STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075257	A. Building B. Wing	01/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside Health & Rehabilitation	745 Main St East Hartford, CT 06108

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** Based on clinical record review, facility documentation review, facility policy review, and interviews for one of three residents (Resident #1) reviewed for change in condition, the facility failed to notify the provider timely when a resident was identified to have low blood sugar levels. The findings include: Resident #1's diagnoses included diabetes, IGG4 related disease (chronic inflammatory condition affects multiple organs) and end stage renal disease. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of fifteen out of fifteen (indicative of no cognitive impairment), was a diabetic and received insulin two (2) days during the prior seven (7) days. The Resident Care Plan (RCP) dated 1/11/2025 identified Resident #1 had diabetes with hypoglycemia. Interventions directed to obtain blood sugars as ordered by the MD, monitor/document/report prn any signs and symptoms of hypoglycemia, monitor/document/report prn compliance with diet, and document any problems. A physician order dated 12/24/2024 directed the following: • Check blood sugar before meals and at bedtime for blood sugar monitoring, notify MD if BS (blood sugar) is less than 70 or greater than 400. • If the BS is less than 70 after the first dose of Glucose Gel and symptomatic, notify the MD to review diabetic medications for possible adjustment as needed for hypoglycemia over 70. • Glucagon Emergency Injection Kit 1 milligrams (mg) inject 1 mg subcutaneously every 24 hours as needed for hypoglycemia over 70. Record review identified the following: 1. (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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(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	On 1/2/2025 Resident #1's blood sugar at 5:39 AM was 57. Glucose Gel was administered at 5:40 AM and noted as ineffective. Further review identified that at 5:55 AM Resident #1's blood sugar was 61 and Resident #1 was given Glucagon Emergency Injection Kit 1 mg. 2. On 1/3/2025 at 4:04 PM Resident #1's blood sugar was 56. Review of the Medication Administration Record (MAR) identified Glucose Gel was administered at 4:05 PM. Additional review identified the blood sugar at 4:09 PM was 56. A physician order start date 1/4/2025 directed finger sticks for blood sugar two (2) times a day for diabetes management. Additional record review identified the following: 1. Blood sugar on 1/6/2025 at 6:20 AM was 66. 2. Blood sugar on 1/7/2025 at 6:06 AM was 55 and Resident #1 was given Glucagon Emergency Injection Kit 1 MG, at 6:07 AM. 3. Blood sugar on 1/9/2025 at 5:57 AM was 44 and Resident #1 was given Glucagon Emergency Injection Kit 1 MG. 4. Blood sugar on 1/10/2025 at 7:40 PM was 61 and Resident #1 was given Glucose Gel 5. Blood sugar on 1/12/2025 at 5:47 AM was 42, and Resident #1 was given Glucagon Emergency Injection Kit 1 MG. Record review failed to identify the physician or APRN was notified of the low blood sugars as listed above. Interview, clinical record review and facility documentation review on 1/21/2025 at 12:45 PM with APRN #1 identified she was not notified of the low blood sugars that occurred as listed above. APRN #1 stated although the physician order directed to notify the physician (APRN) if the blood sugar is less than 70 or greater than 400, she did not need to be notified unless the blood sugar was under 60 (under 60 on 1/7, 1/9, and 1/12/2025). (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and record review with the ADNS #1 on 1/21/2025 at 2:23 PM identified the provider (physician or APRN) should be notified if a resident's blood sugar is critically low, if Glucagon is required or if hypoglycemia persists after three (3) interventions. ADNS #1 stated the provider should have been notified on 1/2, 1/3, 1/6, 1/7, 1/9, 1/10, and 1/12/2025 of the resident's hypoglycemic episodes, and was unable to explain why the provider was not notified. Review of facility Diabetes Management Protocol Policy directed in part to notify the residents' provider in the following situations: per parameters set by provider, hypoglycemia persists after 3 interventions, BG (blood glucose) is critically low less than 50 mg/dl, Glucagon or D50 is administration is required or resident experiences persistent or severe symptoms. Facility record review identified education was initiated on 1/9/2025 and included education regarding notifying the physician if a resident has low blood sugars. Audits were initiated on 1/9/2025 and a QAPI meeting was held on 1/17/2025. Based on record review, a finding of past non-compliance was identified with correction on 1/17/2025.

