STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075252	A. Building B. Wing	11/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westside Care Center	349 Bidwell Street Manchester, CT 06040

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of the clinical record, facility documentation, facility policy, and interviews for one (2) of two (2) residents (Resident #1 and #2) reviewed for resident-to-resident abuse, the facility failed to ensure residents were free from physical and verbal abuse. The findings include: 1. Resident #1 was admitted to the facility with diagnoses that included fibromyalgia and mood disorder. A psychiatric note dated 10/14/24 identified Resident #1 was tolerating his/her medications well and maintaining a stable mood. The quarterly MDS dated [DATE] identified Resident #1 had a BIMS of fifteen (15) indicative of intact cognition, no physical behavioral symptoms and verbal behavior symptoms that occurred one to three days out of a seven-day period. A physician's order dated November 2024 directed independent mobility with a power wheelchair. The care plan dated 10/23/24 identified on 5/0/24 Resident #1 yelled at others, called others names and tended to threaten others when upset with interventions that included to have Resident #1 see the psychiatric team for therapy and medication management, offer 1:1 visits by the social workers so that Resident #1 could express concerns/issues about others, facility- contracted behavioral health services available as needed and to keep Resident #1 separated from residents if bothered by their presence. A psychotherapy note dated 11/5/24 identified one of Resident #1's treatment goals was to decrease conflict dynamics and reduce his/her conflicts with peers and others. Resident #1 expressed difficulty in managing intense emotions during stressful situations, which sometimes lead to conflict dynamics with others. Resident #1 had no current conflict with others reported by Resident #1 or staff. Resident #1 continued to implement coping strategies discussed in previous sessions, including deep breathing and mindfulness techniques. Resident #1 was assessed to be at no harm to self or others. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A nursing note written by RN #1 dated 11/6/24 at 11:41 AM identified she was notified by the supervisor of an alleged resident to resident altercation in the first floor dining room. Resident #2 was sitting at a table coloring when Resident #1 approached the table yelling at Resident #2 that he/she was not allowed to sit at that table ever again. Resident #2 started to gather his/her things to leave when Resident #1 punched Resident #2 on the left side of his/her face. Resident #2 placed Resident #1 in a head lock to prevent him/her from further punches to his/her face. The residents were immediately separated and placed on 1:1. Psychiatry evaluated both residents, discontinued 1:1 and initiated every 15-minute checks. A psychiatry note dated 11/6/24 at 11:59 PM identified Resident #1 was seen for a peer-to-peer altercation. Resident #2 recalled the events, affirmed feeling safe. He recommended every 15-minute checks. Resident #1's care plan was updated on 11/6/24 with the intervention that Resident #1 was re-educated to not have physical altercations with other staff or residents and to notify staff of any issues. 2. Resident #2 was admitted to the facility with diagnoses that included fracture of the sternum, Tourette's disorder and attention deficit disorder (ADD). The nursing admission assessment dated [DATE] identified Resident #2 was alert and oriented, had no behaviors and ambulated with a manual wheelchair. The five-day MDS dated [DATE] identified Resident #2 had a BIMS of fifteen (15) indicative of intact cognition and had no behavioral symptoms. A physician's order dated November 2024 directed ambulation with assistance of one. The care plan dated 11/5/24 identified Resident #2 had a mood problem related to obsessive compulsive disorder (OCD), ADD, and Tourette's disorder. Interventions included to administer medications as ordered, assist Resident #2 to identify strengths and positive coping skills and behavioral consults as needed. A nurse's note dated 11/6/24 at 11:50 AM written by RN #identified she was notified by the supervisor of an alleged resident to resident altercation on the first-floor dining room. Resident #2 was sitting at a table coloring when Resident #1 approached the table yelling at Resident #2 that he/she was not allowed to sit at that table ever again. Resident #2 started to gather his/her things to leave when Resident #1 punched Resident #2 on the left side of his/her face. Resident #2 placed Resident #1 in a head lock to prevent him/her from further punches to his/her face. The residents were immediately separated and placed on 1:1. Psychiatry evaluated both residents, discontinued 1:1 and initiated every 15-minute checks. Resident #2 was provided a room change. A nurse's note dated 11/6/24 at 6:49 PM identified Resident #2 verbalized he/she would not be able to sleep tonight. The room change was completed, in-house APRN was notified and ordered Trazodone 25 mg at bedtime for five days for sleep. (continued on next page)

