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	02/20/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32738 Based on review of clinical records, interviews, and facility documentation for one (1) of three (3) residents (Resident #3) reviewed for pain management, the facility failed to ensure that the physician was notified when the resident's prescribed pain medication was unavailable and an alternate pain medication that was administered was ineffective. Resident #3 had diagnoses of acute osteomyelitis of the left ankle and foot. Review of Resident #3's Care Plan dated 11/1/24 identified the resident was on pain medication therapy with interventions directed to administer analgesic medications as ordered by the physician, and to monitor and document the side effects and effectiveness. The quarterly Minimum Data Set assessment (MDS) dated [DATE] identified Resident #3 had a Brief Mental Interview for Mental Status (BIMS) of seven (7) indicative of severe cognitive impairment. The MDS further identified Resident #3 was independent with Activities of Daily Living. A physician's order dated 12/6/24 directed acetaminophen 325 milligram tablets, two (2) tablets by mouth every six (6) hours as needed for pain. A physician's order dated 12/9/24 directed Oxycodone APAP, 5-325 milligrams by mouth, one (1) tablet every six (6) hours as needed (PRN) for moderate pain and two (2) tablets every six (6) hours as needed (PRN) for severe pain (a narcotic pain reliever). Review of Resident #3's Controlled Substance Disposition Record identified one (1) tablet of Oxycodone 5-325 milligrams was administered on 12/15/24 at 9:00 AM, which left zero (0) available for future administrations. Review of Resident #3's Medication Administration Record (MAR) for December 2024 identified Resident #3's pain level had ranged from five (5) to ten (10) (on a scale from one (1) to ten (10), (one (1) being the least amount of pain and ten (10) being the most pain). Review of the Resident #3's Medication Administration Record (MAR) dated 12/16/24 identified a pain level of nine (9) and 650 milligrams of acetaminophen was administered at 11:39 AM by LPN #1 (location of pain not identified) . (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
	075252	A. Building B. Wing	02/20/2025

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of LPN #1's nursing note dated 12/16/24 at 12:32 PM identified Resident #3 reported a pain level of eight (8) and that the acetaminophen was ineffective at relieving his/her pain. Review of the Controlled Substance Disposition Record identified Resident #3 received his/her next dose of Oxycodone 5-325 milligrams on 12/16/24 at 5:35 PM, thirty-two (32) hours and thirty-five (35) minutes after his last dose. Interview with LPN #1 on 2/18/25 at 1:51 PM identified that he/she did not inform the supervisor that Resident #3 was out of his/her Oxycodone 5-325 milligram pain medication on 12/16/24 and that the back-up emergency supply of Oxycodone 5-325 milligram was also not available on 12/16/24. LPN #1 further indicated at 2:40 PM on 2/16/25 that the charge nurse was aware that there was no Oxycodone available and the pain was unrelieved by acetaminophen. (although he/she was unable to identify who that was) further, the practioner was not contacted to request an alternate pain medication to help relieve the resident's pain. Interview with RN #1 (Nurse Supervisor on 7:00 AM to 3:00 PM shift on 12/16/24) on 2/19/25 at 11:41 AM identified that h/she was not informed that Resident #3 had reported the acetaminophen was ineffective in relieving his/her pain or that Resident #3 reported a pain level of eight (8) following administration of acetaminophen on 12/16/24. RN #1 further identified that he/she did not recall being informed the resident was out of his/her Oxycodone 5-325 milligram medication, if he/she had been informed he/she would have informed the provider of the resident's pain, and that the resident was out of his/her Oxycodone 5-325 milligram medication, checked the availability of the medication in the emergency box/PIXUS (dispenses emergency medication), and inquired about an alternative that could have been given in the meantime until the Oxycodone came in from the pharmacy. Interview with the Assistant Director of Nurses (ADNS) on 2/19/25 at 11:48 AM identified that he/she was not notified Resident #3 was still in pain after being administered 650 milligrams of Acetaminophen on 12/16/24. Interview with the Medical Director on 2/19/25 at 2:10 PM identified he/she would expect the facility to notify him/her or the provider of the resident's unresolved pain and inquire about an alternative medication that could be offered. The Medical Director indicated he/she would have given the resident a one-time dose of an alternate medication to relieve his/her pain and would expect a call back if the resident's pain persisted. Interview with the DON on 2/19/25 at 12:02 PM identified when Resident #3's pain was not relieved following the administration of pain medication, the nurse supervisor should have been notified, and provider informed of the resident's unrelieved pain. The DON further indicated he/she would have reviewed Resident #3's orders for an alternate medication that could have provided pain relief. Review of the change in condition policy identified that a change in condition is a significant clinical development that requires assessment and intervention. The RN supervisor will do an assessment and report findings to the physician.