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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 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 clinical record reviews, review of facility documentation, facility policies and interviews for one (1) of four (4) sampled residents (Resident #4) who were dependent on staff for activities of daily living and reviewed for an allegation of being neglected, the facility failed to ensure Resident #4 was provided with toileting hygiene and transferred off the toilet in an appropriate timeframe. The findings include: Resident #4's diagnoses included Parkinson's Disease, osteoarthritis, chronic kidney disease, and macular degeneration. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #4 was alert and oriented to person, place, and time, was dependent on one (1) staff member for personal and toileting hygiene, required two (2) staff for transfers on and off the toilet and utilized a wheelchair for mobility. The Resident Care Plan dated 11/5/24 identified Resident #4 had a self-care deficit due to Parkinson's Disease. Interventions directed to provide limited assistance of one (1) staff member with most activities of daily living and transfer assistance of two (2) via the Sara lift. The Facility Reported Incident form dated 1/3/25 identified Resident #4 reported that on 12/30/24 he/she was left on the toilet for a long period of time. The investigation identified a review of the camera video showed the timeline of events on 12/30/24: a nurse aide, Nurse Aide (NA) #1, went into Resident #4's room at 10:53 AM and left the room at 10:58 AM, at 11:06 AM and 11:56 AM different staff members went into Resident #4's room due to the call light being activated and immediately came out of Resident #4's room, and then at 12:13 PM, one (1) hour and fifteen (15) minutes after NA #1 first exited the room, NA #1 went back into Resident #4's room. An interview with NA #1 on 1/22/25 at 12:37 PM identified on 12/30/24 at approximately 11:00 AM she put Resident #4 on the toilet and left the room to assist another resident. NA #1 identified for personal reasons after she completed care with the other resident, she left the unit to go to lunch and she did not tell any staff member on the unit that she was leaving the unit or that Resident #4 was on the toilet. NA #1 explained when she returned to the unit, she realized Resident #4 was still on the toilet and proceeded to go into his/her room to assist Resident #4 to get off the toilet. An interview with the Social Worker, SW #1, on 1/22/25 at 12:46 PM identified on 1/3/25 she received a call from Resident #4's family member to report that Resident #4 told the family member a few days earlier, he/she had been left on the toilet for about two (2) hours, during that timeframe two (2) staff members came in and both noted Resident #4 was in the bathroom, and although Resident #4 asked the staff to get his/her aide, the staff members did not and they did not assist Resident #4. SW #1 identified she then spoke with Resident #4, who repeated the same account of the incident with the timeframes. SW #1 indicated she did a three (3) day follow up and Resident #4 experienced no ill effects. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and clinical record review with the Assistant Director of Nursing (ADON) on 1/22/25 at 12:59 PM identified the initial report of the 12/30/24incident with Resident #4 came from a family member. The ADON identified the camera footage showed NA #1 going into Resident #4's room at 10:53 AM and leaving the room at 10:58 AM, the bathroom call light went off several times and on two (2) occasions staff members went in to check on Resident #4 and came out without turning the call light off. The ADON identified the camera showed NA #1 return to Resident #4's room at approximately 12:15 PM, one (1) hour and fifteen (15) minutes. The ADON identified NA #1 should have informed another staff member that Resident #4 was on the toilet prior to her leaving the unit and that another staff member should have taken Resident #4 off the toilet. Review of the facility policy titled Abuse Policy and Procedure, last revised dated 12/2023, directed, in part, it is the policy that each resident has the right to be free from abuse, neglect and misappropriate of resident property and exploitation. The policy further defines neglect as the failure of the facility, its employees or service providers to provide goods and services to a

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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 Based on clinical record review, facility documentation review, facility policy review, and interviews for one of three residents (Resident #1) reviewed for change in condition, the facility failed to ensure staff acted on low blood sugar test results timely, and failed to ensure an endocrinology appointment was made timely for a resident with a known history of low blood sugars. The findings include:

Resident #1's diagnoses included diabetes, IGG4 related disease (chronic inflammatory condition affects multiple organs) and end stage renal disease. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of fifteen out of fifteen (indicative of no cognitive impairment), was a diabetic and received insulin two (2) days during the prior seven (7) days. The Resident Care Plan (RCP) dated 1/11/2025 identified Resident #1 had diabetes with hypoglycemia. Interventions directed to obtain blood sugars as ordered by the MD, monitor/document/report prn any signs and symptoms of hypoglycemia, monitor/document/report prn compliance with diet, and document any problems.

