STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075288	A. Building B. Wing	07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairview	235 Lestertown Rd Groton, CT 06340

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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 0609 Level of Harm - Potential for minimal harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48950 Based on review of staff interviews, review of the clinical records, facility documentation, and facility policy for two sampled residents (Residents #50 and Resident #55) reviewed for a resident to resident altercation, the facility failed to notify Adult Protective Services (APS) of the altercation. The findings include: 1. Resident #50's diagnoses included dementia, insomnia, and anxiety. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #50 was moderately cognitively impaired, required supervision/touching assist for eating, oral hygiene, transferring, and personal hygiene, and partial moderate assist for toilet hygiene. The Resident Care Plan (RCP) dated 5/2/24 identified Resident#50 was at risk of wandering. and had insomnia. Interventions included to identify patterns of wandering, distract the resident from wandering and to communicate resident's potential for wandering to staff at the unit, try to improve sleep, preferred hours of sleep routine, decrease noise level after, and maximize daily activities. 2. Resident #55's diagnoses included dementia, contracture (prevents normal movement), and weakness. The quarterly MDS assessment dated [DATE] identified Resident #55 was severely cognitively impaired, dependent on staff for oral hygiene, eating, toileting, personal hygiene, and dressing, requiring the assist of 2 for transfers with a mechanical lift. The Resident Care Plan dated 5/15/24 identified Resident #55 was at risk for falls related to dementia, and poor safety awareness. Interventions included to anticipate and meet the resident's needs, be sure that Resident #55's call light was within reach and encourage the resident to use it. (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 0609 Level of Harm - Potential for minimal harm Residents Affected - Some	A Reportable Event form dated 5/21/24 identified at 12:45 AM, Licensed Practical Nurse (LPN) #7 heard yelling down the hall get out of my bed. LPN #7 told Nurse Aide (NA) #1 that she would be right back as she headed down the hall from the nurse's station. LPN #7 was walking by Resident #50's room and it was empty. LPN #7 followed the yelling and observed Resident #50 trying to pull Resident #55 out of bed by squeezing and shaking Resident #55's head. Resident #55 was contracted, and his/her legs were hanging off the side of the bed. LPN #7 identified that the railing held Resident #55 in bed. Both residents were immediately separated and assessed. Resident #55 had 2 discolored areas noted, 1 to his/her left eye and the other to the left side of his/her face. LPN #7 returned Resident #50 to his/her room with assistance, was placed on one-to-one supervision, Psychiatric and Social Services were provided. Interview with LPN #7 on 7/10/24 at 2:02 PM identified on 5/21/24 that Resident #50 had been wandering and that they had placed her/him near the nurse's station. LPN #7 identified that she heard yelling, and that Resident #50's room was empty and found her/him in Resident #55's room. LPN#7 identified that Resident #50 was attempting to pull Resident #55 out of bed while yelling get out of my bed. LPN #7 reported the occurrence to the supervisor and a motion sensor was placed at Resident #50's doorway. Additional review of the Reportable Event form dated 5/21/24 at 12:45 AM failed to identify Adult Protective Services were notified of the resident to resident altercation. Interview with the Director of Nursing Services (DNS) on 7/11/24 at 10:33 AM identified she did not feel the situation warranted notifying Adult Protective Services and that she had never notified Adult Protective Services in the past when the situation involved a resident to resident alteration even though the facility policy identified that the agency should be notified within 3 days. The DNS identified she was unaware of the state guidelines regarding notifying Adult Protective Services. Facility's Resident Abuse policy identified reporting requirements include notifying Adult Protective Services within 3 days.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50249 Based on observations, staff interviews, review of the clinical record, facility documentation, and facility policy, for the only sampled resident reviewed (Resident #43) for physical restraints, the facility failed to revise the Resident Care Plan (RCP) upon initiation of a resident's clip alarm. The findings include: Resident #43's diagnoses included vascular dementia, history of transient ischemic attack/cerebral infarction and primary open angle glaucoma. The Nurse Aide (NA) Assignment sheet, last updated on 4/8/24, failed to identify a bed/chair tab alarm under the area of Safety Devices. The annual Minimum Data Set (MDS) assessment dated [DATE] identified Resident #43 was moderately cognitively impaired and dependent with transfers, bed mobility and toileting. The MDS further indicated that a bed alarm and chair alarm were not used and that the resident had two or more falls since his/her last assessment. The Resident Care Plan (RCP) dated 6/30/24 identified Resident #43 had a history of falls with interventions that included a floor mat on the left side of the bed and a Dycem under the wheelchair cushion. The RCP failed to identify a clip alarm was utilized as an intervention. Observations on 7/9/24 at 1:50 PM and 7/11/24 at 10:40 AM identified Resident #43 seated in his/her bedside chair with a clip alarm in place. The alarm box was placed on the side of the