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	075252	A. Building B. Wing	02/20/2025

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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** 43184 Based on clinical record reviews, facility documentation, facility policies, and interviews for one (1) of two (2) sampled residents (Resident #1) who were reviewed for an allegation of resident to resident abuse, the facility failed to ensure Resident #1 was free from physical abuse. The findings include: 1. Resident #1's diagnoses included bipolar disorder and anxiety. The Resident Care Plan (RCP) dated 1/3/25 identified Resident #1 had behavioral problems. Interventions directed to administer medications as ordered, monitor and document for side effects and effectiveness, anticipate and meet the resident's needs, and provide opportunities for positive interaction. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of 14 indicating Resident #1 was alert and oriented to date, time and place and ambulated independently with a cane. 2. Resident #2's diagnoses included anxiety, adjustment disorder, and depression. The quarterly MDS dated [DATE] identified Resident #2 had a BIMS score of 11 indicating Resident #2 had some memory recall deficits, was independent with transfers and utilized a motorized wheelchair. The RCP dated 1/16/25 identified Resident #2 had a mood problem related to anxiety, insomnia and depression. Interventions directed to administer medications as ordered, monitor and document for side effects and effectiveness, behavioral health consults as needed, and monitor, record and report to physician if the resident was at risk for harming others, had increased anger, labile mood or agitation. The nurse's note dated 2/4/25 at 1:46 PM identified Resident #1 was observed sitting on his/her buttocks on the floor and a large laceration was noted to the right side of the forehead. The note identified Emergency Medical Services (EMS) was called and Resident #1 was transferred to the Emergency Department (ED) for treatment. The nurse's note dated 2/4/25 at 7:36 PM identified Resident #1 returned from the hospital and seven (7) sutures were noted to the right lateral aspect of the head. The nurse's note dated 2/4/25 at 2:03 PM identified Resident #2 was involved in a resident-to-resident altercation with Resident #1. The note identified witnesses reported Resident #2 hit Resident #1 in the forehead with a cane. The note identified Resident #2 was sent to the ED for evaluation and treatment to ensure no further harm would be done. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The nurse's note dated 2/5/25 at 2:40 AM identified Resident #2 returned from the hospital at 12:15 AM with a no harm letter. The facility's investigational summary report dated 2/7/25 at 12:00 PM identified Resident #1 and Resident #2 had a verbal altercation in the dining room. Resident #2 then drove his/her motorized wheelchair towards Resident #1 causing Resident #1 to stumble and fall. Resident #2 then picked up Resident #1's cane, struck Resident #1 in the head and Resident #1 sustained a laceration to the right side of the forehead. Interview with the Social Worker (SW) #1 on 2/20/25 at 11:47 AM identified she arrived on the unit while the altercation in the dining room was occurring. SW #1 explained that Resident #2 reported to her that he/she had sugar packets on the table and Resident #2 told Resident #1 not to touch the condiments, but Resident #1 did touch the sugar. Resident #2 reported to her that it was then he/she wheeled towards Resident #1 in his/her motorized wheelchair causing Resident #1 to fall to the ground. Resident #2 identified while on the floor Resident #1 attempted to swing his/her cane at Resident #2 who then grabbed the cane and struck Resident #1 with it. Interview with the Physical Therapy Assistant (PTA) #1, on 2/20/25 at 12:03 PM identified at the time of the incident, he was in the hallway on the unit and observed Resident #1 on the ground in the dining room swinging his/her cane at Resident #2. PTA #1 indicated Resident #2 grabbed the cane from Resident #1 and hit Resident #1 on the head. PTA #1 identified he then took the cane away from Resident #2. Interview with the Certified Occupational Therapy Assistant (COTA) #1 on 2/20/25 at 1:23 PM identified on 2/4/25 she observed Resident #1 being a bit irritated while in the dining room. COTA #1 identified she heard a tussle, and when she turned around she saw Resident #2 going towards Resident #1 with his/her motorized wheelchair, bump into Resident #1 and Resident #1 fell to the floor. COTA #1 indicated Resident #2 continued to move towards Resident #1, and she observed what appeared to be Resident #1 attempting to get Resident #2 to stop by using his/her cane. COTA #1 identified at that time, Resident #2 grabbed the cane from Resident #1 and began to hit Resident #1. COTA #1 indicated she called for help and attempted to redirect the residents away from each other. Interview with the Director of Nursing (DON) on 2/20/25 at 2:01 PM identified on 2/4/25, she responded to the unit when she heard the page overhead and arrived at the dining room. The DON identified both residents were separated, the provider was notified, police were called, and an investigation was immediately initiated. The DON identified the facility policy on abuse is that all residents are to be free from abuse of any type from anybody. Review of the facility policy titled Abuse, last reviewed 3/20/24, directed, in part, abuse, neglect, exploitation, and/or mistreatment of residents is prohibited. The policy further directed, in part, 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 service the residents, family members or legal guardians, friends or other individuals. Review of the facility policy titled Nursing Facility Residents' [NAME] of Rights directed, in part, each resident has the right to be free from verbal, sexual, physical or mental abuse, corporal punishment and involuntary seclusion.

