident #42 was engaged in activities on 7/15/24. No further activities or 1:1 visits were documented.<br><br>An interview with Recreation Therapist (RT) #1 on 7/22/24 at 12:22 P.M. identified the week of 7/14/24 through 7/20/24, she was assigned to Resident #42, and she could not recall any further activities aside from the activities documented on 7/15/24.<br><br>An interview with RT #2 on 7/22/24 at 12:38 P.M. identified there was no further documentation of activities for Resident #42 for the dates of 7/14/24 through 7/21/24. RT #2 further states getting residents to activities is a challenge and describes is between the nursing and recreation departments. RT #2 identified mentioning programs to nursing staff is sometimes effective and other times not. RT #2 further indicated it is particularly challenging for non-verbal residents, like Resident #42, because staff will put him/her back to bed before the opportunity to join an activity.<br><br>An interview with the Recreation Director on 7/22/24 12:38 P.M. indicated the nursing department doesn't always follow through with getting residents up or bringing them to activities. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 075244 | A. Building<br>B. Wing | 07/22/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Avon Health Center | 652 West Avon Rd<br>Avon, CT 06001 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37721<br><br>Based on clinical record reviews, facility documentation, facility policy and interviews for 2 of 3 sampled residents (Resident # 25 and # 42 ) reviewed for pressure ulcers, the facility failed to ensure a nutritional assessment was completed for a newly identified pressure injury and failed to reposition the resident according to the plan of care. The findings include:<br><br>1. Resident # 25's diagnosis include Multiple Sclerosis.<br><br>The quarterly Minimum Data Set, (MDS) assessment dated [DATE] identified Resident #25 was moderately cognitively impaired, required extensive two person assist with bed mobility/transfers, was at risk for the development of pressure ulcers and had no unhealed pressure ulcers.<br><br>The Resident care Plan (RCP) dated 2/12/24 identified Resident #25 was at risk for the development of pressure ulcers. Interventions directed to offload heels, check skin condition weekly and apply skin prep to heels twice daily.<br><br>A Nutritional assessment dated [DATE] identified Resident #52's skin was intact with no pressure ulcers and that the current diet was meeting nutritional needs.<br><br>An initial Pressure Ulcer assessment dated [DATE] identified a stage II pressure ulcer measuring 3 Centimeter ( CM), width: 2.5 CM, depth: 0 CM, with no exudate. A shallow, intact, red blister to left inner heel, surrounding area was blanchable, and noted to be non-tender with no drainage or odor.<br><br>A review of the clinical record failed to identify a subsequent nutritional assessment or progress note detailing the newly identified pressure ulcer to determine what, if any nutritional modifications were warranted.<br><br>An interview and clinical record review with the Dietitian on 7/18/24 at 9:38 AM identified she had been employed by the facility since 6/2024 and worked 20 hours weekly. The Dietitian identified she received a weekly wound report supplied by the wound nurse which was used to monitor the progress of any resident with wounds. For any newly identified wound, the Dietitian would complete a partial assessment including intake, weight and determine if any additional supplementation or protein would be required. The Dietitian identified the limited assessment would be documented in the clinical record. The Dietitian further identified that although she was not employed by the facility when the wound was first known, she was unable to say whether she was aware of Resident #25's pressure ulcer or explain why she had not assessed Resident #25's nutritional status at any time after the receipt of the pressure ulcer report identifying the wound.<br><br>An interview with the Director of Nursing, DNS on 7/18/24 at 9:47 AM identified she would expect a dietary assessment be conducted for any resident with a newly identified pressure injury.<br><br>A review of the facility policy for Medical Nutrition Therapy: Assessment and Care Planning identified the Registered Dietitian was responsible for a comprehensive assessment annually, on referral or as indicated by the clinical condition of the resident and that changes would be communicated to nursing staff.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 075244 | A. Building<br>B. Wing | 07/22/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Avon Health Center | 652 West Avon Rd<br>Avon, CT 06001 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 2. Resident #42's diagnoses included diabetes mellitus, pain and Alzheimer's disease.<br><br>The last nutritional assessment conducted, dated 5/8/24, noted skin is intact. There was no further nutritional assessment conducted with the development of 2 new pressure injuries to the left heel.