top drawer of Resident #43's bedside table and the alarm clip was attached to Resident #43's sweatshirt. Interview, observation and review of facility documentation with NA #4 on 7/11/24 at 10:50 AM identified Resident #43 was a fall risk and the clip alarm was used on both his/her bed and chair. NA #4 demonstrated setting off the alarm and indicated that it was attached to Resident #43's sweatshirt. Additionally, NA #4 identified that she would refer to Resident #43's NA care card to determine if Resident #43 required a clip alarm. NA #4 then reviewed Resident #43's NA care card but could not find documentation for the clip alarm. NA #4 further indicated that the NA care card should have been updated by the nursing supervisor. Interview, observation and review of facility documentation with RN #1 on 7/11/24 at 11:00 AM identified that Resident #43 had a clip alarm in place and that the alarm clip was attached to Resident #43's sweatshirt. RN #1 indicated that nursing staff would know to place the alarm on Resident #43 by reviewing the NA care card and RCP. RN #1 then reviewed Resident #43's NA care card, however could not find documentation for the clip alarm. Additionally, RN #1 identified that it would have been the responsibility of the nursing supervisor to update the NA care card and would notify the nursing supervisor to update the NA care card updated. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview and review of facility documentation and clinical record with the DNS on 7/15/24 at 10:50 AM identified Resident #43 required a clip alarm due to a history of falls, but she was unsure of the date the clip alarm was initiated. The DNS indicated that the resident's clip alarm had been put in place to alert staff when Resident #43 was possibly getting out of his/her bed or chair unassisted. Additionally, although the DNS identified that the need to use the clip alarm for Resident #43 should have been on his/her NA care card and in his/her RCP, review of facility documentation failed to alert staff to the need for a clip alarm. The DNS was unable to state the reason the use of the clip alarm was not added to Resident #43's NA care card and RCP, but that it was the responsibility of the nursing staff who had implemented the use of the clip alarm to update the documentation to ensure all staff knew Resident #43 required an alarm. Subsequent to surveyor inquiry, Resident #43's clip alarm was removed/discontinued by the facility. Review of the facility's Comprehensive Care Plan policy, dated 4/28/22, directs that qualified staff responsible for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out the interventions, initially and when changes are made.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50249 Based on observations, staff interview, review of the clinical record, facility documentation, and facility policy for the only sampled resident (Resident #28) reviewed for activities of daily living, the facility failed to ensure Resident #28's fingernails were clean and trimmed. The findings include: Resident #28's diagnoses included unspecified dementia, cognitive communication deficit and weakness. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #28 was moderately cognitively impaired and dependent with transfers, toileting and personal hygiene. The Resident Care Plan (RCP) dated 6/26/24 identified Resident #28 had deficits in activities of daily living (ADL's) and mobility related to weakness. Interventions included to set-up and assist resident as needed for morning/evening (am/pm) care. The RCP further identified that Resident #28 had a potential for impairment to skin integrity related to decreased mobility with interventions to avoid scratching and keep fingernails short. Observation and interview with Resident #28 on 7/9/24 at 12:48 PM identified that his/her fingernails on both hands were unclean, lengthy, and longer than he/she preferred. Resident #28 indicated that the Nurse Aides (NAs) had not cut his/her fingernails in the last few weeks and that he/she was going to ask them to cut them this week. Observation and interview with Licensed Practical Nurse (LPN) #1 on 7/10/24 at 11:30 AM identified that Resident #28's fingernails on both hands were lengthy and unclean. LPN #1 further indicated that Resident #28's fingernails should have been cleaned and trimmed on his/her last shower day and that she would make Resident #28's assigned NA aware to get them trimmed and cleaned. Additionally, LPN #1 identified that Resident #28's weekly shower day was Saturday on the 3:00 PM to 11:00 PM shift and that the assigned NA for the shower would have been responsible to trim and clean Resident #28's fingernails with his/her shower. Subsequent to surveyor inquiry, observation and interview of Resident #28 on 7/11/24 at 1:40 PM identified that his/her fingernails on both hands were clean and trimmed. Resident #28 further indicated that it was nice to finally have them cut. Interview and review of facility documentation with NA #7 on 7/11/24 at 1:49 PM identified that NA #8 was assigned to Resident #28 on Saturday 7/6/24 for the 3:00 PM to 11:00 PM shift. NA #7 further identified that NA #8 would have been responsible for Resident #28's shower and nail trimming on that shift. NA #7 further indicated she could not find documentation from NA #8 as to the reason Resident #28's fingernails were not cleaned and trimmed on the shower day of 7/6/24. Attempts to contact NA #8 were unsuccessful. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility policy on Nail Care, dated 10/10/23, directed that routine cleaning and inspection of nails would be provided during ADL care and on an ongoing basis. In addition, the policy indicated that routine nail care, to include trimming and filing, would be provided on a regular schedule with weekly bath day.

