Printed: 03/01/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075265	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elim Park Baptist Home, Inc	140 Cook Hill Rd Cheshire, CT 06410

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50179 Based on observations, review of the clinical record, facility policy, and interviews in 1 of 3 dining rooms residents, (Resident #35, Resident #65, and Resident # 430), reviewed for dining services, the facility failed to ensure a dignified dining experience. The findings include: 1. 1. Resident #65's Diagnosis included Alzheimer's dementia, anxiety and depression. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #65 as severely cognitively impaired and required no assistance with eating. Observation on 9/12/24 at 12:15 PM identified Resident # 65 sleeping with his/her lunch meal in front of him/her. NA #4 began assisting Resident #65 with his/her meal and was noted to be standing over, and not at eye level, with the resident. Interview with NA #4 on 9/12/23 at 12:15 PM identified she had been standing over Resident #65 while assisting him/her to eat because her back hurt but subsequent to surveyor inquiry, sat down next to Resident #65 to continue to assist him/her. Interview with Director of Nursing on 9/13/24 at 12:20PM identified that per the facility practice, when NA #4 was assisting Resident #65, she should have been seated and at eye level, not standing over the resident. Review of the Feeding the dependent resident policy failed to identify the position of the caregiver in assisting the resident to eat. 2. a. Resident #35's diagnosis included depression, anxiety, and Parkinson's disease. The quarterly Minimum Data Set assessment dated [DATE] identified Resident #35 was cognitively intact and was independent for eating Interview with Resident #35 on 9/9/24 at 12:32 PM identified that that it took too long to receive his/her meal. b. Resident # 430's diagnosis included pneumonia, and atrial fibrillation. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The admission Minimum Data Set assessment dated [DATE] identified Resident #430 was severely cognitively impaired and did not require assistance with eating. Observations on 9/9/24 at 12:05 PM, identified that although all Resident #430's table mates had been served lunch by 12:05 PM, Resident #430 had not been served until 12:30 PM. Interview with Resident #430's family member identified that it always took too long for Resident #430 to be serviced his/her food. Observations on 9/12/24 at 12:15 PM identified although Resident #430's tablemates received their food by 12:15, Resident #430 had not received his/her meal. Interview with Resident #430s family member on 9/12/24 at 12:15 PM identified he/she had requested a salad to be substituted for lunch at that time as Resident #430 did not like what was on the menu. Further, Resident #430 and his/her family member indicated that it always took staff too long for Resident #430 to be served his/her food and that the family member was upset due to the wait. Observation at 12:30 PM identified Resident #430 had not yet been given his/her salad. Subsequent to surveyor inquiry with the Dietician on 9/12/24 at 12:30 PM she went to the kitchen to check on Resident #430's salad. Resident #430's salad was served to him/her at 12:56 PM (41 minutes) after his/her initial request for a substitution which occurred at 12:15 PM. Interview with NA #4 on 9/12/23 at 12:15 identified that there is always only 1 Dietary Aide available to plate the meal and several NA's delivered and assisted residents with their meals. Interview with Dietician on 9/12/24 at 12:56 PM identified that it took 41 minutes to obtain a salad for Resident #430 because salads are made in the kitchen, so these items take longer to obtain. The Dietician identified that obtaining the food item from the kitchen should take 15 minutes or less and should not take 45 minutes or more to obtain. Additionally, the Dietary Aide that is plating the food being served would be responsible for obtaining the food item from the kitchen as salads were not available in the dining room. Interview with Dietary Operations Manager on 9/12/24 at 1:00 PM identified that it should take 15 minutes to obtain a salad from the kitchen. Additionally, she did not know why it took so long (41) minutes for Resident #430 to receive his/her salad. The Dietary Operations Manager indicated that the Dietary Aide was responsible to ensure that residents receive substitutions. Further, the Dietary Aide plating the food should have stopped plating, left the dining room, went to the kitchen to obtain Resident #430's salad, and then resumed plating meals for the residents who had not yet been served despite making the other residents then wait for their food. Review of the Resident Meal Service policy dated 8/2022 directed, in part, to serve the meal in sequence so all persons at one table are served at the same time. Monitor delivery of meals to Residents to ensure timeliness and appropriateness of service. Additionally, offer all residents participation in meal selection (may include selection of the entire meal or any component of the meal).