A physician order dated 12/24/2024 directed the following:

•

Check blood sugar before meals and at bedtime for blood sugar monitoring, notify MD if BS (blood sugar) is less than 70 or greater than 400.

•

If the BS is less than 70 after the first dose of Glucose Gel and symptomatic, notify the MD to review diabetic medications for possible adjustment as needed for hypoglycemia over 70.

•

Glucagon Emergency Injection Kit 1 milligrams (mg) inject 1 mg subcutaneously every 24 hours as needed for hypoglycemia over 70.

Record review identified the following:

1.

On 1/2/2025 Resident #1's blood sugar at 5:39 AM was 57. Glucose Gel was administered at 5:40 AM and noted as ineffective. Further review identified that at 5:55 AM Resident #1's blood sugar was 61 and Resident #1 was given Glucagon Emergency Injection Kit 1 mg.

Additional record review failed to identify additional steps taken by staff after the repeat blood sugar obtained at 5:55 AM.

2. On 1/3/2025 at 4:04 PM Resident #1's blood sugar was 56. Review of the Medication Administration Record (MAR) identified Glucose Gel was administered at 4:05 PM.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review identified the blood sugar at 4:09 PM was 56. Additional record review failed to identify additional steps taken by staff after the repeat blood sugar obtained at 4:09 PM was unchanged from 4:04 PM (at 56). A physician order start date 1/4/2025 directed finger sticks for blood sugar two (2) times a day for diabetes management. Additional record review identified the following: 3. On 1/6/2025 at 6:20 AM, Resident #1's blood sugar was 66. Record review failed to identify additional actions taken by staff when the results were under 70 on 1/6/2025 at 6:20 AM. 4. On 1/7/2025 at 6:06 AM, Resident #1's blood sugar was 55 and Resident #1 was given Glucagon Emergency Injection Kit 1 MG, at 6:07 AM. Record review failed to identify additional actions taken by staff when the results were under 70 on 1/7/2025 at 6:07 AM. 5. On 1/9/2025 at 5:57 AM Resident #1's blood sugar was 44 and Resident #1 was given Glucagon Emergency Injection Kit 1 MG at 5:58 AM. Record review failed to identify additional actions taken by staff when the results were 44 on 1/9/2025 at 5:58 AM. 6. On 1/10/2025 at 7:40 PM, Resident #1's blood sugar was 61 and Resident #1 was given Glucose Gel at 7:40 PM. Record review failed to identify additional actions taken by staff when the results were under 70 on 1/10/2025 at 7:40 AM. 7. On 1/12/2025 at 5:47 AM, Resident #1's blood sugar was 42, and Resident #1 was given Glucagon Emergency Injection Kit 1 MG at 5:48 AM. Further review identified the blood sugar was rechecked at 7:01 AM and was 135. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Additional record review identified on 1/12/2025 Resident #1's blood sugar at 5:30 PM was 36. Nursing note dated 1/12/2025 at 7:32 PM indicated Resident #1 was transferred to the hospital, and the family was notified. Resident #1 was out of the facility during the survey. Interview and record review with APRN #1 on 1/21/2025 at 12:45 PM identified Resident #1 was functional with blood sugars in the 60's and both the facility policy and physician orders directed to notify the provider if the blood sugar was under 70. Interview, clinical record review, and facility documentation review on 1/21/2025 at 2:23 PM with ADNS #1 identified the facility protocol directed if a resident's blood sugar is below 70, treatment for a conscious resident was to treat with 15 grams of carbohydrate and recheck the blood sugar in 15 minutes, and if still below 70 to repeat the carbohydrate; if unconscious or unable to swallow to give Glucagon and recheck blood sugar in 15 minutes. The ADNS indicated that the provider should be notified if the blood sugar is critically low, if Glucagon is administered, or if hypoglycemia persists after three (3) interventions. The ADNS identified although the facility policy was to recheck blood sugar 15-minutes after Glucagon was administered, the blood sugar was not rechecked on the dates listed, the ADNS #1 was unable to explain why blood sugars were not rechecked in accordance with facility policy. Review of facility Diabetes