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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** 50177 Based on observations, interviews, facility policy, and review of the clinical record for 2 of 3 residents (Resident #6 and Resident #25) reviewed for skin conditions, the facility failed to follow physician orders regarding the application of compression stockings and heel offloading. Additionally, for 1 of 3 sampled residents (Resident #25) reviewed for pressure ulcers, the facility failed to complete weekly skin assessments 2 of 4 weeks. Also, for 1 of 3 residents (Resident #82), reviewed for nutrition, the facility failed to follow a physician's order for 1-to-1 assistance with eating for a dependent resident. The findings include: 1. Resident #6's diagnoses included cerebral infarction (stroke), hyperlipidemia, hypertension, and altered mental status. A Nurse Aide (NA) care card dated 4/19/24 directed TED (thrombo-embolic deterrent) hose to be applied on Resident #6 in the morning and to be removed in the evening. A significant change Minimum Data Set assessment dated [DATE] identified Resident #6 was severely cognitively impaired, was dependent with toileting hygiene and showering/bathing self, and required partial/moderate assistance with personal hygiene. A physician's order dated 5/7/24 directed compression stockings to be applied on Resident #6 in the morning and to be removed in the evening. The Resident Care Plan dated 5/23/24 identified Resident #6 was at risk for an altered cardiovascular status related to hypertension, hyperlipidemia, embolic stroke, and the presence of a cardiac monitor. Interventions included to administer medications per physician's orders and to wear compression stockings as ordered. Observations on 7/8/24 at 12:40 PM, 7/9/24 at 11:06 AM, 7/10/24 at 12:20 PM, and 7/11/24 at 10:59 AM identified that Resident #6 was not wearing compression stockings. The Electronic Medication Administration Record (EMAR) for the month of June 2024 identified that compression stockings were signed as being applied on all dates. Review of the EMAR for 7/1/24 through 7/11/24 identified that compression stockings were signed as being applied (despite on 7/8/24, 7/9/24, 7/10/24 and 7/11/24, Resident #6 was not wearing compression stockings). Interview, clinical record review, and observation with RN #4 on 7/11/24 at 11:07 AM identified that Resident #6 was not wearing compression stockings despite having a current order for compression stockings to be worn daily. Additionally, RN #4 had signed for the application of the compression stockings on 7/11/24 despite Resident #6 not wearing any compression stockings. RN #4 identified that the NA would apply the compression stockings on Resident #6. RN #4 further indicated she would change her documentation on the EMAR for 7/11/24 since the compression stockings were not observed on Resident #6. Subsequent to surveyor inquiry on 7/11/24, compression stockings were discontinued by the physician. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Although requested, a facility policy for compression stockings was not provided. Interview with the Director of Nursing Services on 7/11/24 at 1:48 PM identified that in lieu of a policy, it would be expected that compression stockings be applied per the physician's order. 2. Resident #25's diagnosis included stroke, peripheral artery disease, and diabetes mellitus. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #25 had intact cognition, required partial/moderate assistance for bed mobility, and was at risk for developing pressure injuries. The Resident Care Plan (RCP) dated 4/17/24 identified Resident #25 as having the potential for impairment to skin integrity related to impaired mobility, history of pressure wound, and diabetes mellitus. A physician's order dated 5/14/24 directed facility staff to elevate and offload Resident #25's right heel while in bed, at all times and for facility staff to not place a pillow under the left limb to prevent contracture. a. Observation on 7/9/24 at 8:55 AM identified Resident #25 in bed asleep with his/her right heel flat on the mattress. The foot of the bed was noted to be elevated. Subsequent observations on 7/9/24 at 9:20 AM, 9:33 AM, 9:48 AM, 10:03 AM, 10:15 AM, 10:28 AM, 10:43 AM, 11:00 AM, 11:15 AM and 11:30 AM, identified Resident #25's position remained unchanged. Interview with NA #5 on 7/9/24 at 11:15 AM identified the NA care card included handwritten instructions including the symbol circle with a line through it, (signifying without) but she was unaware of the meaning of the symbol. NA #5 was unaware of what the initials AATs meant after the words foot of bed flat AAT's (at all times). Further, NA #5 identified the care card did not direct offloading of Resident #25's right heel. Interview and review of the clinical record with LPN #5 on 7/9/24 at 11:25 AM identified a physician's order directing offloading of the right heel and that the NA should know offloading instructions based on the NA care card. However, review of the Resident Care Plan (RCP) and NA care card failed to indicate that Resident #25's right heel was to be off-loaded according to physician orders. LPN #5 further identified the 11:00 PM to 7:00 AM shift was responsible for updating the NA care card and the care cards were frequently not updated. An interview with the DNS on 7/9/24 at 11:35 AM identified the NA care card should be updated by the licensed nurse who notes a new order and Resident #25's care card should have been updated with the right heel offloading order. The DNS stated it was facility policy for staff to follow physician's orders. b. Review of the facility's Weekly Bath Skin Observations identified 2 out of 4 assessments missing in June of 2024. Interview with the DNS on 7/9/24 at 10:40 AM, identified skin checks were to be completed weekly. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility Pressure Injury Prevention and Management Policy included licensed nurses will conduct a full body assessment weekly. 