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F 0570 Level of Harm - Potential for minimal harm Residents Affected - Some	Assure the security of all personal funds of residents deposited with the facility. 50179 Based on facility documentation and interviews for the Resident Trust Account, the facility failed to ensure the current Surety Bond was sufficient to cover the current total balance amount in the Resident Trust Account. The findings include: A current Resident Trust Account balance statement dated 9/12/24 identified a balance of $73,524.38. Review of the Surety Bond from the insurance group provider, effective 6/4/2024 thru 6/4/2025, was for $10, 000 indicating a shortage of $63,524.38. An interview with Accounts Receivable person on 9/13/24 at 10:06 AM identified she was not aware that the amount of the surety bond was insufficient to cover the Resident Trust Account balance. An interview with the Administrator on 9/13/24 at 12:10 PM identified that the surety bond was for $10,000 and the Resident Trust Account balance was $73,524.38. The Administrator was unaware that the amount of the surety bond was not enough to cover the Resident Trust Account balance and subsequent to surveyor inquiry, was working to obtain a surety bond amount sufficient to cover the balance ($63,524.38) in the Resident Trust Account.

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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** 50179 Based on interviews, review of the clinical record, and facility policy for 1 of 2 residents (Resident #72) reviewed for edema, the facility failed to notify the physician of a weight gain greater than 3 pounds in 1 day, per the physician's order, for a resident with Congestive Heart Failure (CHF). The findings include: Resident #72's diagnoses included unspecified diastolic congestive heart failure, stage 3, chronic kidney disease, and essential hypertension. The admission Minimum Data Set assessment dated [DATE] identified Resident #72 was cognitively intact, independent with eating, and was dependent with toileting, personal hygiene, and transfers. The Resident Care Plan dated 8/14/24 identified Resident #72 had CHF. Interventions included weight monitoring as ordered and to monitor/document/ report signs and symptoms of congestive heart failure such as dependent edema of legs and feet, distended neck veins, and weight gain. A physician's order dated 8/14/24 directed to weigh Resident #72 once daily for CHF and notify the cardiology and the physician or Advanced Practice Registered Nurse (APRN) if the weight was greater than 3 pounds in one day, or greater than or equal to 5 pounds in one week. Review of Resident #72's weights identified that his/her weight was 203.6 pounds on 8/23/24, no weight was recorded for 8/24/24, and on 8/25/24 Resident #72's weight was 208.2 pounds (a 4.6 pound weight gain). Review of the visual/bedside Kardex Report identified Resident #72 was to be monitored for edema including a weight gain of over 2 pounds a day. Interview and record review with Registered Nurse (RN) #1 identified that Nurse Aides were responsible to obtain weights. Additionally, the facility policy for a resident who had a diagnosis of CHF and gained weight was to update the provider with any weight gain of 3 pounds in one day or 5 pounds in one week. RN #1 identified that the nurses progress notes failed to reflect the weight gain or that the physician or APRN was notified but the provider should have been notified per the order. Interview and record review with APRN #1 on 9/11/24 at 11:38 AM identified she would have expected to have been notified of Resident #72's weight gain per the physician's order but she had not been. Further, APRN #1 indicated that she would have expected an RN assessment of Resident #72 to check for swelling, fluid buildup, and lung sounds but during a review of the clinical record/progress notes, she failed to identify nurses or practitioner progress notes addressing the weight gain. Review of the CHF Residents Policy directed in part that residents identified as having congestive heart failure are weighed daily, and the practitioner is notified of a weight gain greater than 3 pounds. 51102

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F 0684

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide appropriate treatment and care according to orders, resident’s preferences and goals.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 50177

Based on obsevations, staff interviews, record reviews, and review of facility policy for 1 of 4 residents (Resident #18) reviewed for nutrition, the facility failed to appropriately supervise a resident during a meal per the meal ticket and failed to obtain weights per the physician's order, for 1 of 3 residents (Resident #53) reviewed for a skin condition the failed to apply TEDS (compression stockings) according to the physician's order, and for 1 of 2 residents (Resident #72) reviewed for edema, the facility failed to obtain a daily weight daily for a resident with Congestive Heart Failure (CHF) per the facility policy. The findings include:

1. Resident #18's diagnoses included dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and moderate protein-calorie malnutrition.