<br><br>The quarterly Minimum Data Set assessment dated [DATE] identified Resident #42 as severely cognitively impaired, non-verbal, incontinent, at risk for developing pressure injuries and dependent for all aspects of care to include bed mobility, transfers, eating and hygiene.<br><br>A progress note dated 5/24/24 identified discoloration to the left heel, an intact blister to the left heel, and supervisor notification.<br><br>The facility Wound Pressure Ulcer Weekly Record assessment dated [DATE] identified a new facility acquired pressure injury with black eschar to the left heel, which was noted to be located over the site of a previously healed pressure injury. The assessment further noted an adjacent dark purple deep tissue injury.<br><br>An APRN progress note dated 5/31/24 identified Resident #42 was at high risk for skin impairment due to immobility.<br><br>The facility Braden Scale assessment dated [DATE] identified Resident #42 as a high risk for developing pressure injuries.<br><br>The Resident Care Plan (RCP) and Nurse Aide (NA) care card dated 7/16/24 directed Resident #42 to be out of bed and in his/her custom wheelchair for lunch and dinner, not to exceed 2 hours in the wheelchair at a time. The RCP further directs Resident #42 to be transferred back to bed 1 hour after meals and to be turned and repositioned side to side every 2 hours. The RCP did not include interventions for pain or nutrition related to the 2 new pressure injuries. The RCP did not include diabetic foot monitoring and care.<br><br>During an observation on 7/16/24 at 11:08 A.M., Resident #42 was sitting in his/her wheelchair, sleeping. During further observations at 11:35AM., 12:15 P.M., 12:40 P.M., 1:04 P.M., 1:30 P.M., 1:53 P.M., 2:10 P.M., and 2:30 P.M., Resident #42 was observed in his/her wheelchair in the same position.<br><br>An interview and review of the NA care card with NA #3 on 7/16/24 at 2:25 PM indicated Resident #42 was out of bed and in his/her wheelchair for breakfast and remained in the wheelchair without any changes in position since transferred out of bed. When reviewing the NA care card, NA #3 indicated the turning and repositioning instructions were for when Resident #42 was in bed and that Resident #42 was not turned or repositioned while in the wheelchair. NA #4 stated we do not reposition him/her in the chair, only in bed. When reviewing the section of the NA care card that directed a 2-hour maximum time in the wheelchair, NA #3 indicated the instructions referred to lunch and dinner, and further indicated Resident #42 should be transferred back to bed after lunch and that she was late transferring him/her back to bed.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 075244 | A. Building<br>B. Wing | 07/22/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Avon Health Center | 652 West Avon Rd<br>Avon, CT 06001 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Interview and review of the clinical record with LPN #4 on 7/16/24 at 2:30 P.M. identified Resident #42 had care planned instructions for a 2-hour maximum time in the wheelchair, had a pressure injury to the left heel and a history of a pressure injury to the coccyx area. LPN #4 indicated any resident who has an active pressure injury or history of a pressure injury should be repositioned every 2 hours. LPN #4 indicated Resident #4 is usually transferred out of bed for lunch and then is transferred back to bed after lunch. LPN #4 indicated after lunch would be by 2:00 P.M. When notified by the surveyor, that Resident #4 was still in his/her wheelchair, LPN #4 indicated he/she should be in bed. After surveyor inquiry of Resident #42's skin integrity identified the plan of care was not followed, LPN #4 performed a skin assessment.<br><br>An interview with the Director of Nursing Services on 7/19/24 at 12:30 P.M. identified the expectation for repositioning a resident with a pressure injury or at risk of developing a pressure injury is every 2-3 hours unless there is an out of bed schedule.<br><br>The facility Wound Management Program policy states, in part, in the prevention Protocol section, residents will be turned and repositioned every 2 hours as tolerated while in bed and every 60-90 minutes when in a wheelchair and to improve/maintain nutrition and hydration status as feasible, all residents will have a nutritional consult with condition change.<br><br>50890 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 075244 | A. Building<br>B. Wing | 07/22/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Avon Health Center | 652 West Avon Rd<br>Avon, CT 06001 |

