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	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Riverside Health Care Center, Inc.	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 0656 Level of Harm - Minimal harm or potential for actual harm 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. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**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 three (3) residents (Resident #3) reviewed for behaviors, the facility failed to ensure the care plan was reviewed and revised with appropriate interventions to manage behaviors for a resident who expressed suicidal ideations with intent. The findings include:Resident #1 had diagnoses that included suicidal ideation, paranoid schizophrenia, bipolar disorder, hallucinations, psychosis, anxiety, and depression.The physician's orders dated 6/7/2025 directed to monitor the number of behavior occurrences of restlessness, withdrawn, sadness, agitation, intervention, and outcome every shift.The 5-day Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had intact cognition (BIMS score of 15), was occasionally incontinent of bowel, presence of an indwelling foley catheter, dependent with personal hygiene, toileting, required substantial assistance with eating, toileting, required touching assistance with transfers, and independent with bed mobility.The Resident Care Plan (RCP) plan dated 6/18/2025 identified Resident #1 has a behavior problem with suicidal ideation related to paranoia history of multiple hospitalizations due to homicidal and suicidal ideations. Interventions directed to administer medications as ordered, monitor and document side effects and effectiveness, encourage the resident to express feelings appropriately, anticipate and meet the resident's needs, approach and speak in a calm manner, divert attention, remove from an overstimulating environment, caregivers provide the opportunity for positive interaction, attention, stop and talk with h/her as passing by, and assist the resident to develop more appropriate methods of coping and interacting. The care plan failed to identify a concern related to Resident #1's suicidal ideations with intent and include personalized interventions to manage behaviors.The nurse's note dated 6/29/2025 at 11:42 P.M. written by Registered Nurse (RN) #2 identified that Resident #1 verbalized that h/she wanted to hurt h/herself with h/her a weighted silverware knife. RN #2 indicated Resident #1 was alert, verbal, with no evidence of distress and handed the knife over. RN #2 identified the on-call provider was notified and Resident #1 was transferred to the ER for a Psych evaluation.The nurse's note dated 6/30/2025 at 2:01 P.M. written by Licensed Practical Nurse (LPN) #4 identified Resident #1 returned from the hospital with no acute issues noted.Review of the clinical record failed to identify any revisions to the plan of care for Resident #1 on 6/30/2025.Review of APRN #1's note dated 7/1/2025 at 8:00 A.M. identified Resident #1 was seen for follow up visit h/she is back from a recent acute hospitalization for suicidal ideations. APRN #1 indicated Resident #1 exhibits attention seeking behaviors which include placing self on the floor and claiming seizure activity. APRN #1 identified Resident #1 would likely benefit from a structured psychiatric therapeutic environment. The nurse's note dated 7/9/2025 at 11:16 P.M. written by LPN #3 identified at approximately 10:50 P.M. Resident #1 notified LPN #3 that h/she was hearing voices in h/her head telling h/her to kill people. LPN #3 indicated he notified the supervisor, RN #4. The nurse's note dated 7/10/2025 at 12:31 A.M. written by RN #4 identified that Resident #1 was a danger to self or others and a suicidal potential.The nurse's note dated 7/10/2025 at 10:29 P.M. written by RN #2 identified Resident #1 returned to the facility from the hospital post evaluation due to suicidal ideation. RN #2 indicated the psychiatrist cleared Resident #1 and Resident #1 has no intent to harm self or others.Review of the clinical record failed to identify revisions to the plan of care for Resident #1 on 7/10/2025.Interview and clinical record review with the Director of Nursing (DNS) on 8/13/2025 at 10:51 A.M. identified on 6/29/2025 and 7/9/2025 following Resident #1's expressions of suicidal ideations with intent to harm self the care plan was not revised to address and manage the behavior. The DNS identified she was not sure Resident #1's care plan needed to be updated with new intervention and if it needed to be updated, she was not sure why it was not updated.Review of the facility baseline/comprehensive person-centered care plan policy dated 3/2023; in part, identified the comprehensive person-centered care plan will be reviewed and revised episodically, as the plan of care changes, and at the time of hospital readmission to ensure that the plan reflects resident's current status.