The quarterly Minimum Data Set assessment dated [DATE] identified Resident #18 was severely cognitively impaired, independent with eating, required partial to moderate assistance with bed mobility, and was independent with transfers and ambulation.

The Resident Care Plan dated 6/4/24 identified a problem with nutrition. Interventions included appetite stimulant, nutritional supplement, and monitor intake.

A. A physician's order dated 8/28/24 directed to provide Resident #18 with a regular diet, regular/thin consistency fluids with pre-cut bite sized pieces and assist with 1 staff.

Observations on 9/9/24 at 12:47 PM identified Resident #18 was in the bathroom. Resident #18's meal tray was on his/her over bed table and consisted of a peanut butter jelly sandwich cut diagonally, (not bite-sized), blueberries, and chocolate milk. Resident#18's meal ticket directed supervision at meals and tray set-up. Alerts noted on the meal ticked included aspiration precautions, assist of one, and pre-cut bit size portions.

Observation on 9/9/24 at 12:59 PM identified Resident #18 sitting on the side of bed, eating unsupervised. The peanut butter and jelly sandwich was not cut into bite sized pieces and was diagonally cut. The nurse consultant immediately summoned the nurse.

Observation and interview with LPN #1 on 9/9/24 at 1:02 PM identified Resident #18's meal ticket directed supervision at meals and tray set-up. Alerts for aspiration precautions, assist of 1, and pre-cut bite sized portions was written on the meal ticket. LPN #1 stated that due to the information on the meal ticket, Resident #18 required supervision during his/her meal intake and indicated that she would remain with the resident to supervise the meal until relieved by another staff member.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation and interview with NA #2 on 9/9/24 at 1:05 PM identified that she was not aware that Resident #18 required supervision at meals, was an assist of one, was on aspiration precautions, or required bit sized food. NA #2 stated she had delivered the residents tray and only looked at top portion of the slip which noted double portions and failed to read supervision at meals, aspiration precautions, assist of 1 staff, or the pre-cut bite size portions. NA #2 indicated that when she looked at her Resident Care Card (Resident Care Assignment) there was no indication that Resident #18 required supervision, assistance, was on aspiration precautions or needed his/her food cut to bite sized pieces. NA #2 identified that the Resident Care Card was how she knew to care for Resident #18 despite what the meal ticket directed. A subsequent observation on 9/10/24 at 12:34 PM identified that Resident #18's meal ticket still directed supervision of the meal, aspiration precautions, assistance of 1 staff and bite sized pieces. The resident was alone in the room with his/her meal and was eating. Interview with Director of Dietary on 9/12/24 at 1:15 PM identified that her understanding of the policy was if a resident had supervision at meals on his/her meal ticket, then a staff member was to always be with that resident during the meal. Interview with Speech Pathologist on 9/13/24 at 10:30 AM identified that if a residents meal ticket stated supervision, aspiration precautions, and assistance of 1 staff, then a staff member should always stay with that resident when food was available. Interview with Director of Nursing Services on 9/13/24 at 12:39 PM identified that if a resident meal ticket directed supervision, then a staff member should always stay with that resident when food was available. If there was a question about the orders on the meal ticket, then it should be brought to attention of charge nurse, but staff should have remained with Resident #18 until the order could be verified. B. A physician's order dated 6/30/24 directed facility staff weight Resident #18 weekly for 4 weeks. A review of the electronic health record identified although weights were ordered by the physician to be taken on 7/3/24, 7/10/24, 7/17/24 and 7/24/24, weights were only obtained on 7/3/24 and 7/10/24. Interview with LPN #1 on 9/12/24 at 8:10 AM identified that Resident #18's physician directed that weekly weights be obtained every week and that only 2 of the 4 weights on 7/3/24 and 7/10/24 had been completed. LPN #1 was unable to identify why the weights were not taken, but should have been. Review of the Resident Weights and Weight Changes policy dated 3/23/2023 directed, in part, weights may be done more frequently, such as weekly or daily, per the physician order, as a nursing measure, or as a dietician recommendation. 2. Resident #53's diagnoses included heart failure, atrial fibrillation (irregular heartbeat), and abnormalities of gait and mobility. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The annual Minimum Data Set assessment dated [DATE] identified Resident #53 was moderately cognitively impaired and required partial/moderate assistance with toileting hygiene and personal hygiene, and walking was not attempted. The Resident Care Plan dated 8/5/24 identified Resident #53 had an altered cardiovascular status related to heart failure and atrial fibrillation. Interventions included diet consult as necessary and to monitor vital signs per protocol. A Nurse Aide (NA) Resident Care Card (Resident Care Assignment) in effect from 9/1/24 through 9/9/24 and last updated 3/27/24 directed TEDS to be applied on Resident #53 in the morning and to be removed in the evening. The physician orders in effect from 9/1/24 through 9/9/24 directed TEDS to be applied on Resident #53 in the morning and to be removed in the evening. Observations on 9/9/24 at 11:49 AM, 9/10/24 at 12:14 PM, 9/11/24 at 10:40 AM, 9/12/24 at 9:27 AM, and 9/12/24 at 1:47 PM identified that Resident #53 was not wearing TEDS. The Electronic Treatment Administration Record (ETAR) from 9/1/24 through 9/12/24 identified that TEDS were signed as being applied on all dates, except for 9/1/24 and 9/10/24. Interview, clinical record review, and observation with LPN #3 on 9/12/24 at 1:47 PM identified that Resident #53 was not wearing TEDS despite having a current order for TEDS to be worn daily. LPN #3 further indicated that the overnight nurse (LPN #6) had documented on the ETAR that the TEDS were applied in the morning on 9/12/24. LPN #3 identified that the overnight nurses were responsible for applying the TEDS and documenting on the ETAR since the application time for the TEDS was 6:00 AM. Interview and clinical record review with LPN #6 on 9/12/24 at 2:18 PM identified that she had documented on the ETAR that the TEDS were applied in the morning on 9/9/24, 9/11/24, and 9/12/24 despite not having applied the TEDS on Resident #53. Additionally, LPN #6 indicated that the overnight NAs were responsible for applying the TEDS and advising the nurse if the resident refused to wear the TEDS. Interview with the overnight NA #6 on 9/12/24 at 2:49 PM identified that he did not apply the TEDS to Resident #53 and that the day NAs were responsible for applying the TEDS. Interview and observation with the day NA #7 on 9/13/24 at 10:00 AM identified that Resident #53 was wearing TEDS. Additionally, NA #7 identified that she had not applied the TEDS to Resident #53 on any days before the morning of 9/13/24 because she was unaware that Resident #53 had to wear TEDS daily. NA #7 further indicated that Staff Development had told her the morning of 9/13/24 that Resident #53 had to wear TEDS daily and provided NA #7 with a pair of TEDS for Resident #53 to wear. Subsequent to surveyor inquiry, the TEDS order was changed on 9/13/24 from an application time of 6:00 AM to an application time of 8:00 AM per Resident #53's request. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with the Director of Nursing Services on 9/12/24 at 2:41 PM identified that there was no policy for application of TEDS stockings, but in lieu of a policy, it would be expected that TEDS be applied per the physician's order and that the nurses would verify the application of the TEDS since the nurses were responsible for the TEDS documentation on the ETAR. 3. Resident #72's diagnoses included unspecified diastolic congestive heart failure, stage 3 chronic kidney disease, and essential hypertension. The admission Minimum Data Set assessment dated [DATE] identified Resident #72 was cognitively intact, was independent with eating, and was dependent with toileting, personal hygiene, and transfers. A physician's order dated 8/1/24 directed to monitor Resident #72 one time a day for signs and symptoms of fluid overload, including weights trending up, and notify the physician or Advanced Practice Registered Nurse (APRN) of abnormalities. A physician's order dated 8/14/24 directed to weigh Resident #72 one time a day for CHF and notify cardiology and the physician or APRN if the weight was greater than 3 pounds in one day, or greater than or equal to 5 pounds in one week. The Resident Care Plan dated 8/14/24 identified the resident had congestive heart failure. Interventions included weight monitoring as ordered and to monitor/document/report signs and symptoms of congestive heart failure such as dependent edema of legs and feet, a distended neck vein, and weight gain. Review of the Electronic Medication Administration Record (EMAR) identified that Resident #72's weights were documented as completed during the time period of 8/1/24 to 9/12/24. Review of the clinical record failed to identify weights were recorded on 8/9/24, 8/15/24, 8/24/24, 8/26/24, 8/30/24, 9/5/24, 9/6/24, 9/7/24, 9/8/24, 9/9/24, and 9/10/24 (11 of 43 missed opportunities, 25%). Additionally, the clinical record failed to identify if Resident #72 refused to be weighed on any of these days. Review of the visual/bedside Kardex Report (Resident Care Card/Resident Care Assignment) identified Resident #72 was to be monitored for weight gain of over 2 pounds a day. Interview and record review with Registered Nurse (RN) #1 on 9/11/24 at 10:34 AM identified that the Nurse Aide (NA) was responsible for obtaining the weight for Resident #72, documenting the weight in the computer, and verbally reporting to the nurse. Record review failed to identify that weights were done daily, but should have been. Interview and record review with APRN #1 on 9/11/24 at 11:38 AM identified weights were not done daily as ordered, furthermore APRN #1 stated the weights were not being done because the resident was COVID positive, therefore the resident's weights were on hold. Review of the clinical record failed to identify the daily weights order was on hold. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Interview with Nurse Aide (NA) #1 on 9/12/24 at 12:59 PM identified she knew to obtain a resident's weight when she was told by her nurse, weights were done rotating odd and even days on Wednesdays, and that either the total mechanical lift or wheelchair was used to weigh residents. Review of the CHF Residents Policy directed in part that residents identified as having Congestive Heart Failure are weighed daily, and the practitioner is notified of a weight gain greater than 3 pounds. Review of the Resident Weight and Weight Changes Policy dated 3/22/23 directed for regular monitoring of weights to screen residents for significant weight changes. 50179 51101 51102