Management Protocol Policy directed in part, hypoglycemia is defined as blood sugar level less than 70 and to treat promptly even is asymptomatic. If conscious and able to swallow, provide 15 grams of fast acting carbohydrates (such as 4 ounces of juice or regular soda, or 1 tube of glucose gel). Recheck blood sugar in 15 minutes, if remains under 70 to repeat treatment. If unconscious or unable to swallow, call for emergency medical assistance immediately and administer Glucagon as per provider orders; recheck blood sugar every 15 minutes until stable. The Policy further directed, to notify the provider if hypoglycemia persists after three (3) interventions, if the blood sugar is critically low (under 50) and if Glucagon is administered. A. Record review identified that Resident #1 was seen by Endocrinology Clinic on 10/18/2024 and 11/15/2024 with directions to return in four (4) weeks. Return appointment was scheduled for 12/20/2024. Record review failed to identify Resident #1 was seen by Endocrinology on 12/20/2024. Interview and record review with ADNS #1 on 1/22/2025 at 10:35 AM identified Resident #1 had a follow-up Endocrinology appointment booked on 12/20/2024, but it conflicted with another medical appointment and the Endocrinology appointment was cancelled. Interview failed to identify the facility rescheduled the 12/20/2024 Endocrinology appointment. ADNS #1 stated the appointment should have been re-booked.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, review of facility documentation, facility policy and interviews for one (1) of four (4) sampled residents (Resident #4) who required a mechanical lift for transfers, the facility failed to ensure the appropriate number of staff conducted the transfer in accordance with the physician's order. The findings include: Resident #4's diagnoses included Parkinson's Disease, osteoarthritis, , chronic kidney disease, and macular degeneration. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #4 was alert and oriented to person, place, and time, was dependent on one (1) staff member for personal and toileting hygiene, required two (2) staff for transfers on and off the toilet and utilized a wheelchair for mobility. The Resident Care Plan dated 11/5/24 identified Resident #4 had a self-care deficit due to Parkinson's Disease. Interventions directed to provide limited assistance of one (1) staff member with most activities of daily living and transfer assistance of two (2) via the Sara lift. A physician's order dated 11/27/23 directed to transfer Resident #4 with the assistance of two (2) staff members utilizing the [NAME]-Lift (a device used to assist a resident from a sitting position to a standing position). The Facility Reported Incident form dated 1/3/25 identified Resident #4 reported that on 12/30/24 he/she was left on the toilet for a long period of time. During the investigation it was noted the nurse aide, Nurse Aide (NA) #1, assigned to Resident #4 on 12/30/24 had transferred Resident #4 off the toilet using the [NAME]-Lift without the benefit of another staff member assisting. Interview with NA #1 on 1/22/25 at 12:37 PM identified on 12/30/24 at approximately 12:15 PM, she went in to assist Resident #4 off the toilet using the Sara lift. NA #1 explained she did not ask another staff member to assist her and although she was aware Resident #4 required two (2) staff members to transfer, she did not ask another staff member to assist in the transfer. Interview with the Assistant Director of Nursing (ADON) on 1/22/25 at 12:59 PM identified a physician's order directed to transfer Resident #4 with the assistance of two (2) and Sara lift. The ADON identified the facility did not have a policy on the use of the Sara lift, however the Sit to Stand Lift competency each staff was given does direct that two (2) staff members are present when using the Sara lift. The ADON identified on 12/30/24, NA #1 transferred Resident #4 without another staff member present. Review of the facility Sit to Stand Lift Competency form directed, in part, for staff to check transfer status against the NA care card and obtain stand lift (Sara lift) and an additional staff member to assist with the transfer.