3. Resident #82 was admitted to the facility with diagnoses that included dementia, dysphagia (swallowing difficulty), and osteoporosis. The quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #82 was severely cognitively impaired, required substantial/maximal assistance for bed mobility, was dependent for toileting, and was independent for eating. The Resident Care Plan dated 6/30/24 identified Resident #82 had an Activity of Daily Living (ADL)/mobility status deficit related to dementia and included an intervention to set up and assist as needed with eating. Review of the APRN's orders and progress note dated 7/4/24 directed that Resident #82 required 1-to-1 assistance with eating. During an observation on 7/9/24 at 9:10 AM, Resident #82 was sleeping in bed, with the head of bed elevated to approximately 45 degrees. Resident #82's breakfast tray was noted in front of him/her on the over bed table and was within Resident #82's reach. The meal was noted to be covered. No staff were observed in Resident #82's room or outside the door. Subsequent observations at 9:25 AM, 9:40 AM, 9:55 AM, 10:10 AM, and 10:25 AM were unchanged. At 10:40 AM Resident #82 was up in the wheelchair and the breakfast tray had been removed. During an observation on 7/9/24 at 12:45 PM Resident #82 was seated in his/her wheelchair in the main dining room at a table with 3 other residents. Resident #82 was noted to be independently eating a toasted piece of bread. There were no staff observed in the dining room. Review of the Nurse Aid (NA) care card dated 5/2/24 identified contradictory instruction to assist Resident #82. In one area staff were directed to provide Resident #82 with supervision but in another area, the resident was totally dependent on staff to eat. Review of the NA flow sheets titled Documentation Survey Report identified staff documented Resident #82 was independent for eating (no help or staff oversight at any time) for 87 out of 90 meals in June of 2024 and 27 out of 42 meals in July of 2024. An interview with RN #3 on 7/11/24 at 10:54 AM identified that residents who were dependent with 1-to-1 assistance meant that a staff member must always be present while the resident ate. RN #3 indicated that 1 NA was assigned and required to remain in the dining room while residents were eating due to the risk of choking. Additionally, RN #3 stated Resident #82's meal tray should not have been left within his/her reach on 7/9/24. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with NA #6 on 7/11/24 at 12:45 PM, indicated on 7/9/24 she placed Resident #28's breakfast tray in front of him/her and left because she had 3 other residents who required assistance. NA #6 identified she should not have left the meal within the resident's reach because Resident #82 required supervision with meals but had done so because she thought another NA was going to assist Resident #82 with breakfast. Further, NA #6 also indicated facility policy was to ensure a staff member was present, at all times, in the dining room, during meals to supervise residents while eating and that a staff member should have been present on 7/9/24 when Resident #28 was observed eating his/her bread. An interview with the DNS on 7/11/24 at 1:30 PM identified that a resident who is 1-to-1 dependent or 1-to-1 supervision with meals should not be left alone with a meal tray within reach and that physician orders should be followed for supervision directed during meals. Review of the facility's Assist Level with Feeding policy dated 1/25/24 defined, in part, dependent, as a resident who required total physical assistance to safely eat an entire meal and defined distant supervision as a resident requiring staff to be within eyesight to consume meals and may need intermittent verbal cues/encouragement. 50890

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51102 Based on observation, staff interview, review of the clinical record, and facility policy for 1 of 3 residents (Resident #80) reviewed for pressure ulcers, the facility failed to maintain infection control practices during a dressing change. The findings include: Resident #80's diagnoses included Parkinson's disease, generalized muscle weakness, abnormal posture, and age-related cognitive decline. An Interdisciplinary Transfer document from the hospital (W-10) dated 4/17/24 identified Resident #80 had a stage 2 pressure injury on the coccyx. The admission Minimum Data Set (MDS) assessment dated [DATE] identified Resident #80 was moderately cognitively impaired and required partial/moderate assistance. Additionally, the MDS identified that Resident #80 had an unstageable pressure ulcer. The Resident Care Plan dated 6/28/24 identified Resident #80 had an unstageable pressure ulcer (coccyx) and potential for pressure ulcer development related to a decline in mobility and bowel incontinence. Interventions included to administer treatments as ordered and monitor for effectiveness, follow facility policies/protocols for the prevention/treatment of skin breakdown, inform the resident/family/caregivers of any new area of skin breakdown, monitor nutritional status, serve diet as ordered, monitor intake and record, monitor/document/report PRN any changes in skin status, weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate. The physicians order dated 7/3/24 directed to cleanse the coccyx area with Normal Saline, pat dry, apply Triad to the peri wound, apply Silver Alginate to the wound bed, cover with foam dressing daily and as needed (prn) for excess drainage/dislodgement every evening shift for wound healing. Observations of the treatment to Resident #80's coccyx wound on 7/11/24 at 5:00 PM identified Licensed Practical Nurse (LPN) #4 appropriately donned personal protective equipment indicated for enhanced barrier precautions, removed the soiled dressing which contained a heavy amount of exudate, changed her gloves without the benefit of performing hand hygiene, applied the sterile gauze which already contained the normal saline and then cleaned the wound. LPN #4 then attempted to open the clean foam dressing with the gloved hands that she removed the soiled dressing with. The surveyor intervened to question clean dressing change technique (changing gloves and performing hand hygiene when going from dirty to clean). LPN #4 then applied the foam dressing per physician order. Facility policy for Clean Dressing Technique identified to remove the soiled dressing, remove gloves, wash your hands, and put on clean gloves.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41018 Based on review of the clinical record, facility policy, and interviews for 2 of 6 sampled residents (Resident #23 and Resident #48) who were reviewed for unnecessary medications, the facility failed to ensure timely responses to pharmacy recommendations for the use of psychotropic medications. The findings include: 1. Resident #23's diagnoses included Alzheimer's disease, dementia and received hospice services. A Quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #23 was severely cognitively impaired and required maximal assistance with eating and was totally dependent for toilet use, upper/lower body dressing and personal hygiene. The MDS further identified Resident #23 was on Antidepressant and Opiod medication. The Resident Care Plan identified Resident #23 used antidepressant medication related to depression, and poor appetite with interventions that include administering antidepressant medications as ordered by the physician monitoring/documenting side effects, and effectiveness every shift, educate the resident/family/caregivers about risks, benefits, and the side effects and or toxic symptoms. Additional interventions included to monitor/document/report as needed (PRN) adverse reactions to antidepressant therapy and change in behavior/mood/cognition. Physician orders dated 3/31/24 directed Trazodone (an antidepressant) 25 milligrams (mg) every 8 hours as needed for anxiety and agitation, but failed to identify a stop date. Medication Administration Records (MAR) for as needed (PRN) medications for