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48950 Based on staff interview, clinical record review, and facility policy for 1 of 5 sampled residents (Resident #63) reviewed for unnecessary medications, the facility failed to ensure an as needed (PRN) psychotropic medication was limited to 14 days per the requirement. The findings include: Resident #63's diagnoses included dementia, hypertension, and a fractured left femur. The admission Resident Care Plan dated 7/8/24 identified Resident #63 was taking a psychotropic medication, Trazodone, (an antidepressant). Interventions included to monitor Resident #63 as related to behavior, cognition, and mood. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #63 was severely cognitively impaired and required extensive assistance of 2 for bed mobility, limited assistance of 2 for transfers, set up/supervision for eating, and that an antidepressant was in use. The physician orders dated 7/8/24 through 8/1/24 directed Trazodone 50 milligrams (mg), administer 0.5 mg every 8 hours as needed for agitation, but failed to include a medication stop date. A pharmacist recommendation dated 7/29/24 identified that Trazodone was required to be reevaluated after 14 days of use and that if therapy was to continue beyond 14 days, to please note the medical justification for the continued use in a progress note and specify the number of days the as needed medication order was to continue. Review of facility census records indicated that Resident #63 was discharged on [DATE] and readmitted to the facility, after a medical leave, on 8/2/24. The readmission physician orders dated 8/2/24 through 9/12/24 directed Trazodone 50 mg, administer 0.5 mg every 8 hours as need for agitation but failed to reflect a stop date. Review of the Medication Administration Record (MAR) dated 8/2/24 to 9/12/24 directed Trazodone 50 mg, administer 0.5 mg every 8 hours as needed for agitation but failed to reflect a stop date. An interview with APRN #1 on 9/12/24 at 1:39 PM identified that Resident #63's order for Trazodone should have only been place for 14 days and that the lack of a stop date when Resident #63 returned from the medical leave on 8/2/24 was an error. APRN #1 identified that all psychotropic medication that were ordered PRN required a stop date which cannot exceed 14 days. Subsequent to surveyor inquiry, Resident #63's order for Trazodone was re-written to include a stop date after 14 days. The facility Psychotropic Medication policy dated 3/22/23 identified that as needed orders for psychotropic drugs are limited to 14 days. If the physician believed that the as needed order should be extended beyond the 14 days, the physician must document a rationale in the medical record.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 51102 Based on a tour of the Dietary Department, interviews and facility documentation, the facility failed to provide lunch at appropriate and appetizing temperatures. The findings included: Interview with Resident #27 on 9/9/24 at 1:38 PM identified that vegetables were always cold. Interview with Resident #58 on 9/9/24 at 11:24 AM identified that the food was not hot and some of the food was overcooked, especially the vegetables that are mushy. Interview with Resident #72 on 9/9/24 at 11:55 AM identified that food was often cold. Interview with the Dietary Manager on 9/12/24 at 11:40 AM identified the process to ensure foods were served hot included the cook taking temperatures before taking the food out of the oven, checking the holding temperatures in the hot box, and taking the temperatures of the food when it was being plated. Interview and review of the temperature log with [NAME] #2 on 9/12/24 at 11:45 AM identified cooking temperature were recorded for service dates 9/1/24 to 9/11/24, but the log failed to identify temperatures in the hot box and plated temperatures. In addition, [NAME] #2 identified that two food trucks had already been sent to the units for lunch, he had only checked food oven temperatures, and he was unaware of the requirement to check food temperatures once the food had been plated. On 9/12/24 at 12:01 PM, a test tray for appropriate temperatures was conducted with the Dietary Manager. The lunch meal was plated in the Residential Care (RCH) dining room that serves the resident's residing on the East Wing (residents residing on the sub acute unit). At 12:35 PM, the meal truck arrived on East Wing at 12:39 PM, and at 12:39 PM 3 Nurse Aides were observed to begin passing out the meal trays to residents. The last tray was delivered at 12:43 PM, temperatures were conducted with the Dietary Director at that time, and identified the following: a. The kielbasa's internal temperature was 118.2 degrees Fahrenheit from the surveyor's thermometer and 116 degrees Fahrenheit from the Dietary Manager's thermometer. The Dietary Manager identified the internal temperature should be 145 degrees Fahrenheit. b. The roast beef internal temperature was 132.4 degrees Fahrenheit from the surveyor's thermometer and 130 degrees Fahrenheit from the Manager's thermometer. The Dietary Manager identified the internal temperature should be 145 degrees Fahrenheit. c. The mashed potato internal temperature was 143 degrees Fahrenheit from the surveyor's thermometer and 142 degrees Fahrenheit from the Dietary Manager's thermometer. The Dietary Manager identified the internal temperature should be 165 degrees Fahrenheit. An interview with the Dietary Manager on 9/12/24 at 12:46 PM identified that temperatures for the lunch tray were low because these foods just don't hold their temperature, and she planned on redoing the menus to include items that hold their temperature better. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 075265	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elim Park Baptist Home, Inc	140 Cook Hill Rd Cheshire, CT 06410