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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 clinical record review, facility documentation review, facility policy review, and interviews for one of three residents (Resident #1) reviewed for change in condition, the facility failed to ensure to ensure the Glucagon order was written accurately the clinical record was complete and accurate to include accurate orders for Glucose/Glucagon, and failed to ensure documentation of nursing actions for a resident with low bloods sugars. The findings include: Resident #1's diagnoses included diabetes, IGG4 related disease (chronic inflammatory condition affects multiple organs) and end stage renal disease. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of fifteen out of fifteen (indicative of no cognitive impairment), was a diabetic and received insulin two (2) days during the prior seven (7) days. The Resident Care Plan (RCP) dated 1/11/2025 identified Resident #1 had diabetes with hypoglycemia. Interventions directed to obtain blood sugars as ordered by the MD, monitor/document/report prn any signs and symptoms of hypoglycemia, monitor/document/report prn compliance with diet, and document any problems. A. A physician order dated 12/24/2024, directed: • if the blood sugar is less than 70 after the first dose of Glucose Gel and symptomatic, notify the MD to review diabetic medications for possible adjustment as needed for hypoglycemia over 70. • Glucagon Emergency Injection Kit 1 milligrams (mg) inject 1 mg subcutaneously every 24 hours as needed for hypoglycemia over 70. A physician's order dated 12/24/2024, start 11/18/2024, end 1/3/2025 check blood sugar before meals and at bedtime for blood sugar monitoring, notify MD if BS is less than 70 or greater than 400. Interview and record review with APRN #1 on 1/21/2025 at 12:45 PM identified Resident #1 was functional with blood sugars in the 60's and the physician orders should have indicated for hypoglycemia under 70. Interview, record review with ADNS #1 on 1/21/2025 at 2:23 PM identified the orders should have indicated for hypoglycemia under 70, and was unable to explain why the order was entered as over 70. B. Review of the Medication Administration Record identified the following: • (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	On 1/2/2025 Resident #1's blood sugar at 5:39 AM was 57. Glucose Gel was administered at 5:40 AM and noted as ineffective. Repeat blood sugar at 5:55 AM was 61 and Resident #1 was given Glucagon Emergency Injection Kit 1 mg. • On 1/3/2025 at 4:04 PM Resident #1's blood sugar was 56. Review of the Medication Administration Record (MAR) identified Glucose Gel was administered at 4:05 PM. Repeat blood sugar at 4:09 PM was 56. • On 1/6/2025 at 6:20 AM, Resident #1's blood sugar was 66. • On 1/7/2025 at 6:06 AM, Resident #1's blood sugar was 55 and Resident #1 was given Glucagon Emergency Injection Kit 1 MG, at 6:07 AM. Blood sugar was rechecked at 7:02 AM, but failed to identify the results. • On 1/9/2025 at 5:57 AM Resident #1's blood sugar was 44 and Resident #1 was given Glucagon Emergency Injection Kit 1 MG. • On 1/10/2025 at 7:40 PM, Resident #1's blood sugar was 61 and Resident #1 was given Glucose Gel. • On 1/12/2025 at 5:47 AM, Resident #1's blood sugar was 42, and Resident #1 was given Glucagon Emergency Injection Kit 1 MG. Blood sugar was rechecked at 7:01 with results 135. Additional record review failed to identify nursing notes that identified additional steps (additional treatment, results of treatment, notification of provider and if the resident was symptomatic) taken by staff after the low blood sugar levels obtained on 1/2 at, 1/3, 1/6, 1/7, 1/9, 1/10, 1/11 and 1/12/2025. Interview, record review and facility documentation review with ADNS #1 on 1/21/2025 at 2:23 PM failed to identify nursing notes were written when Resident #1 had low blood sugars on the dates above. ADNS #1 stated nursing notes should have been written, and if they were written she would have been aware of it on the 24-hour report and Resident #1 would have been reviewed during the daily Morning Meeting report. ADNS #1 was unable to explain why nursing notes were not written. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075257	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/22/2025
NAME OF PROVIDER OR SUPPLIER: Riverside Health & Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 745 Main St East Hartford, CT 06108	

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility Diabetes Management Protocol Policy directed in part; documentation of all episodes of hypoglycemia must be documented in the medical record, including symptoms observed, blood glucose (sugar) levels before and after treatment, interventions performed, provider notification and any new orders, the resident's response to treatment.