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 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37721<br><br>Based on clinical record reviews, observations, review of policy for 2 of 2 residents ( Resident # 32 and Resident # 52) reviewed for respiratory treatment, the facility failed to ensure the residents nebulizer tubing was changed and stored according to facility policy. The findings included:<br><br>1. Resident #32's diagnoses included centrilobular emphysema and presence of a cardiac pacemaker.<br><br>The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #32 was moderately cognitively intact and required one person assist with bed mobility, supervision with transfers, eating and toileting.<br><br>The Resident Care Plan, (RCP) dated 6/7/24 identified Resident #32 experienced a decline in activities of daily living (ADL) related to dementia and oxygen due to shortness of breath related to emphysema. Interventions directed to provide two caregivers for ADL care and change tubing weekly.<br><br>The physician's orders dated 6/27/24 directed DuoNeb (medication prescribed to open airways) 0.5mg-3 mg (2. 5mg base/3 ml solution for nebulization for one dose and every (6) hours for (5) days for wheezing.<br><br>An observation on 7/16/24 at 10:15 AM with Licensed Practical Nurse, LPN #1 identified the tubing on nebulizing mask was dated 7/2/24.<br><br>An interview with LPN #1 on 7/16/24 at 10:15 AM tubing for respiratory equipment should have been changed weekly while in use.<br><br>An interview with the Director of Nursing Services, DNS on 7/16/24 at 2:38 PM identified she would expect respiratory equipment to be changed weekly according to policy.<br><br>A review of the facility policy for Oxygen/ Respiratory Equipment Maintenance and Storage (no date) directed that nebulizer masks be changed weekly and as needed based on wear and tear and be stored in a clear bag when not in use.<br><br>2. Resident #51 had diagnoses that included congestive heart failure, (CHF) and a history of acute respiratory failure with hypoxia.<br><br>The quarterly MDS assessment dated [DATE] identified Resident #51 was cognitively intact and required extensive two person assist with bed mobility, transfers and independent with eating.<br><br>Physician orders dated 4/17/24 directed DuoNeb 0.5mg-3 mg (2. 5mg base/3 ml solution for nebulization every four hours as needed for shortness of breath.<br><br>The RCP dated 4/25/24 identified Resident #51 had decreased cardiac output related to CHF. Interventions directed to observe for signs of respiratory distress, shortness of breath and administer medications as ordered.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 075244 | A. Building<br>B. Wing | 07/22/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Avon Health Center | 652 West Avon Rd<br>Avon, CT 06001 |

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 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A review of the medication administration record, (MAR) for July 2024 identified Resident #51 last received DuoNeb on 7/10/24.<br><br>An observation on 7/16/24 at 10:15 AM with LPN #1 identified Resident #51's nebulizer mask was observed directly on h/her bedside table without the benefit of a storage bag.<br><br>An interview with LPN #1 on 7/16/24 at 10:15 AM identified the nebulizer mask should have been stored in a plastic bag after use.<br><br>An interview with the Director of Nursing, DNS on 7/16/24 at 2:38 PM identified she would expect respiratory equipment to properly stored in a plastic bag when not in use according to policy.<br><br>A review of the facility policy for Oxygen/ Respiratory Equipment Maintenance and Storage (no date) directed that nebulizer masks be changed weekly and as needed based on wear and tear and be stored in a clear bag when not in use.<br><br>3. Resident #52's diagnoses included chronic obstructive pulmonary disease, (COPD).<br><br>The quarterly MDS assessment dated [DATE] identified Resident was moderately cognitively intact and required extensive two person assist with bed mobility, transfers, independent with eating.<br><br>The RCP dated 2/1/24 identified Resident #52 diagnosis of COPD. Interventions directed to notify the physician of a change in condition, administer medications as ordered and monitor for therapeutic/side effects.<br><br>The physician's orders dated 4/19/24 directed Duoneb 0.5mg-3 mg (2. 5mg base/3 ml solution for nebulization three times daily for (5) days.<br><br>A review of the Medication Administration Record ( MAR) identified Resident #52 last received Duoneb was on 4/24/24 at 10:51 AM.<br><br>An observation with LPN #1 on 7/16/24 at 10:55 AM identified the nebulizer mask observed directly on the bedside table without the benefit of bag with a date on tubing of 12/13/23.<br><br>An interview with LPN #1 on 7/16/24 at 10:55 AM at 10:55 AM identified the nebulizer mask should have been changed weekly and placed in a bag after use.<br><br>An interview with the Director of Nursing Services, DNS on 7/16/24 at 2:38 PM identified she would expect respiratory equipment to be changed weekly and placed in a bag after use according to policy.<br><br>A review of the facility policy for Oxygen/ Respiratory Equipment Maintenance and Storage (no date) directed that nebulizer masks be changed weekly and as needed based on wear and tear and be stored in a clear bag when not in use. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 075244 | A. Building<br>B. Wing | 07/22/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Avon Health Center | 652 West Avon Rd<br>Avon, CT 06001 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | Ensure that residents are free from significant medication errors.