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	075252	A. Building B. Wing	02/20/2025

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47491 Based on review of clinical records, interviews, and review of facility policy and documentation for two (2) of three (3) residents (Resident #4, and #5) reviewed for medication administration, the facility failed to administer resident's medications in accordance with facility policy. The findings included: 1. Resident #5 had diagnoses that included schizoaffective disorder, major depressive disorder, and Crohn's disease. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #5 had a Brief Mental Interview for Mental Status (BIMS) of fifteen (15) indicative of intact cognition. The MDS further identified Resident #5 was independent with oral, toileting and personal hygiene. Review of Resident #5's Care Plan dated 12/18/24 identified an alteration in gastro-intestinal status related to Crohn's, use of antidepressant medication related to depression, chronic pain and arthritis, and for staff to be alert for the efficacy of his/her pain medication with interventions that directed to administer medications as ordered by the physician and to monitor for side effects and effectiveness. Review of the physician's orders dated 2/1/25 and the Medication Administration Record dated 2/19/25 identified the following medication orders: -Hydroxyzine (Antihistamine), 25 milligram tablet, three (3) tablets to be given twice daily at 8:00 AM and 5:00 PM. -Omega-3 Acid (Supplement), 1 gram capsule, twice daily at 8:00 AM and 5:00 PM. -GuaFENesin (Expectorant), 400 milligram tablet, twice daily at 8:00 AM and 5:00 PM. -Morphine Sulfate Extended Release (Narcotic Pain Reliever), 15 milligram tablet, twice daily at 9:00 AM and 9:00 PM. -Furosemide (Diuretic), 40 milligram tablet daily at 9:00 AM. -Loratadine (Antihistamine), 10 milligram tablet daily at 9:00 AM. -Multivitamin Tablet (Supplement), one (1) daily at 9:00 AM. -Senna with Docusate (Laxative), 8.6-50 milligram tablet, two tablets twice daily at 9:00 AM and 5:00 PM. -Lisinopril (Antihypertensive), 20 milligram tablet, one tablet daily at 9:00 AM. -Gabapentin (Anticonvulsant), 400 milligram tablet three (3) times daily at 9:00 AM, 1:00 PM, and 5:00 PM. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Potassium Chloride (Supplement), 10 milliequivalent tablet, daily at 9:00 AM. -Metoprolol Succinate (Antihypertensive), 100 milligram Extended Release tablet daily at 9:00 AM. -Sertraline (Antidepressant), 100 milligram tablet, two tablets daily at 9:00 AM. -Metamucil Powder (Laxative), one serving daily at 9:00 AM. Review of the time the aforementioned medications were administered was recorded as 10:53 AM and 11:17 AM, one (1) hour and fifty-three (53) minutes and two (2) hours and seventeen (17) minutes after their scheduled administration times. 2. Resident #4 had diagnoses that included metabolic encephalopathy, diffuse traumatic brain injury, and adjustment disorder. Review of the admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #4 had a Brief Mental Interview for Mental Status (BIMS) of fifteen (15) indicative of intact cognition. The MDS further identified Resident #4 was dependent with toileting hygiene, bathing, dressing, and mobility. Review of Resident #4's Care Plan dated 1/6/25 identified a nutritional problem or potential nutritional problems related to diabetes mellitus, hypertension, congestive heart failure, dysphagia/shortness of breath, and obesity with interventions that directed to administer medications as ordered and provide and serve supplements as ordered. Observation of LPN #1 on 2/19/25 at 10:20 AM identified he/she was administering morning medications. Review of the Physician's orders dated 2/1/25 and the Medication Administration Record dated 2/19/25 identified the following medication orders: -Prosource Protein Liquid (Supplement), 30 milliliters to be administered daily at 8:00 AM -Prednisone (Anti-Inflammatory), 2.5 milligram tablet to be administered daily at 9:00 AM -Eliquis (Anticoagulant), 5 milligram tablet, to be administered twice daily at 9:00 AM and 9:00 PM. -Incruse Ellipta Inhalation Aerosol Powder (Bronchodilator), 62.2 micrograms to be given daily at 9:00 AM. -Suboxone Sublingual Film (Substance Addiction), 12-3 milligrams to be administered daily at 9:00 AM. -Ferrous Sulfate (Supplement), 325 milligrams to be administered daily at 9:00 AM. -Ascorbic Acid Tablet (Supplement) 250 milligrams to be administered daily at 9:00 AM. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Allopurinol Tablet (Uric Acid Depletion), 100 milligrams daily to be administered daily at 9:00 AM. -Metoprolol Tartrate Oral Tablet (Antihypertensive), 25 milligrams given twice daily at 9:00 AM and 6:00 PM. Review of the time the medications were administered was recorded in the electronic medical record system as administered at 11:29 AM and 11:30 AM, two (2) and one-half (1/2) to three (3) and one-half (1/2) hours past their scheduled times. Interview with LPN #1 on 2/19/25 at 1:55 PM identified he/she did not communicate to the supervisor that he/she was running late in administering medication because he/she was running late was due to a heavy resident assignment (thirty (30) to thirty-one (31) residents) with multiple medications to administer. LPN #1 further identified that the late medication administrations is not something new and that the facility was aware that this was happening. Interview with RN #1 on 2/19/25 at 2:00 PM identified he/she was not aware that resident's medications were being administered late and had he/she known, he/she would have discussed the issue with the Director of Nursing Services (DNS) to resolve the issue so that medications were administered timely. Interview with the DNS on 2/19/25 at 4:00 PM identified resident medications could be administered up to one (1) hour before and one (1) hour after the scheduled time and that staff should notify the nursing supervisor that medications were being administered late in order for the issue to be attended to and resolved. Review of the Medication Administration policy directed medications were to be administered within sixty (60) minutes of the scheduled administration time and that unless otherwise specified by a prescriber, routine medications were administered according to the established medication administration schedule for the facility.