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Psychiatric note dated 11/6/24 at 11:59 PM identified Resident #2 was seen for a peer-to-peer altercation. Resident #2 recalled the events and affirmed feeling safe. He recommended every 15-minute checks. Resident #2's care plan was updated on 11/6/24 with the intervention that Resident #2's room was changed to a different wing to avoid interactions with Resident #1. a. Review of the accident and incident form dated 11/6/24 identified Resident #2 was punched by Resident #1 in the head in the dining room. The residents were placed on 1:1, evaluated by psychiatry and then placed on every 15-minute checks. Resident #2's room was changed. The summary identified the allegation was substantiated related to the fact that the statements from the witnesses were consistent. Review pf RN #2's statement dated 11/6/24 identified RN #2 heard noise in the dining room and rushed over. He identified Resident #1 and Resident #2 were observed fighting and Resident #2 had Resident #1 in a headlock. The residents were immediately separated. Resident #2 reported he/she was sitting at the table when Resident #1 approached him/her and asked him/her to leave. Resident #2 stated he/she was leaving but Resident #1 told Resident #2 he/she could not use the table anymore and punched Resident #2. Resident #1 stated he/she had to protect him/herself by putting Resident #1 in a headlock. Upon assessment, Resident #2 had no injuries. Interview with Resident #2 on 11/26/24 at 2:10 PM identified he/she was able to recall the event that occurred on 11/6/24. Resident #2 identified he/she was in the dining room working on a craft when Resident #1 rolled up in his/her wheelchair and stated that was his/her table. Resident #2 started to pack up his/her belongings and leave the table when Resident #1 then ran into Resident #2 with his/her wheelchair at full force and punched Resident #2 three times. Resident #2 stated he/she put Resident #1 in a head lock to stop Resident #1 from punching him/her. Resident #2 identified Resident #1 stated I will kill you. Interview with LPN #1 on 11/26/24 at 2:35 PM identified he was assigned Resident #1 and Resident #2's unit on 11/6/24. He identified Resident #1's behavior that day was calm, friendly and did not identify any concerns. He identified he last saw Resident #1 in the common room in his/her power wheelchair and Resident #2 in the common room sitting at the table where Resident #1 usually sat around 11:20 AM. He identified he was passing through the common room at that time. He identified he was in the supervisor's office when he heard yelling and went to the common room where Resident #1 and Resident #2 were already separated. Interview with NA #1 on 11/26/24 at 2:40 PM (identified on the staffing for 11/6/24 as working in Resident #1 and Resident #2's unit) identified on 11/6/24 she heard he/she's hitting in the common room and ran over. Resident #2 was at a table gathering his/her supplies and Resident #1 was yelling at Resident #2 close to the table. Interview with the DNS and Administrator on 11/26/24 at 3:00 PM identified that the facility has no tolerance for abuse. He identified subsequent to the event; recreation was notified to ensure when Resident #2 comes to the common room after activities to clear a spot for Resident #2 and continue education on handling his/her emotions. He identified this is the first event where Resident #2 was territorial about his/her table in the common area. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Attempts to interview RN #1 were unsuccessful. Review of the abuse policy directed that abuse, exploitation and/or mistreatment of residents is prohibited. It further directed residents will not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants, volunteers, and staff of other agencies serving the resident.

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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** Based on review of the clinical record, facility documentation, facility policy, and interviews for one (1) of two (2) residents (Resident #2) reviewed for resident-to-resident abuse, the facility failed to complete and document 1:1 and every fifteen minute (Q 15) checks subsequent to a resident-to-resident abuse event per facility policy. The findings include: physical altercations with other staff or residents and to notify staff of any issues. 2. Resident #2 had diagnoses that included fracture of the sternum, Tourette's disorder and attention deficit disorder (ADD). The nursing admission assessment dated [DATE] identified Resident #2 was alert and oriented, had no behaviors and ambulated with a manual wheelchair. The five-day MDS dated [DATE] identified Resident #2 had a BIMS of fifteen (15) indicative of intact cognition and had no behavioral symptoms. A physician's order dated November 2024 directed ambulation with assistance of one. The care plan dated 11/5/24 identified Resident #2 had a mood problem related to obsessive compulsive disorder (OCD), ADD, and Tourette's disorder. Interventions included to administer medications as ordered, assist Resident #2 to identify strengths and positive coping skills and behavioral consults as needed. A nurse's note dated 11/6/24 at 11:50 AM written by RN #identified she was notified by the supervisor of an alleged resident to resident altercation on the first-floor dining room. Resident #2 was sitting at a table coloring when Resident #1 approached the table yelling at Resident #2 that he/she was not allowed to sit at that table ever again. Resident #2 started to gather his/her things to leave when Resident #1 punched Resident #2 on the left side of his/her face. Resident #2 placed Resident #1 in a head lock to prevent him/her from further punches to his/her face. The residents were immediately separated and placed on 1:1. Psychiatry evaluated both residents, discontinued 1:1 and initiated every 15-minute checks. Resident #2 was provided a room change. A nurse's note dated 11/6/24 at 6:49 PM identified Resident #2 verbalized he/she would not be able to sleep tonight. The room change was completed, in-house APRN was notified and ordered Trazodone 25 mg at bedtime for five days for sleep. A Psychiatric note dated 11/6/24 at 11:59 PM identified Resident #2 was seen for a peer-to-peer altercation. Resident #2 recalled the events and affirmed feeling safe. He recommended every 15-minute checks. Resident #2's care plan was updated on 11/6/24 with the intervention that Resident #2's room was changed to a different wing to avoid interactions with Resident #1. (continued on next page)

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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	Review of the accident and incident form dated 11/6/24 identified Resident #2 was punched by Resident #1 in the head in the dining room. The residents were placed on 1:1, evaluated by psychiatry and then placed on every 15-minute checks. Resident #2's room was changed. The summary identified the allegation was substantiated related to the fact that the statements from the witnesses were consistent. Interview with the DNS and Administrator on 11/26/24 at 3:00 PM identified he could not locate Resident #2's 1:1 or Q15 minute monitoring flowsheet for 11/6/24. He identified he would expect staff to document in a nursing note or the 1:1 or Q15 minute monitoring flowsheet when a patient is on increased monitoring. He further identified that he was not aware of when Resident #2 was taken off of fifteen-minute checks. He identified the process for taking a patient off Q15 checks is usually based on psychiatry feedback, discussion during morning rounds and/or during behavior rounds every Monday. Review of the close observation policy identified that residents are placed on close observation when the physician, nursing supervisor or the interdisciplinary team deem it necessary to ensure their safety or the safety of others. The policy directed that if an observation level is ordered by a physician, PA or APRN, it must be entered into the physician order sheets in the clinical record and must be discontinued by a physician, PA or APRN order. It directed the initiation of checks must be documented in an appropriate location in the clinical record. Documentation of staff monitoring of any resident on observation should be entered on either a Q15 or Q30 minute flowsheet. Documentation of 1:1 monitoring should be entered on a Q15 minute flowsheet.