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the policy and procedure on Meal Assembly Procedures and Taste/Temperature Record dated 8/22 identified all food items are monitored for temperature and listed on the taste/temperature log.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51102 Based on the tour of the Dietary Department, interviews and facility documentation, the facility failed to ensure open items were dated, failed to identify expiration dates, failed to ensure food was served under sanitary conditions, and failed to ensure correct dishwasher temperatures. The findings included: During a tour of the Dietary Department on [DATE] at 9:15AM with the Dietary Manager and Sous Chef the following was identified: 1a. The walk-in refrigerator was noted to contain an opened 5 pound bag of cheddar cheese (,d+[DATE] full), wrapped with plastic cling, with no date when opened, an opened 5 pound bag of cheddar cheese (, d+[DATE] full), wrapped in plastic, with no open date, an opened 5 pound bag of cheddar cheese (,d+[DATE] full), wrapped in plastic with no open date, an opened 5 pound bag of blue cheese (,d+[DATE] full), wrapped in plastic, with no open date and an opened 5 pound bag of blue cheese (,d+[DATE] full), wrapped in plastic with no open date, an opened 5 pound bag of parmesan cheese (,d+[DATE] full), wrapped in plastic, with no open date and an opened 5 pound portion of pepper jack cheese (,d+[DATE] full), wrapped in plastic, with a white substance accumulating on one end of the cheese, with no open date. In order to observe the expiration date on the packages, the packages had to be completely unwrapped. b. The walk-in refrigerator was noted to contain an opened plastic container of salsa (,d+[DATE] full), with no open date, a second opened plastic container of salsa (,d+[DATE] full) with no open date, an opened jug of BBQ sauce (,d+[DATE] full) with no open date, and an opened jug of hot sauce (,d+[DATE] full) with no open date. c. The first 2-door reach in cooler was noted to have heavy splatter stains on both outer doors. The reach in cooler was noted to contain an unopened 2 pound package of fresh broccoli which contained water and a yellow liquid on the bottom of the bag with no expiration date, 2 metal pans with pureed egg (about 2 pounds) unlabeled, a metal pan with pureed pork (8 ounces) labeled [DATE], a metal pan with pureed oatmeal (8 ounces) unlabeled, a metal pan with pureed pancake (1 pound) unlabeled, and a 2 inch metal hotel pan full of French toast that unlabeled as to when the food was placed in the pans. d. The shelving unit next to the 2-door reach in cooler was noted to contain an opened 5-pound bag of egg noodles (,d+[DATE] full), wrapped in plastic with no date identified for the date it was opened and in order to view the expiration date, the package needed to be completely unwrapped. e. The second 2-door reach in cooler was noted to contain a full metal pan of pureed chicken dated , d+[DATE], a 5-pound bag of breakfast sausage patties (,d+[DATE] full) with no open date and no expiration date, and a teal colored 32 ounce water bottle (10 ounces full of liquid) identified by the Sous Chef to be a personal water bottle that belonged to one of the weekend cooks. f. The soap dispenser next at the hand washing station was noted to have a large brown colored stain on the dispenser. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	g. A 25-pound plastic container with thickening powder (half full) was noted to be opened, with no open date or expiration date on the container and heavily soiled on the outside. h. Three 50-pound plastic containers were noted to be splattered and dirty on the exterior, one contained flour with no date as to when the flour was opened and placed in the container or expiration date, one contained panko crumbs with no open date or expiration date, and one with sugar noted to be clumpy with a date of ,d+[DATE]. i. The ice machine door was noted to be open, no scoop was identified in the scoop holder, and the scoop was located stored on a kitchen counter (not covered) across the kitchen. j. On [DATE] at 9:10 AM a walk-through of the dry stock room with the Dietary Manager identified a 25-pound plastic container, unlabeled with a tan powdery substance (,d+[DATE] full) that could not be identified by the Dietary Manager, a 25-pound plastic container with rice flour (,d+[DATE] full) with no open date to identify when the rice flour was put in the container and failed to identify an expiration date, a 25-pound plastic container with semolina (,d+[DATE] full) with no open date to identify when the semolina was put in the container and failed to include an expiration date and a 25 pound plastic container with clam fry (,d+[DATE] full) powder with no open date to identify when the clam fry powder was put in the container and failed to include an expiration date. An opened 10-pound bag of bowtie pasta (,d+[DATE] full) in plastic wrap that lacked a date when opened, an opened 10-pound bag of spaghetti (,d+[DATE] full) in plastic wrap that lacked a date when opened, an opened 10 pound bag of penne pasta (,d+[DATE] full) in plastic wrap with no open date, and an opened 10 pound bag of tavolini pasta (,d+[DATE] full) in plastic wrap with no date when opened. Interview with the Sous Chef on [DATE] at 11:08 AM identified the cooks were responsible for checking the food labels daily and labeling food after it is opened. Interview