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	075252	A. Building B. Wing	02/20/2025

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47491 Based on review of clinical records, interviews, and facility documentation for one (1) of three (3) residents (Resident #3) reviewed for pain management, the facility failed to ensure medications were available to and treat a resident's unrelieved pain. The findings included: Resident #3 had diagnoses of acute osteomyelitis of the left ankle and foot. Review of Resident #3's Care Plan dated 11/1/24 identified the resident was on pain medication therapy with interventions directed to administer analgesic medications as ordered by the physician, and to monitor and document the side effects and effectiveness. The quarterly Minimum Data Set assessment (MDS) dated [DATE] identified Resident #3 had a Brief Mental Interview for Mental Status (BIMS) of seven (7) indicative of severe cognitive impairment. The MDS further identified Resident #3 was independent with Activities of Daily Living. A physician's order dated 12/6/24 directed acetaminophen 325 milligram tablets, two (2) tablets by mouth every six (6) hours as needed for pain. A physician's order dated 12/9/24 directed Oxycodone - APAP, 5-325 milligrams by mouth, one (1) tablet every six (6) hours as needed (PRN) for moderate pain and two (2) tablets every six (6) hours as needed (PRN) for severe pain (a narcotic pain reliever). Review of Resident #3's Controlled Substance Disposition Record identified one (1) tablet of Oxycodone 5-325 milligrams was administered on 12/15/24 at 9:00 AM, which left zero (0) available for future administrations. Interview with RN #2 on 2/19/25 at 12:35 PM identified he/she had approached Resident #3 in the hallway during second shift (3:00 PM to 11:00 PM) on 12/15/24 as the resident had appeared frustrated. RN #2 identified that Resident #3 had informed him/her that the facility had run out of h/her Oxycodone 5-325 milligrams pain medication. RN#1 identified the facility was also out of the emergency supply of Oxycodone 5-325 milligrams so she contacted the APRN to request a prescription be sent to the pharmacy. A Nurse's note written by (RN) #2 dated 12/15/24 at 7:32 PM identified the facility was out of Resident #3's PRN (as needed) Oxycodone 5-325 milligram medication, a call was made to the on-call Advanced Practice Registered Nurse (APRN) who informed a script would be called into the pharmacy, a substitute medication was requested until the resident's pain medication was delivered, however, APRN stated the medication should be in the facility sometime today, and to continue to offer Tylenol to the resident. Review of Resident #3's Medication Administration Record (MAR) for December 2024 identified Resident #3's pain level had ranged from five (5) to ten (10) (on a scale from one (1) to ten (10), one (1) being the least amount of pain and ten (10) being the most pain). (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Resident #3's Medication Administration Record (MAR) dated 12/16/24 identified a pain level of nine (9) and the administration of 650 milligrams of acetaminophen at 11:39 AM by LPN #1. Review of LPN #1's nursing note dated 12/16/24 at 12:32 PM identified Resident #3 reported a pain level of eight (8) and that the tylenol was ineffective at relieving his/her pain. Review of the Controlled Substance Disposition Record identified Resident #3 received his/her next dose of Oxycodone 5-325 milligrams on 12/16/24 at 5:35 PM, thirty-two (32) hours and thirty-five (35) minutes after his last dose. Interview with LPN #1 on 2/18/25 at 1:51 PM identified that he/she did not inform the supervisor that Resident #3 was out of his/her Oxycodone 5-325 milligram pain medication on 12/16/24 and that the back-up emergency supply of Oxycodone 5-325 milligram was