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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 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder. (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 0742 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**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 three (3) residents (Resident #1) reviewed for accidents, the facility failed to remove environmental hazards and implement safety interventions for a resident with expressed suicidal ideation and intent. The resident was transferred to the emergency department (ED) 4 times over a 38-day period for expressions of suicidal ideations with intent. The findings include:Resident #1 had diagnoses that included suicidal ideation, paranoid schizophrenia, bipolar disorder, hallucinations, psychosis, anxiety, and depression. Review of the undated Kardex Report identified Resident #1 requires supervision and assistance with self-feeding after set-up with intermittent verbal cues for attention to task with one staff. The physician's orders dated 6/7/2025 directed to monitor the number of behavior occurrences of restlessness, withdrawn, sadness, agitation, intervention, and outcome every shift. The 5-day Minimum Data Set (MDS) assessment dated [DATE] identified Resident #1 had a Brief Interview for Mental Status (BIMS) score of fifteen (15) indicative of intact cognition, was occasionally incontinent of bowel, presence of an indwelling foley catheter, dependent with personal hygiene, toileting, required substantial assistance with eating, toileting, required touching assistance with transfers, and independent with bed mobility.The Resident Care Plan (RCP) plan dated 6/18/2025 identified Resident #1 had a behavior problem with suicidal ideation related to paranoia history of multiple hospitalizations due to homicidal and suicidal ideations. Interventions directed to administer medications as ordered, monitor and document side effects and effectiveness, encourage the resident to express feelings appropriately, anticipate and meet the resident's needs, approach and speak in a calm manner, divert attention, remove from an overstimulating environment, caregivers provide the opportunity for positive interaction, attention, stop and talk with h/her as passing by, and assist the resident to develop more appropriate methods of coping and interacting. The nurse's note dated 6/29/2025 at 11:42 P.M. written by Registered Nurse (RN) #2 identified Resident #1 verbalized that h/she wanted to hurt h/herself with a weighted silverware knife. RN #2 indicated Resident #1 was alert, verbal, with no evidence of distress and handed the knife over. RN #2 identified the on-call provider was notified and Resident #1 was transferred to the ER for a Psych evaluation. The nurse's note dated 6/30/2025 at 2:01 P.M. written by Licensed Practical Nurse (LPN) #4 identified Resident #1 returned from the hospital with no acute issues noted. Review of the clinical record failed to identify any revisions to the plan of care or mitigation of the environmental risk factors for Resident #1 on 6/30/2025. Review of APRN #1's note dated 7/1/2025 at 8:00 A.M. identified Resident #1 was seen for follow up visit secondary to a recent acute hospitalization for suicidal ideations. APRN #1 indicated Resident #1 did not exhibit any evidence of acute psychosis. APRN #1 indicated Resident #1 exhibits attention seeking behaviors which includes placing self on the floor and claiming seizure activity. APRN #1 identified Resident #1 would likely benefit from a structured psychiatric therapeutic environment. The nurse's note dated 7/9/2025 at 11:16 P.M. written by LPN #3 identified at approximately 10:50 P.M. Resident #1 notified LPN #3 that h/she was hearing voices in h/her head telling h/her to kill people. LPN #3 indicated he notified the supervisor, RN #4. The nurse's note dated 7/10/2025 at 12:31 A.M. written by RN #4 identified Resident #1 as a danger to self or others and a suicidal potential. RN #4 identified that Resident #1 was sent out to the emergency room. The nurse's note dated 7/10/2025 at 10:29 P.M. written by RN #2 identified Resident #1 returned to the facility from the hospital after an evaluation due to suicidal ideation. RN #2 indicated the psychiatrist cleared Resident #1 and Resident #1 has no intent to harm self or others. Review of the clinical record failed to identify any revisions to the plan of care or mitigation of the environmental risk factors for Resident #1 on 7/10/2025.The facility's accident and incident report dated 7/22/2025 at 8:05 P.M. identified Resident #1 exited h/her room holding a butter knife and observed rubbing it against h/her wrist while stating h/she wanted to harm h/herself. Resident #1 was immediately placed on one to one, an order obtained to transfer Resident #1 to the ED for evaluation. Review of the clinical record failed to identify the safety risk of Resident #1 having access to knives or silverware on 7/22/2025. The nurse's note dated 7/23/2025 at 1:43 P.M. written by LPN #1 identified Resident #1 returned to from the hospital with a no harm letter. Review of APRN #2's note dated 7/23/2025 at 8:30 A.M. identified Resident #1 was evaluated today after a hospital visit for increased suicidal ideation and self-harm by attempting to cut h/herself with a butter knife as evidenced by superficial scratches to h/her arms. APRN #2 indicated Resident #1 denies any suicidal ideation and was able to commit to safety. APRN #2 identified Resident #1's