with the Dietary Manager on [DATE] at 9:10 AM identified that the stock person oversees the dry stock and removing expired items, but currently that position was not filled, and the Sous Chef was intermittently filling in for the position. She further identified the pureed pork dated ,d+[DATE] and pureed chicken dated ,d+[DATE] should have been discarded within 3 days of being stored in the refrigerator. Subsequent to surveyor observation, the container of pureed pork and chicken were discarded by the Dietary Manager. Review of the Labeling Food for Storage Policy identified that by accurately and completely labeling all food for storage, you can minimize the risk of foodborne illnesses. In addition, the label must include following; the name of the product, the date the product was opened, the time the label is completed, the date the product will expire and the initials of the person who completed the label. 2. Observation of the Dietary prep area on [DATE] at 11:25 AM identified [NAME] #1 wearing gloves, plating BLT sandwiches, a personal cell phone was noted to be laying on the counter next to the open bacon. When prompted about phone being on the counter, [NAME] #1 picked it up with her gloved hand and threw it on another counter, then continued to plate the sandwiches without the benefit of hand hygiene or changing her gloves. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview with the Dietary Manager on [DATE] at 11:09 AM identified per policy no phones or personal belonging should be out on the counter, if an emergency arises gloves should be taken off, then upon return perform hand hygiene and apply new gloves. Interview with the [NAME] on [DATE] at 11:32 AM identified she was aware of the policy on personal belongings on the counter but was waiting for an emergency phone call. She identified she should have kept the cell phone in her pocket, taken off her gloves, washed her hands and taken the call outside of the kitchen. 3a. On [DATE] at 9:30 AM a tour of the dish room with the Dietary Manager identified the gauges on the dish machine that the wash the healthcare units dishes identified the wash temperature read 146 degrees Fahrenheit, the rinse read at 159 degrees Fahrenheit, and final sanitizing read rinse 180 degrees Fahrenheit. Per the manufacturer guidelines posted on the dish machine, washing temperature was to reach 150 degrees Fahrenheit, rinse was to reach 160 degrees Fahrenheit, and final sanitizing rinse was to reach 180 degrees Fahrenheit. b. Observation of the dish room for the healthcare machine on [DATE] at 9:30 AM identified Dietary Aide (DA) #1 removed her gloves after handling the dirty dishes, then applied new gloves to handle the clean dishes without the benefit of hand hygiene in between glove changes. She then stacked wet hot plates and wet hot lids without the benefit of air drying them before storing them. Interview with the DA #1 on [DATE] at 9:40 AM identified that she took off her dirty gloves and applied a clean pair without the benefit of hand hygiene because she believed the gloves were not dirty since she was working with water and was not aware wet dishes should not be stacked Interview with the Dietary Manager on [DATE] at 9:35 AM identified she was not sure if the temperatures were accurate and stated the Dish Washing staff was responsible for the temperatures. She identified that many times they put a thermometer though to check the temperatures, and do not utilize the gauges on the machine. The thermometer provided by the Dietary Manager read 150 degrees Fahrenheit, but the Dietary Manager was unable to identify if the temperature shown was for the wash, rinse, or sanitize temperatures. Interview and Dish Machine Temperature Record review with the Dietary Manager on [DATE] at 9:40 AM identified that temperatures were supposed to be checked at breakfast, lunch, and dinner on both dish machines. Review of the temperature logs for the Healthcare Dish Machine and the Pots and Pans Dish machine noted the temperatures were last documented on [DATE] at 8:00 AM (there was no documentation of temperatures taken for [DATE], [DATE] and [DATE]). Interview with Dish Washer #1 on [DATE] at 9:45 AM identified she was only responsible for taking the temperatures on the dishwasher used for the pots and pans, and checks them at 12:00 PM, and the person working the healthcare dish machine was responsible for taking the temperatures for that machine. Interview with DA #1 on [DATE] at 9:40 AM identified that she did not check the dishwasher temperatures for the healthcare dishwasher, and that was the responsibility of the person assigned as the Dish Washer. Furthermore, she identified she took off her dirty gloves and applied a clean pair without the benefit of hand hygiene because she believed the gloves were not dirty since she was working with water and was not aware wet dishes should not be stacked. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the policy and procedure on Handwashing dated ,d+[DATE] identified hands should be washed at the kitchen hand sink station with soap and water after removing gloves. Review of the policy and procedure on Dish Machine Temperatures dated ,d+[DATE] identified a single tank conveyor machine wash temperature should be 150 degrees Fahrenheit, and the final rinse should be 180 degrees Fahrenheit. In addition, a High Temperature Dish machine was to have temperatures recorded during each period of use.