also not available on 12/16/24. LPN #1 further indicated at 2:40 PM on 2/16/25 that the charge nurse was aware that there was no Oxycodone available and the pain was unrelieved by tylenol. (although he/she was unable to identify who that was) further, the APRN was not contacted to request an alternate pain medication to help relieve the resident's pain. Interview with RN #1 (Nurse Supervisor on 7:00 AM to 3:00 PM shift on 12/16/24) on 2/19/25 at 11:41 AM identified that h/she was not informed that Resident #3 had reported the acetaminophen was ineffective in relieving his/her pain or that Resident #3 reported a pain level of eight (8) following administration of acetaminophen on 12/16/24. RN #1 further indicated he/she did not recall being informed the resident was out of his/her Oxycodone 5-325 milligram medication, if he/she had been informed he/she would have informed the provider of the resident's pain, and that the resident was out of his/her Oxycodone 5-325 milligram medication, checked the availability of the medication in the emergency box/PIXUS, and inquired abot an alternative that could have been given in the meantime unitl the Oxycodone came in from the pharmacy. Interview with the Assistant Director of Nurses (ADNS) on 2/19/25 at 11:48 AM identified that he/she was not notified Resident #3 was still in pain after being administered 650 milligrams of Acetaminophen on 12/16/24. Interview with the DON on 2/19/25 at 12:02 PM identified when Resident #3's pain was not relieved following the administration of pain medication, the nurse supervisor should have been notified, and provider informed of the resident's unrelieved pain. The DON further indicated he/she would have reviewed Resident #3's orders for an alternate medication that could have provided pain relief. (continued on next page)

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	075252	A. Building B. Wing	02/20/2025

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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 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Clinical Service Manager (CSM) of the On-Call Nurse Practitioner Service) on 2/20/25 at 12:03 PM identified a call was received on 12/15/24 at 5:34 PM from the facility requesting a new script for Oxycodone 5-325 milligrams be placed for Resident #3 as the resident had run out of his prescription and the facility did not have any of the medication on hand. The CSM further indicated the caller had inquired about substituting the Oxycodone 5-325 mg with Tramadol and indicated the facility was giving the resident Acetaminophen, 650 milligrams, for his/her pain in between administration of his/her Oxycodone. RN #1 did not indicate the resident was experiencing any pain during the call and that APRN #1 did not direct the facility to use Acetaminophen for the resident's pain in the meantime. An order for eight (8) tablets of Oxycodone 5-325 milligrams was electronically submitted to the pharmacy immediately following the call, however was not placed as a stat order (to be filled and delivered immediately). The CSM identifed that no additional calls were received into the on-call service following the prescription refill request through to 8:00 AM the following day (12/16/24) for Resident #3. Interview with the Medical Director on 2/19/25 at 2:10 PM identified he/she would expect the facility to notify him/her or the provider of the resident's unresolved pain and inquire about an alternative medication that could be offered. The Medical Director indicated he/she would have given the resident a one-time dose of an alternate medication to relieve his/her pain and would expect a call back if the resident's pain persisted. Review of the Pain Management policy directed pain strategies to include as applicable, pharmacologic, and non-pharmacologic interventions.