April 2024 through 7/15/24 identified Trazodone 25 mg every 8 hours as needed for anxiety/restlessness was signed off as being administered on 4/1/24, 4/16/24, 4/18/24, 4/20/24, 4/21/24, 4/22/24, 4/23/24, 4/26/24, 4/29/24 and 4/30/24 (10 times in April 2024). The MAR further identified Resident #23 received PRN Trazodone 25 mg on 5/1/24, 5/4/24, 5/5/24, 5/6/24, 5/7/24, 5/8/24, 5/21/24, 5/23/24, and 5/27/24 (9 times in May 2024) and 6/21/24, 6/25/24 and 6/27/24 (3 times in June 2024). The MAR further identified Resident #23 received PRN Trazodone once (7/5/24) in July 2024. Pharmacy review dated 4/29/24 recommended including a stop date for the PRN psychotropic medication (Trazodone) due to The Centers for Medicare and Medicaid (CMS) guidelines not allowing open-ended orders for PRN psychotropics on medication profiles. Further review identified hospice patients were not excluded from this regulation. Physician orders failed to reflect a stop date, after the pharmacy recommendation dated 4/29/24. A progress note dated 5/30/24 identified another medication review was completed by the pharmacy consultant, although no recommendations for the prescriber were documented on this visit, an interview with Pharmacist #1 on 7/15/24 at 1:15 PM identified that the pharmacist spoke to the DNS verbally on 5/30/24 about the Medication Review (MRR) for Resident #23 not being addressed from 4/29/24 regarding including a stop date for PRN Trazodone. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairview	235 Lestertown Rd Groton, CT 06340

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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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An additional pharmacy recommendation dated 6/27/24 was identified with another recommendation for the prescriber to include a stop date for the PRN psychotropic medication (Trazodone) identifying that hospice patients were not excluded from this regulation. The further review identified on 7/3/24 the Advanced Practice Registered Nurse (APRN) responded to a pharmacy recommendation that was made on 6/27/24 and directed Trazodone 25 mg every 8 hours PRN anxiety/restlessness for 30 days. A progress note dated 6/28/24 identified that the APRN had an encounter with Resident #23 however did address the addition of the stop date for the PRN Trazodone in the note. Further review identified another progress note dated 7/4/24 of an encounter by MD #1 and ordered Trazodone 25 mg orally every eight hours as needed for anxiety with no stop date indicated. An interview with the Director of Nursing Services (DNS) on 7/15/24 at 12:25 PM identified that there was no specific time frame for addressing pharmacy recommendations on their facility policy, she did not have a copy of the pharmacy policy for MRRs, and that she did not remember if the pharmacy policy for MRR included an expected time frame for addressing their recommendations. An interview with Pharmacist #1 on 7/15/24 at 1:15 PM, identified that the expectation for addressing pharmacy recommendations was within 14 days. The interview further identified the 4/29/24 MRR for Resident #23 was not addressed and they spoke verbally to the DNS on 5/30/24 to reiterate the April 2024 recommendation for adding a stop date to the PRN Trazodone. The interview further identified the prescriber had still not addressed the recommendation by the 6/27/24 MRR so a third recommendation was made. The pharmacist was due to return for the July 2024 MRR at the end of the month. Facility policy for Medication Regimen Review (MRR) identified facility staff shall act upon all MRR recommendations according to procedures for addressing MRR irregularities; however, the policy is not specific to the facility staff's responsibility for ensuring the recommendations are brought to the prescriber's attention or the expected timeframe for addressing the pharmacy recommendations. 2. Resident #48's diagnoses included generalized anxiety disorder, depression, and insomnia. The admission baseline Resident Care Plan dated 1/24/24 identified Resident #48 received an anti-anxiety medication related to an anxiety disorder. Interventions included administering anti-anxiety medications as ordered by physician, monitor for side effects and effectiveness every shift, and to monitor the resident for safety. The admission Minimum Data Set assessment dated [DATE] identified Resident #48 was cognitively intact, required setup or clean-up assistance with eating, supervision or touching assistance with personal hygiene, and supervision or touching assistance with chair/bed-to-chair transfers. APRN's orders dated 1/22/24 directed to administer Hydroxyzine (Atarax) 25 milligrams (mg) by mouth every 8 hours as needed for anxiety/insomnia and to administer Trazodone 25 mg by mouth nightly as needed for insomnia/sleep. A pharmacy consultant note dated 1/23/24 at 11:40 AM identified recommendations were made for Resident #48's medication regimen for the prescriber to review. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the pharmacist recommendations dated 1/23/24 included to either provide a stop date for the as needed medications (Atarax and Trazodone) or consider discontinuing the medication(s) (Atarax and Trazodone) per Centers for Medicare and Medicaid Services guidance. The recommendation was not noted to be addressed. Further review of the clinical record identified a second request from the pharmacy consultant dated 3/29/24 (66 days following the initial request) for the prescriber to, again, either provide a stop date for the as needed medications (Atarax and Trazodone) or consider discontinuing the medication(s) (Atarax and Trazodone). Review of the psychiatric APRN orders dated 4/23/24 (91 days after the original request) directed to discontinue the as needed Trazodone and add a stop date to the Atarax medication for 90 days. Review of the Medication Regimen Review policy dated 3/12/2024 directed, in part, the pharmacist shall communicate any irregularities to the facility; written communication to the attending physician, the facility's Medical Director, and the Director of Nursing; and facility staff shall act upon all recommendations according to procedures for addressing medication regimen review irregularities. 51183