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46046<br><br>Based on review of the clinical record, observations, facility policy and interviews for 1 of 7 residents (Resident #69) reviewed during medication administration, the facility failed to ensure staff appropriately prepared Extended release/delayed release medications for administration to a resident. The findings include.<br><br>Resident #69's diagnoses included essential hypertension, mood disorder and gastric esophageal reflux.<br><br>A physician's order dated 3//19/2024 at 11:07 PM directed to provide Propranolol 120 MG, 24 hour extended-release capsule by mouth daily at 9:00 AM for hypertension.<br><br>A physician's order dated 3//19/2024 at 11:07 AM directed to provide Duloxetine 60 MG capsule, delayed release by mouth daily at 9:00 AM for mood disorder.<br><br>The care plan dated 4/1/2024 indicated Resident #69 had dysphagia with swallowing difficulty and interventions included in part to provide speech therapy as needed.<br><br>The quarterly Minimum Data Set (MDS) dated [DATE] indicated Resident #69 as severely cognitively impaired.<br><br>On 7/17/2024 at 8:42 AM observation and interview with LPN #6 during medication administration for Resident #69 identified Resident #69 requires medications to be crushed therefore s/he would be opening the capsules and crushing the other medications to put into applesauce. Further observation included LPN #7 preparing all medications as ordered for the time opening the capsule of Duloxetine Delayed Release and the capsule of Propranolol Extended-Release place in applesauce with the other medications mix and entered Resident #69's room again, LPN #1 scoop the medication onto spoon and start to administer to Resident #69. The surveyor intervened and asked LPN #7 to step out of the room with the surveyor for a moment. Once at the medication cart after surveyor inquiry, LPN#7 reviewed the medication orders and indicated the Propanol, and the Duloxetine capsules should not have opened, and s/he would need to repour the medications and provide whole in applesauce.<br><br>On 7/17/24 at 9:07 AM LPN #7 repoured all medications crushed in applesauce with the Duloxetine and Propranolol capsules intake in the applesauce. Medications were administered via spoon of in applesauce to Resident #69 who at which time spit out the capsules but took all the other crushed medication. LPN #7 indicated s/he would call the supervisor to and provide an update and inform the APRN regarding refusal for further orders.<br><br>After surveyor inquiry, a physician's order dated 7/17/2024 at 9:55 AM directed to provide Propranolol 60 mg tablet by mouth twice daily at 9:00 AM and 9:00 PM for hypertension.<br><br>After surveyor inquiry, a physician's order dated 7/17/2024 at 10:42 AM directed to provide Duloxetine 60 mg delayed release capsule by mouth and not to open capsule.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 075244 | A. Building<br>B. Wing | 07/22/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Avon Health Center | 652 West Avon Rd<br>Avon, CT 06001 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few<br><br>Note: The nursing home is disputing this citation. | An interview and medication review for Resident #69 with Pharmacist #1 on 7/19/2024 at 11:26 AM indicated Propranolol 120 MG Extended release and the Duloxetine 60 mg delayed release<br><br>should not be opened and the Propranolol information provided no option at all for opening the capsule.<br><br>The facility policy labeled Medication Crushing Guidelines dated 6/2024, indicated in part time released capsules are designed to release medication over a sustained period usually 8-24 hours in which the contents are designed to dissolve at different times, utilized to reduce stomach irritation, in some cases and to achieve a prolonged medication action in other cases. Before opening a capsule to administer in food a reference or pharmacist should be consulted before administering in this manner. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 075244 | A. Building<br>B. Wing | 07/22/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Avon Health Center | 652 West Avon Rd<br>Avon, CT 06001 |

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 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>49100<br><br>Based on observation, review of facilities policy and interview for 1 out of 2 medication rooms, the facility failed to label medications appropriately once opened. The finding include:<br><br>Observation of the A/B Wing medication room on 7/19/24 at 10:53 AM identified Morphine Sulfate 100 MG every 4 hours as needed prescribed to Resident # 98; was opened, however, a date open sticker was not on the medication.<br><br>Interview with LPN #2 on 7/19/24 at 10:53 AM identified the date was documented somewhere else. The Medication Book indicated the Morphine was opened 7/7/24. After inquiry, RN#2 prompted LPN #2 to place the open date on the container.<br><br>The facility's Storage of Medications Policy notes when the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated. The nurse shall place a date open/ sticker on the medication. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 075244 | A. Building<br>B. Wing | 07/22/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Avon Health Center | 652 West Avon Rd<br>Avon, CT 06001 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46046<br><br>Based on observations, review of the kitchen, facility policy, and interviews, the facility failed to ensure staff wore facial hair covering appropriately for 2 of 2 residents (Resident #19 and Resident #54) and the facility failed to perform hand hygiene and failed to handle and transport linens to prevent the spread of infection. The findings included:<br><br>1. On 7/17/2024 at 8:01 AM observation of the breakfast tray line in the kitchen noted while Dietary Aide #1 was plating food his/her facial hair covering was below the facial hair of the upper lip. After surveyor inquiry, the Dietary District Manager advised Dietary Aide #1 of the need to cover the upper lip facial hair and further indicated the covering must have slipped down. Dietary Aide #1 proceeded to adjust the facial hair net removed gloves and proceeded to apply a new pair of gloves without the benefit of conducting hand hygiene in between glove changes. The Dietary District Manager after surveyor inquiry indicated hands should be washed after removing old gloves and then proceed to reminded Dietary Aide #1 to wash his/her hands and apply new gloves<br><br>The facility policy labeled Hand Hygiene dated 6/2024 indicated in part hand hygiene should be performed after gloves are removed and hands washed with soap and water after performing personal hygiene.<br><br>2.a. Resident #19's diagnoses included displaced fracture of 2nd cervical vertebrae, depression and hypertension.<br><br>The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #19 as cognitively intact, requiring partial/moderate assistance for toileting and set up/clean up assistance with personal care.<br><br>During an observation on 7/16/24 at 11:10 A.M., Nurse Aid (NA) #4 was observed, exiting Resident #19's bathroom, with gloves on both hands and holding dirty linens in the right hand. NA #4 used the gloved left hand to open and close doors, and to access the dirty linen cart across the hall without the benefit of removing the dirty gloves.<br><br>An interview with NA #4 on 7/16/24 at 11:10 A.M. indicated it was acceptable for her/him to walk into the hallway with two dirty gloves on because she did so quickly. S/he further stated she did not know the linen cart had been moved from right outside of the room to across the hall. NA #4 then stated she was going on break, removed the dirty gloves, placed them in the trash in the room, and walked down the hall without performing hand hygiene.<br><br>Review of the facility's Hand Hygiene policy identifies, in part, hand hygiene should be performed immediately after gloves are removed, after handling soiled linens, and before and after assisting a resident with personal care.<br><br>b. Resident #54's diagnoses included Alzheimer's disease, acute respiratory failure with hypoxia, and chronic obstructive pulmonary disease.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 075244 | A. Building<br>B. Wing | 07/22/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Avon Health Center | 652 West Avon Rd<br>Avon, CT 06001 |

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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The quarterly MDS assessment dated [DATE] identified Resident #54 as severely cognitively impaired, requiring set up or clean up assistance for eating and dependent for transfers, hygiene and dressing.<br><br>During an observation on 7/16/24 at 12:45 P.M. NA #4 was observed standing at the end of the hallway eating a bag of chips and licking his/her soiled fingers. Resident #54 began to cough while eating lunch. NA #4 walked into Resident #54's room within full visual range of the surveyor, picked up a box of tissues from the dresser, pulled 1 tissue out and handed it to Resident #54 to cough in without the benefit of washing his/her hands before giving the tissue to the resident. NA #4 then exited the room and utilized the alcohol-based hand sanitizer on the outside of the room to perform hand hygiene.<br><br>Review of the facility's Hand Hygiene policy identifies, in part, hands should be washed with soap, either plain or antimicrobial, and water, for at least 15 seconds when visibly soiled, before and after eating and handling food and before and after assisting a resident with toileting.<br><br>An interview with the DNS on 7/19/24 at 12:30 P.M. identified NA #4 as an agency NA.<br><br>Review of the Need-to-Know Information document, which is reviewed and signed by agency staff members who work in the facility, includes no food or drink on the wings but does not include any information related to infection control.<br><br>An interview with the DNS on 7/19/24 at 12:30 P.M. indicated hand hygiene should be performed before and after providing resident care and before and after wearing gloves. She further identified the facility is within a COVID-19 outbreak, although there are no current cases, that started 6/6/24, s/he aims to close the outbreak if there are no new cases by 7/26/24. The DNS identified there was no additional staff education performed regarding infection control or hand washing during the most recent outbreak.<br><br>50890 |