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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** 41018 Based on staff interviews, record review, and facility policy for 1 of 5 sampled residents, (Resident #23) who were reviewed for unnecessary medications, the facility failed to include a stop date on an as needed (PRN) psychotropic physician order. The findings include: Resident #23's diagnoses included Alzheimer's disease, dementia and received hospice services. A Quarterly Minimum Data Set (MDS) assessment dated [DATE] identified Resident #23 was severely cognitively impaired and required maximal assistance with eating and was totally dependent for toilet use, upper/lower body dressing and personal hygiene. The MDS further identified Resident #23 was on Antidepressant and Opiod medication. The Resident Care Plan identified Resident #23 used antidepressant medication related to depression, and poor appetite with interventions that include administering antidepressant medications as ordered by the physician monitoring/documenting side effects, and effectiveness every shift, educate the resident/family/caregivers about risks, benefits, and the side effects and or toxic symptoms. Additional interventions included to monitor/document/report as needed (PRN) adverse reactions to antidepressant therapy and change in behavior/mood/cognition. Physician orders dated 3/31/24 directed Trazodone (an antidepressant) 25 milligrams (mg) every 8 hours as needed for anxiety and agitation, but failed to identify a stop date. Medication Administration Records (MAR) for as needed (PRN) medications for April 2024 through 7/15/24 identified Trazodone 25 mg every 8 hours as needed for anxiety/restlessness was signed off as being administered on 4/1/24, 4/16/24, 4/18/24, 4/20/24, 4/21/24, 4/22/24, 4/23/24, 4/26/24, 4/29/24 and 4/30/24 (10 times in April 2024). The MAR further identified Resident #23 received PRN Trazodone 25 mg on 5/1/24, 5/4/24, 5/5/24, 5/6/24, 5/7/24, 5/8/24, 5/21/24, 5/23/24, and 5/27/24 (9 times in May 2024) and 6/21/24, 6/25/24 and 6/27/24 (3 times in June 2024). The MAR further identified Resident #23 received PRN Trazodone once (7/5/24) in July 2024. Pharmacy review dated 4/29/24 recommended including a stop date for the PRN psychotropic medication (Trazodone) due to The Centers for Medicare and Medicaid (CMS) guidelines not allowing open-ended orders for PRN psychotropics on medication profiles. Further review identified hospice patients were not excluded from this regulation. Physician orders failed to reflect a stop date, after the pharmacy recommendation dated 4/29/24. (Refer to F #756). A progress note dated 5/30/24 identified a medication review was completed by the pharmacy consultant; however, no recommendations for the prescriber were documented. An additional pharmacy recommendation dated 6/27/24 was identified with another recommendation for the prescriber to include a stop date for the PRN psychotropic medication (Trazodone) and that hospice patients were not excluded from this regulation. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the record from 7/3/24 identified the Advanced Practice Registered Nurse (APRN) responded to pharmacy recommendations from 6/27/24 and directed Trazodone 25 mg every 8 hours PRN anxiety/restlessness for 30 days. An interview with Pharmacist #1 on 7/15/24 at 1:15 PM, identified that the expectation for addressing pharmacy recommendations was within 14 days. The interview further identified the 4/29/24 MRR for Resident #23 was not addressed and they spoke verbally to the DNS on 5/30/24 to reiterate the April recommendation for adding a stop date to the PRN Trazodone. The interview further identified the prescriber had still not addressed the recommendation by the 6/27/24 MRR so a third recommendation was made. A review of facility policy and an Interview with the DNS on 7/15/24 at 12:15 PM did not identify a policy for including stop dates on psychotropic medications.

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50177 Based on interviews, review of the clinical record, and facility documentation for the only sampled resident (Resident #1) reviewed for dental, the facility failed to follow up regarding dental treatment. The findings include: Resident #1's diagnoses included dysphagia (swallowing difficulty), paraplegia, and osteoporosis. The annual Minimum Data Set assessment dated [DATE] identified Resident #1 was cognitively intact and was independent with eating, required setup or clean up assistance with oral hygiene, and required partial/moderate assistance with personal hygiene. The Resident Care Plan dated 2/6/24 identified Resident #1 had oral/dental health problems related to missing teeth and for denture placement. Interventions included to coordinate arrangements for dental care, transportation as needed/as ordered, and to consult with the dietitian to have the diet order changed if chewing/swallowing problems were noted. A facility agreement with a Dental service provider was effective as of 2/1/24. A Dental Consent and Problem form identified that Resident #1 indicated he/she wanted to discuss an upper denture on 2/14/24. A dental progress note dated 2/29/24 identified Resident #1 reported he/she was in the process of having his/her front teeth fixed and would like to continue treatment. The dentist referred Resident #1 to a community dentist for treatment of root tips #7 and #8. Interview with Resident #1 on 7/8/24 at 11:54 AM identified that he/she was supposed to get an upper denture at the beginning of 2024 and that he/she had scans completed, but the previous dental group left the facility. Resident #1 was seen by the facility's new dental group, (the Dental service provider from 2/1/24), however he/she was unsure what the status was of his/her upper denture. Interview with the Priority Care Supervisor at the Dental service provider on 7/15/24 at 9:45 AM identified that there was no documentation that Resident #1 wanted to receive an upper denture, however Resident #1 would need to have his/her root tips treated before he/she could receive an upper denture. The Priority Care Supervisor indicated that she would make a note of the request for an upper denture in Resident #1's chart. Interview with the Unit Secretary on 7/15/24 at 9:55 AM identified that Resident #1 was seen by a community dentist on 3/22/24, however Resident #1 preferred not to return to that specific dental provider. The Unit Secretary indicated that even though she was aware Resident #1 did not want to return to the community dental provider Resident #1 had been to on 3/22/24, she did not attempt to find an alternate dental provider, or discuss the issue with Social Services (SS) or the Director of Nursing Services (DNS). Additionally, the Unit Secretary identified that it was her responsibility to advise the facility contracted Dental service group of the residents' problems via email and was unable to confirm communication occurred via email regarding Resident #1 wanting to receive an upper denture. (continued on next page)

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the DNS on 7/15/14 at 12:45 PM identified that she was not aware Resident #1 did not want to return to the community dental provider Resident #1 had been to on 3/22/24. Additionally, the DNS indicated that had she been aware, she would have discussed the issue with the interdisciplinary team and SS, and would have searched for a new dental provider after the 3/22/24 dental appointment. Subsequent to surveyor inquiry, the Unit Secretary emailed the facility contracted Dental service provider on 7/15/24 requesting information for additional dental providers. Additionally, the Unit Secretary contacted an alternative dental provider and indicated she would also discuss the need to find a different dental provider with SS.

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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** 50167 Based on the tour of the Dietary Department, staff interviews, and facility documentation, the facility failed to ensure open food items were dated, failed to ensure food was served under sanitary conditions, and failed to ensure correct dishwasher temperatures. The findings included: Tour of the Dietary Department on [DATE] at 10:42 AM with the Assistant Dietary Manager identified the following: 1a. The windowsill, across from the walk-in freezer, was noted to have a heavy accumulation of dirt, dust, and a dead insect was present. b. The window tracking on the window outside of the walk-in refrigerator was noted to have a heavy accumulation of dirt, dust, and dead bugs. c. A brown substance was noted splattered on the door frame in between the kitchen and dish room and on the ceiling tiles in the dish room. d. The fan pointing over the 3 bay sink area was noted with a heavy accumulation of dust. e. The fan over a clean dish rack where clean items were stored (2 ladles, 1 hotel pan, 2 serving spoons, a scooper and a small pan) was noted with a heavy accumulation of dust. f. The inside of a Convection oven on the side of the tray line was noted to have an accumulation of crumbs and a dried splattered substance on the sides and bottom of the oven. g. A 10-gallon bin of flour was noted to have a heavy accumulation of a dried white substance on the lid. h. A 1-gallon jug of molasses stored on a tray with spices was noted to have a brown, sticky substance all over the outside of the container. i. The walk-in freezer was noted to contain an opened 3-pound bag of hash browns (that was ,d+[DATE] full), an opened 2-pound bag of french fries (that was ,d+[DATE] full), an opened 2-pound bag of blueberries (that was ,d+[DATE] full), and an opened 10-pound bag of tilapia fish (that was ,d+[DATE] full) with no open date or expiration date identified. j. The walk- in refrigerator was noted to contain an opened 5-pound bag of mozzarella cheese (that was , d+[DATE] full) with no open date or expiration date. k. On [DATE] at 12:39 PM observation of the dry storage room with the Assistant Dietary Manager identified an opened 10-pound bag of macaroni noodles (that was ,d+[DATE] full), an opened bag of nuts (that was , d+[DATE] full) and an opened ,d+[DATE] bag of coconut flakes with no open date or expiration date. (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 Assistant Dietary Manager at that time identified that the staff member who opened the food items should have labeled the food item with a date when opened, as well as when items should have been discarded or expired. She also identified that it was her responsibility to do spot checks in the freezer, refrigerator, and dry storage room to ensure open items were dated and labeled correctly at least weekly but must have overlooked the non-dated items. Review of the Date Marking for Food Safety policy dated [DATE] directed, in part, that food should be clearly marked to indicate the date or day by which the food shall be consumed or discarded. The individual opening or preparing a food should be responsible for the date marking the food at the time the food is opened or prepared. The marking system should consist of a label, the day/date of opening, and the day/date the item must be consumed or discarded. The discard day or date may not exceed the manufacturer's use-by date, or four days, whichever is earliest. The date of opening or preparation counts as day 1. The Dietary Manager, or designee, should spot check refrigerators weekly for compliance, and document accordingly. Additionally, the Assistant Dietary Manager identified there was a cleaning schedule for cleaning equipment and areas of the Dietary department, she was responsible for ensuring areas were clean and did not identify the soiled areas. 2a. On [DATE] at 12:17 PM dishwasher temperature logs were reviewed with the Assistant Dietary Manager for [DATE], [DATE], [DATE] and [DATE], which identified the wash and rinse temperatures were low. On [DATE], [DATE], [DATE], and [DATE] the rinse temperatures were recorded at 160 degrees Fahrenheit, (should be 180 degrees Fahrenheit or above but not exceed 194 degrees Fahrenheit, per manufactures guidelines). On [DATE], [DATE], and [DATE] the wash temperatures were recorded at 140 degrees Fahrenheit, (should be 150 to 165 degrees Fahrenheit, per manufactures guidelines). The temperature logs failed to reflect any follow up regarding the low temperatures. Interview with the Assistant Dietary Manager at that time identified the temperatures were taken by Dietary Aide (DA) #1 for the dishwasher, which were inaccurate because he must have been reading the wrong dial on the dishwasher, however, DA #1 did not report obtaining low temperatures, so the reason for low temperatures could be identified. She identified that she noticed the incorrect temperature readings in the logs on [DATE] and notified the dishwasher company at that time to come out and assess the dishwasher. Additionally, she identified DA #1 should have reported obtaining low temperatures at the time he took them. Subsequent to surveyor inquiry of low dishwashing temperatures, Dietary staff were in-serviced on how to take dishwashing temperatures and the dials on the machine have been labeled according to the in-service instructions. On [DATE] at 1:06 PM interview with DA #1 identified that he documented the dishwashing temperatures on [DATE], [DATE], [DATE] and [DATE] and he was unsure of which gauge to look at to record the temperatures for the wash and rinse cycle. He stated that he was not aware of what the correct temperatures should be and that was the reason he did not notify the Assistant Dietary Manager of the low readings. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2b. On [DATE] at 9:55 AM observation with the Assistant Dietary Manager identified a plastic tray of metal cutlery being put through the dishwasher by DA #2. The wash temperature was 126 degrees Fahrenheit (normal temperature should be 150 to 165 degrees Fahrenheit) and the rinse temperature reading was 160 degrees Fahrenheit (normal temperature should be 180 to 194 degrees Fahrenheit) DA #2 did not note the low temperatures during or after the tray of utensils passed through the dishwasher and proceeded to load a plastic tray with lid covers through the machine even after a low wash cycle reading. Interview on [DATE] at 10:00 AM with the Assistant Dietary Manager identified that the wash and rinse temperatures were low and DA #2 should have checked the temperatures at the start of the dishwashing process and documented on the log. She identified that DA #2 should have been checking the temperatures throughout the process of running the machine and should have stopped the dishwashing and notified her of the low temperature, and she would have contacted the dishwasher company. She stated that they would put the cutlery through the sanitizing solution. Interview on [DATE] at 10:04 AM with DA #2 identified that he saw the temperatures were reading low and that he was going to tell the Assistant Dietary Manager later, but continued to pass items through the dishwasher. Review of the Dishwasher Temperature Policy identified the correct wash temperature should be ,d+[DATE] degrees Fahrenheit and the final rinse temperature should be 180 degrees Fahrenheit. Policy identified if the dishwasher is not working properly to notify the cook, supervisor, and the maintenance department. Corrective action for temperatures below the final rinse temperature (180 degree F) All dishes after being washed through the dishwasher will be submerged in premeasured sanitizer for greater than 30 seconds and racked to air dry. Corrective action taken for dishwasher being out of service would be All dishes would be scraped, washed, rinsed, and sanitized (submerged in premeasured sanitizer for greater than 30 seconds and racked to air dry) in a three-compartment sink. Another Corrective action for dishwasher being out of service would be to serve meals on all paper products until dishwasher is operational.

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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 0921 Level of Harm - Potential for minimal harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48950 Based on observations and interviews for 3 of 6 shower rooms, the facility failed to provide a homelike, sanitary, and safe environment. The findings include: Observation during the initial facility tour of the facility on 7/8/24 at 10:30 AM of the Coastguard Way Shower Room A second floor identified the following: a. A tub container of 150 bleach wipes, left open b. Chipped tile on the corners of the walls c. Chipped paint on the walls and ceiling d. Two broken blinds were noted to be leaning against the wall behind the tub e. A walker was left on a piece of shower equipment f. A commode was stored behind the tub Observation during the initial facility tour on 7/1/24 at 10:35AM of the [NAME] River Shower Room B on the second floor identified the following: a. A foot cradle was noted to be left on the floor b. A basin was left on the sink and an empty coat hanger was left on the sink c. The toilet was soiled with brown stains on the rim and along the outside of the bowl Observation on 7/1/24 at 10:40AM on [NAME] Walk Shower Room C second floor identified the following: a. Broken trim was hanging along the doorway into the shower b. A drain cover measuring 2 1/8-inch circumference was not secured to the floor c. [NAME] substances were noted along the floor in the corners Interview with LPN #2 on 7/8/24 at 11:30 AM identified that the equipment found in the shower rooms was not to be stored in them and that it was a hazard having the blinds left on the floor, equipment left in shower room, bleach wipes left open and unattended, basins left, trim coming loose from the wall, broken tile, and drain cover not being secure to the floor. LPN#2 identified that the shower rooms were not clean and that every staff member was responsible for keeping the shower rooms clean and safe. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	075288	A. Building B. Wing	07/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairview	235 Lestertown Rd Groton, CT 06340

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 0921 Level of Harm - Potential for minimal harm Residents Affected - Some	Interview with NA #2 on 7/9/24 at 11:40 AM identified that she bathed a resident in Shower Room A on the second floor on 7/8/24 and noticed the blinds leaning against the wall. Interview with the Director of Maintenance (DM) on 7/9/24 at 11:45 AM identified that the drain cover in Shower Room C on the second floor was not secured to the floor and measured 2 1/8-inch. He was unsure of how long it had not been secured to the floor. He was not aware that the tile was broken in Shower Room A on the second floor. The DM identified that when something needed to be repaired that there was a ticket station at the nursing station and the staff was trained on what to report. The DM identified that he does environmental rounds monthly but by the time he circulates the whole building it can take up to 3 months and the rounds do not include common areas.